# REPORT OF NATIONAL WORKING GROUP MEETING ON PROVIDER PAYMENT MECHANISMS AND RATES UNDER THE NHIS HELD IN THE MAJORIE Y HOTEL TEMA FROM 26TH TO 27TH SEPTEMBER 2006

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## List of Abbreviations

| | |
|---|---|
| BAR | Brong Ahafo Region |
| CHAG | Christian Health Association of Ghana |
| DG | Director General |
| ER | Eastern Region |
| GAR | Greater Accra Region |
| GHS | Ghana Health Service |
| GNDP | Ghana National Drugs Program |
| GNEMHO | Ghana Network of Mutual Health Organizations |
| GNOST | GHS NHIS Oversight and Support Technical team |
| MOH | Ministry of Health |
| NHIC | National Health Insurance Council |
| NHIS | National Health Insurance Scheme |
| PPME | Policy Planning Monitoring and Evaluation |
| PSGH | Pharmaceutical Society of Ghana |
| RHA | Regional Health Administration |
| RHD | Regional Health Directorate |
| UER | Upper East Region |
| WR | Western Region |

# 1. Objectives /Agenda

1. To arrive at consensus on standard itemized fee for service schedules for the different types of provider agencies contracting with schemes under the NHIS that will be used for billing for the rest of 2006 through to 2007. All providers under the MOH are involved vis:
    a. Public sector (GHS)
    b. Public sector (Teaching hospitals)
    c. Quasi government sector
        i. Military hospital
        ii. Police hospital
        iii. University hospitals
        iv. Others e.g. Cocoa clinic etc
    d. Private mission sector (CHAG)
    e. Private self financing sector

2. To agree on mechanisms for regular review and updating of the standardized itemized fee schedules

3. To discuss progress on work on alternative provider payment mechanism and way forward

4. To discuss other issues affecting effective provider engagement in the NHIS
    a. Contractual agreements with schemes
    b. Facility attendance card and claims processing forms and procedures
    c. Administrative claims processing costs
    d. Working relationships with schemes and NHIS
    e. Dispute arbitration mechanisms
    f. How soon can we expect the unified national essential drug list
    g. Any others

## 2. Participants and institutions represented

| NAME | RANK | INSTITUTION |
|---|---|---|
| Mr. B. C. K. Botwe | Hosp. administrator | Wenchi Methodist hospital |
| Mr. A. Ofori Mensah | Administrator | (AMC) CHAG |
| Mr. Dan Osei | Deputy director | GHS |
| Dr. Joe Bonney | Deputy director | GHS |
| Dr. Cynthia Bannerman | Deputy director | GHS |
| Mr. Richard Basedi | Research officer | GHS, RHA, WA |
| Mr. Philibert Kankye | Exec. director | CHAG |
| Dr. Andreas Grueb | Nat. Admin. | GNEMHO |
| Mr. J. Owusu-Agyemang | Deputy director (pharm) | GHS, RHD, GAR |
| Col. (Dr.) F. Kwashie | Director | GHQ (MED) |
| Mrs. Doris Attafua | Chairperson | Com. practice pharmacy assistant |
| Mrs. Marion Fati Wash | NHIS coordinator | GHS, Bolga UER |
| Mr. G. K. Kyeremeh | NHIS coordinator | GHS, E/R |
| Mr. Akodam K. Karbo | GHS, B/A,DDPS | GHS, B/A |
| Mr. Philip Akanzinge | Reg. NHIS coordinator | B/A |
| Dr. Caroline Jehu-Appiah | Deputy Director PPME | GHS, Accra |
| Mr. James Ohemeng Kyei | DDPS | GHS – W/R |
| Mr. F. G. Dakpallah | HD, PPME | MOH |
| Robert Adatsi | SNR. PHARM. | GHS |
| Mr. Harry Taviah | Reg. NHIS Coordinator | GHS |
| Mr. Benjamin Abrokwah | CO-ORD. NHIS | Korle-Bu |
| Mr. J. E. K. Pratt | President | GNEMHO |
| Mr. Richard K. Gybillah | Administrator | Police Hospital |
| Nana Afrakoma Ashia | Pharmacist | Ghana National Drugs Program |
| Dr. K. A. Odum | Specialist | RHD, Cape Coast |
| Mr. P. C. Adjei | Deputy director | |
| Dr. Nii Ayite Coleman | Specialist | MOH |
| Mr. C. Essilfie | Observer | IBS |
| Mr. E. H. Gaisey | Administrator | Legon hospital |
| Mr. Frank Boateng | President | PSGH |
| Mr. Isaac Mensah Addo | HIS | 37 military hospital |
| Mr. Sam K. Boateng | Accountant/NHIS | MOH/HQ |
| Mr. Ayugane Theophilus | NHIS coordinator | GHS, N/R |
| Dr. Irene A. Agyepong | RDHS - GAR | RHD |
| Mrs. Cecilia Opong-Peprah | NHIS coordinator | RHD, GAR |
| Dr. Eddie Addae | Director, | PPME MOH, Accra |

# 3. Summary of Key Issues /Recommendations for action

1. There were great difficulties in standardization of rates to be used for billing of services under itemized fee for service because accurate data on the true costs of services provided by the different provider agencies was not available. The current rates are mainly based on historical rates and estimation of cost. It is recommended as a matter of urgency that:
    a. Work is jointly commissioned by MOH, NHIC, GHS, CHAG, Quasi government and Tertiary health institutions from now to December 2006 to obtain objective information that can assist the development of a more evidence based standardization of rates under itemized fee for service. Funding ideally should be by the NHIC or MOH or both
    b. In the specialized areas i.e. Eye, Dental, ENT, General and Specialized surgical procedures, professionals who work in these areas should be involved to provide advice

2. Given the need to minimize the current confusion around billing and paying for services provided to clients under the NHIS, the meeting has come up with suggestions /recommendations on standard rates to be used for billing from October to December 2006 /January 2007 to provide a breathing space while more work is done to fine tune the rates.

3. We recommend that work to monitor implementation and its effects on providers and schemes be commenced from October 2006

4. A meeting needs to be convened to table the results of the work to improve the information base /evidence for standard fees and review the draft /interim rates suggested at this meeting by December 2006 /January 2007

5. Representatives from the private pharmaceutical sector were present at the meeting and have made inputs into the recommended standard rates for pricing of medicines (EDL, Generic)

6. Unfortunately though invited, there was no representation from the private self financing sector to make inputs into what would be reasonable reimbursement rates for services (non medicines) in the private self financing sector.

7. The NHIS cannot operate effectively without service provision by the private self financing sector. Already the work load on GHS and CHAG institutions is steadily increasing and creating tensions in provider/ client relationships because of work overload. We recommend that the MOH NHIS desk should work on organizing and coordinating the private self financing sector to come up with appropriate means of effectively engaging them in the NHIS – including contractual arrangements for billing etc

8. In the medium term there is a need for a radical shift in the way budgets are allocated for clinical care service provision by the MOH so that money follows clients rather than infrastructure. We recommend that the director PPME MOH

sets up a technical task team to deliberate on this issue and come up with suggestions and alternatives. If needed research should be commissioned to support decision making

9. The regional NHIS coordination units/secretariats are critical to the success of the NHIS. They are inadequately funded and supported. This year for example none of the regions has received any funds to support regional coordination. In previous years, GHS funded these units but is currently under severe financial constraints and cannot do so. We recommend that the MOH/NHIC should budget for these units and support them to coordinate NHIS implementation in the regions.

10. Coordination of work on provider issues under the NHIS to date has been done though the GNOST. An expanded GNOST with representation from all key stakeholders including the NHIC secretariat should continue the work as discussed at the inter-stakeholders forum in the MOH conference room in July 2006. The issues of effective provider engagement in the NHIS affect the health sector as a whole.

11. There was no representation from the secretariat of the NHIC. The meeting was informed that they did not receive the invitation even though it was supposed to have been delivered. We wish to appeal to the NHIC and its secretariat to take a greater interest in dialogue, consensus building and decision making with providers.

12. Work started by GNOST to explore the feasibility and impact of alternative provider payment mechanisms such as case based payments and capitation must continue to provide alternatives for the medium term.

13. As an important follow on, a smaller group from this meeting needs to meet the NHIC, and provide an adequate brief to enable them adopt this document as the basis for further work to move provider engagement forward.

14. The MOH, GHS and CHAG were represented as were Military, Police the University hospital (Legon) and Korle-Bu. However the Minister for health and the provider agency directors i.e. DG GHS etc also need to be briefed on the outcome of this working group meeting to enable the needed policy decisions to be taken

# 4. Report of proceedings

## *4.1 Day 1: Tuesday 26th September 2006*

The meeting opened at 9:15 a.m. with an opening prayer by Dr. Cynthia Bannerman. Mr. George Dakpallah apologized on behalf of the Minister of Health for his inability to attend. He had just returned from a trip the previous day. He then opened the meeting on behalf of the Minister of health and summarized the purpose of the meeting as detailed in (3) above. He emphasized the importance of agreeing on standardized rates to be used for billing of services under itemized fee for service fee system to replace the somewhat haphazard billing system under itemized fee for service that we now have. He gave examples of arbitrary items introduced at anybody's whim such as charges to clients for reporting late to the facility; charges for retrieving of patients folders etc.

A series of presentations were then made to provide a background to the meeting as summarized in the table below. Mr. Philip Akanzinge chaired the presentation session. The presentation slides are attached in appendix 1

| | *Topic* | *Presenter* |
|---|---|---|
| **1** | Provider payment mechanisms options, pros and cons | Dr. Irene Agyepong |
| **2** | Conclusions from summary data on costs under NHIS and fee for service from the ER and BA | Dr. C. Jehu-Appiah |
| **3** | Presentation of results of costing study | Mr. Dan Osei PPME |
| **4** | Factors affecting enrolment in the NHIS: A study from the Ho municipality | Mr. Robert Adatsi |

In the discussion that followed, concerns were raised by participants about the absence of representation from the Secretariat of National Health Insurance Council. The only person present from the NHIC was Mr. Pratt, a member of the council. He was also present in his capacity as president of the Network of Mutual Health Organizations. It was explained by the organizers that just as was done with the Director General for the Ghana Health Service and the Minister for Health, the proposal for the current meeting was discussed with the Executive Secretary of the National Health Insurance council and endorsed by him. There was no question of the secretariat of the National Health Insurance council having been deliberately left out. A copy of the invitations for the meeting that was signed by the Deputy Minister for Health was also delivered to the NHIC secretariat. A phone call to the NHIC secretariat revealed that there had apparently been some sort of mix up and the invitation letter had not been received. All key members of the secretariat were otherwise engaged and it was not possible for anyone to attend the meeting.

Mr. Philip Akanzinge and Dr. Irene Agyepong provided an introduction to the group work on standardization of itemized fee for service schedules categories and rates for

2006/2007. The draft categories and rates for medicines and services that come out of the earlier work by GNOST was used as a template for discussion by the groups. After some discussion on the composition of the groups, four groups were set based on expertise in the issues at stake and common platforms as follows:

GROUP ONE – MEDICINES GROUP

- Private/community pharmacists
- Chief pharmacist (GHS /HQ)
- Pharmacists /Deputy directors of Pharmaceutical services from the regions – GHS
- Representative – CHAG
- Representative – Quasi-government institutions

GROUP TWO – SERVICES GROUP

- GHS NHIS coordinators from the regions
- MOH Coordinator NHIS
- Director PPME MOH
- CHAG representatives
- Representative of GNEMHO

GROUP THREE – QUASI GOVERNMENT

- Military hospital
- Police hospital

GROUP FOUR – TERTIARY REFERRAL HOSPITALS
- Military hospital
- Korle-Bu Teaching hospital

The rest of the day was spent in group work with the meeting closing at 6.00pm.

## *4.2 Day 2: Wednesday 27th September 2006*

Work in the groups continued all through the morning up to lunchtime. After lunch, the groups presented their work in a plenary session. Dr. Cynthia Bannerman chaired the session. Key presentation and discussion points in the plenary session are as summarized below.

### Group One – Medicines

The group summarized the key points of their approach to standardizing the price of medicines as follows:
- All prices from the different medicine outlets i.e. public and private were compared. These included GHS lists, MOH lists, GNDP, NHIC and the private retail medicines lists. The median for the retail prices was used. In all the group ended up listing five hundred and six items.

- Slow moving drugs were priced at a somewhat higher margin than the retail price to cater for losses due to expiring.
- The group agreed that prices of medicines have been stable for sometime now and therefore upward adjustment should not be too steep or not allowed at all.
- Medicines with wide unexplained price differentials were listed for further consideration. This requires further survey to find a reasonable median price.
- Subsidized drugs under special programs (e.g. artesunate amodiaquine provided by the Global fund) were priced with the open market prices because of the need to provide a realistic idea of the true cost of the drug to sustain the supply of the drugs when the special program ends. Where a subsidized medicine is not available in the system for whatever reason, institutions are compelled to purchase the medicine at the open market price.
- They also agreed to delete some of the program drugs from the list such as psychotic drugs.
- They again agreed that all the schemes should have pharmacists to assist in drug related issues.
- Pre-packed medicines should be encouraged to avoid contamination.
- For some items the prices were not available. The group reviewed about ninety five percent of all the price lists made available to them.

Discussions
The slow moving drugs were identified as B-complex, Folic Acid and Chloropheniramine. These drugs though slow moving cannot be removed from the list because the patients' still needs them. One tablet of Folic Acid costs about two cedis and a one-month course (thirty days) will cost about sixty cedis. However the envelope used to wrap the drug alone costs about four hundred cedis. Normally the envelope is not charged for separately. It is covered by the low mark up on the drug. Thus in deciding to make one tablet a hundred and fifty cedis it is still not too high since the mark up can pay for the envelope.

In spite of the explanation of the reason for determining the true cost of subsidized program drugs, some members of the larger group felt that the program drugs should be taken off the list because they were heavily subsidized or given out free to the patients. Some of them such as the TB drugs are not normally found on the open market and they are given out for free to the patients. If they are listed here some people may decide to charge for them, which shouldn't be.

However after discussion, it was agreed that it was necessary to have a subsidiary list where some program drugs such as Artesunate Amodiaquine or the combination drugs could be listed by the true market cost. Artesunate Amodiaquine is sold for three thousand at he medical stores but they have run out of stock now, so if it will continue to be subsidized then the malaria control program should ensure its regular supply.
A member of the house questioned whether subsidies for certain drugs such as anti snake venom serum should be continued. When there is shortage at the medical stores they go to the open market for it. Again when the private practitioners are in trouble they purchase it from the open market. The response was that the policy on providing antisnake serum free is backed by legislation as is the policy on antirabies vaccine.

In answer to a question concerning which medicine brands were used for the medicine pricing and the guarantee of their quality, it was stated that generic medicine prices

were used. However given that there are different brands of generic drugs on the market, considerations were also given to the quality of the brands and not just the price. It is essential that medicines are of as good quality as the original patented ones as well as affordable to the people.

The quality of every drug in the system is supposed to be ensured by the Foods and Drugs Board (FDB). The group admitted that in their estimates they put into consideration the fact that some inferior generic drugs bypass the FDB. The scheme or the MOH should go for the drugs of assured quality with the lower price as a matter of policy. At the same time it should be possible to say that these are the list of medicines be used when available and provide alternatives to be used when they are not available. It should also be possible for practitioners to honestly say that they are changing to another source when the recommended drugs are not available in the system for one reason or the other.

There was also a consensus that there is a need to allay the public fear that NHI card bearing clients are getting cheap and inferior drugs because the NHIS pays for generic rather than brand name drugs. If this fear is not allayed it will eventually break down public confidence in the scheme.

Some of the issues discussed were related to medicines procurement. Questions were also raised about how to ensure that the locally manufactured drugs are going to be used.

## Group Two – Services GHS / CHAG

The group acknowledged that the basic prices upon which they deliberated were historical. However empirical evidence on real economic costs are still being worked out. In the interim, there must be a uniform standard to minimize disputes and exploitation whether of schemes or of providers. They therefore agreed to work with what was available as an interim measure. CHAG said they had decided to work with GHS and have a uniform standard but with some adjustments to take care of the fact that they do not receive most of the government subsidies that GHS receives. They also endorsed the principle of a grading of prices as clients move up the referral system. This would take care of the increasing complexity of care, and also provide an incentive for the NHIS to strengthen the gatekeeper system and primary care service access in health centers and polyclinics rather than hospitals as a first choice for OPD care. Dr. Amenuveve, the surgeon at Tema General hospital, as well as an obstetrician were invited to briefly advice the group on the pricing of surgical procedures.

It was agreed to simplify the classification of operative procedures for billing purposes into Minor, Medium and Major Operations and others. The detailed itemization procedure by procedure is not necessary and simply introduces further administrative complexity with its time costs. Surgeons are already familiar with classifying surgery this way and factor in the time the surgery takes as well as the specialized skills required. A supplementary detailed guide to classifying surgery based on these bands can be provided to guide surgeons where there is doubt. There would therefore be 3

main fee bands based on the classification and then individual fees for the few minor procedures classified under others.

Where General Anesthesia is used for the operation, it was recommended that 30% of the surgical fee (minor, medium or major) be charged for anesthesia.

The group discussed extensive the need to maintain a balance between whether or not the Insurance Council will be able to pay the bill and realistic reimbursement rates that would not collapse providers or reduce the quality of their services. In looking at the pricing of services it was necessary to consider what was needed in other to provide adequate quality services.

There was an extensive debate about whether to build administrative and processing charges into other fees, or whether they should be clearly separated out. It was decided to put together Administration, Processing and Documentation. This would cover every cost involved in processing patient claims including data entry, referral forms etc. It was agreed that data processing procedures are similar at all levels and a flat rate should be fixed for this service at all facilities be it HC/ CHIPS/SC (no Doctor), Polyclinic, HC (with Doctor) and Regional Hospitals.

It was clear that the major difference between CHAG facilities and GHS facilities was the fact that CHAG receives no government subsidy for maintenance and payment of utilities fees. Also not all CHAG staff are seconded by government. Some are paid directly by CHAG. The group therefore also agreed that utility, maintenance and infrastructure development should be charged at a flat rate of C 10,000 per client for all categories of CHAG facilities. Otherwise all rates used for CHAG facilities are to be the same as rates used for GHS facilities. There was extensive debate as to whether ten thousand cedis charge on utilities at the HC/CHIPS/SC (with no Doctor) is too high. In the absence of conclusive data however, it was also noted that it could prove to be too low. It was therefore agreed to let it stand for now but to closely monitor and gather more information on economic costs. This fee could then be subjected to review along with all the other fees suggested. It was also emphasized that only institutions whose utilities are not paid for by GOG should charge clients for utilities and maintenance.

Scenarios were worked out as to how much it would cost a patient to walk in and walk out of a primary care health facility for OPD care. The scenarios is attached as table 1 for the most common condition at outpatients (malaria) for the different categories of facility.

The scenario was also compared with the data from Dr. Aikens review of costs in Brong Ahafo and Eastern region in the last quarter of 2005, Mr. Philip Akanzinge's data for the first half of 2006 and Mr. Dan Osei's costing data. It was agreed that from the comparisons, the current fee schedules look reasonable for implementation as an interim measure while the work on costing continues.

Table 1 – Scenarios for the cost of outpatient malaria treatment at different levels under the rates developed for GHS and CHAG

| **Health Center/CHPS/SC - No doctor** | | | | | | | |
|---|---|---|---|---|---|---|---|
| | GHS | | | | CHAG | | |
| | 1st visit - Adult/Child | Follow up (same episode) | Subsequent visits (new) | | 1st visit - Adult/Child) | Follow-up (same episode) | Subsequent visits (new) |
| Consultation fee (inclusive of administration) | 11,000.00 | 5,500.00 | 11,000.00 | | 11,000.00 | 5,500.00 | 11,000.00 |
| Patient folder | 12,500.00 | - | - | | 12,500.00 | - | - |
| Utilities & Maintenance | - | - | - | | 10,000.00 | 10,000.00 | 10,000.00 |
| Drugs (Antimalaria) | 30,000.00 | | 30,000.00 | | 30,000.00 | | 30,000.00 |
| Antipyretic (Paracetamol) | 3,000.00 | | 3,000.00 | | 3,000.00 | | 3,000.00 |
| Laboratory (B/F & Hb) | 10,000.00 | | 10,000.00 | | 10,000.00 | | 10,000.00 |
| TOTAL (Max) | 66,500.00 | 5,500.00 | 54,000.00 | | 76,500.00 | 15,500.00 | 64,000.00 |
| | | | | | | | |
| Total if patient not sent to lab and malaria control program drugs available | 29,500.00 | | 7,000.00 | | 29,500.00 | | 17,000.00 |
| Total if patient not sent to lab and malaria control program drugs not available | 56,500.00 | 5,500.00 | 44,000.00 | | 66,500.00 | 15,500.00 | 54,000.00 |
| | | | | | | | |
| **Polyclinic, HC with doctor, District hospital** | | | | | | | |
| | GHS | | | | CHAG | | |
| | 1st visit - Adult/Child | Follow up (same episode) | Subsequent visits (new) | | 1st visit - Adult/Child) | Follow-up (same episode) | Subsequent visits (new) |
| Consultation fee (inclusive of administration) | 20,000.00 | 10,000.00 | 20,000.00 | | 20,000.00 | 10,000.00 | 20,000.00 |
| Patient folder | 12,500.00 | - | - | | 12,500.00 | - | - |
| Utilities | - | - | - | | 10,000.00 | 10,000.00 | 10,000.00 |
| Drugs (Antimalaria) | 30,000.00 | | 30,000.00 | | 30,000.00 | | 30,000.00 |
| Antipyretic | 3,000.00 | | 3,000.00 | | 3,000.00 | | 3,000.00 |
| Laboratory (B/F & Hb) | 20,000.00 | | 20,000.00 | | 20,000.00 | | 20,000.00 |
| TOTAL (Max) | 85,500.00 | 10,000.00 | 73,000.00 | | 95,500.00 | 20,000.00 | 83,000.00 |
| | | | | | | | |
| Total if patient not sent to lab and malaria control program drugs available | 38,500.00 | | 26,000.00 | | 48,500.00 | | 36,000.00 |
| | | | | | | | |

## Group Three – Quasi government institutions

This group comprised of University of Ghana Hospital and Police Hospital. Police Hospital charges were higher than University Hospital. They agreed to strike averages of these two institutions. Their charges were generally higher across board than the GHS/CHAG prices. For instance adult normal consultation the Police Hospital was currently charging hundred thousand cedis whilst the University Hospital was charging forty thousand cedis. They felt it should be possible to come down to thirty thousand cedis.

The group did not make their rates available at the end of the meeting. They agreed that they needed to brief their hierarchy and clear any decisions with them. It is recommended that the MOH and NHIC needs to follow up on this issue of contracting with quasi-government institutions and what rates would be reasonable. It is also recommended that there are included in future data collection to improve evidence for setting of fee schedules.

Both hospitals also explained that they do not have adequate staff and contract with specialist doctors from Korle-Bu and elsewhere to assist them. Thus for example since most of the specialist surgeons come from Korle Bu to perform every afternoon; they take fifty percent of the charges. Where their own Doctors also perform operations their charges are far lower than locum doctors from Korle Bu. These must be factored into any request for fee reductions. The University hospital made similar comments.

It was noted that further work was needed since if the prices quoted here are higher than that of the private hospitals who receives no subsidies then there is something wrong with the pricing. There will be more confusion if this price is left to stand and we cannot justify it.

## Group Four – Tertiary institutions: (Korle-Bu, 37 military hospitals).

Like the Police hospital and University hospital group, this group could not leave any clear price suggestions for inclusion in the report. They both needed to go back and get clearance from their organizational hierarchy in any decision concerning pricing of services. Again it is recommended that the MOH and NHIC need to follow up with this group on price standardization. Komfo Anokye was not represented because the organizers decided to let the closest teaching hospital stand in for them.

The group stated that agreed to go back to the working table on Tuesday 3rd Oct. 2006 to work out the final charges for services.

Discussions

The VIP services are not covered under the scheme and therefore none of the groups gave close attention to the charges for these facilities.

# Appendix 1 – Suggested Medicines Standard Price list

| No. | Generic Name, Dosage Form and Strength | Unit of pricing | Proposed Prices |
|---|---|---|---|
| 1 | Acetazolamide Inj, 500mg | Vial | 505,000 |
| 2 | Acetazolamide Tablet, 250mg | Tab | 600 |
| 3 | Acetyl Salicylic Acid Tablet, 300mg | Tab | 50 |
| | Acetylsalicylic acid 300 | tab | 210 |
| 4 | Acetyl Salicylic Acid Tablet, 75mg | Tab | 200 |
| 5 | Acetylcysteine Inj 200mg/ml | 1ml | 40,000 |
| 6 | Acyclovir Eye Ointment 3% | 5G | 37,000 |
| 7 | Acyclovir Cream, 5% | 15G | 72,000 |
| 8 | Acyclovir Inj 250mg vial | Vial | 102,000 |
| 9 | Acyclovir Inj ,25mg/ml | 1ml | 80,000 |
| 10 | Acyclovir Tablet 200mg | Tab | 7,500 |
| 11 | Activated Charcoal Tablet,200mg | 200mg | 1,500 |
| 12 | Adrenaline Eye drops,1% | 5ml | 25,000 |
| 13 | Adrenaline inj,1mg/ml (1;1000) | 1ml | 2,800 |
| 14 | Albendazole Syrup,100mg/5ml | 20ml | 7,000 |
| 15 | Albendazole Tab, 200mg | Tab | 3,500 |
| | Ammonia and ipecacuana miture | 200ml | 10,000 |
| | Amlodipine 10mg | Tab | 3,500 |
| | Amlodipine 5mg | Tab | 2,500 |
| 16 | Allopurinol Tab.100mg | Tab | 600 |
| 17 | Allopurinol Tab,300mg | Tab | 1,800 |
| 18 | Aluminium Hydroxide Mixture | ml | 60 |
| 19 | Aluminium Hydroxide Tab 500mg | Tab | 100 |
| 20 | Amino Acid Solution Inj. (10% or 20% | 1ml | 4,500 |
| 21 | Aminophyline Inj,250mg/10ml | 10ml | 7,500 |
| 22 | Amiodarone Tab,200mg | Tab | 4,100 |
| | Atrovastatin 20mg | Tab | 15,850 |
| | Atrovastatin 10mg | Tab | 11,760 |
| 23 | Amitriptyline Tab,25mg | Tab | 300 |
| 24 | Amitriptyline Tab, 50mg | Tab | 200 |
| 25 | Amitriptyline Tab ,10mg | Tab | 250 |
| 26 | Amodiaquin Syrup,50mg/ml | 60ml | 6,000 |
| 27 | Amodiaquin Tab,150mg | Tab | 400 |
| 28 | Amodiaquin Tab 200mg | Tab | 500 |
| 29 | Amodiaquin Tab 75mg | Tab | |
| 30 | Amoxicillin+ Clavulanic acid Inj, 500mg+100mg | Vial | 60,000 |
| 31 | Amoxicillin+ Clavulanic acid Susp, 250mg+62mg | 100ml | 91,000 |
| 32 | Amoxicillin +Clavulanic acid Susp,400mg+57mg | 100ml | 75,000 |
| 33 | Amoxicillin+ Clavulanic Acid Tab,500mg+125mg | Tab | 6,000 |
| 34 | Amoxicillin Cap, 250mg | Cap/tab | 250 |
| 36 | Amoxicillin Susp,125mg/5ml | 100ml | 6,000 |
| 37 | Ampicillin Inj,500mg | Vial | 1,750 |
| 38 | Anastrozole Tab,1mg | Tab | 118,174 |
| 39 | Anti D Rh Immune Globulin Inj (1ml) | ml | 750,000 |
| 40 | Antirabies Immunoglobulins Inj, 1000IU/5ml (100IU/ml) | 5ml | 6,209,599 |
| 41 | Antirabiques Immunoglobulines Inj, 150IU/ml, 2ml | 2ml | 4,068,200 |
| 42 | Anti-Snake Venom, Polyvalent Inj | Vial | 460,000 |

| No. | Generic Name, Dosage Form and Strength | Unit of pricing | Proposed Prices |
|---|---|---|---|
| 43 | Aqueous Cream BP | 500G | 45,000 |
| 44 | Artesunate Suppository,50mg | Supp | 6,660 |
| 45 | Artesunate Tabs,100mg | Tab | 6,100 |
| 46 | Artesunate Tabs,200mg | Tab | 7,500 |
| 47 | Artesunate Tabs,25mg | Tab | |
| 48 | Artesunate Tabs,50mg | Tab | 3,500 |
| 49 | Atenolol Tabs, 100mg | Tab | 500 |
| 50 | Atenolol Tabs, 50mg | Tab | 470 |
| 51 | Atracurium Inj, 10mg/ml in 2.5ml | 2.5ml | 53,000 |
| 52 | Atropine Eye Drops, 1% | 5ml | 24,000 |
| 53 | Atropine Inj,0.6mg/ml | 1ml | 2,000 |
| 54 | Azithromycin Cap,250mg | Cap/tab | 8,000 |
| 55 | Azithromycin Susp,200mg/5ml (15ml) | 15ml | 42,000 |
| 56 | Badoe's Solution Inj,1000ml | 1000ml | 23,000 |
| 57 | Beclometasone dipropionate Inhaler,100mcg/metered dose | 200doses | 130,000 |
| 58 | Beclometasone dipropionate Inhaler,50mcg/metered dose | 200doses | 130,000 |
| 59 | Bedrofluamethiazide Tab,5mg | Tab | 200 |
| 60 | Bendroflumethiazide Tab 2.5mg | Cap/tab | 200 |
| 61 | Benzathine Benzylpenicillin Inj,1.2MU | Vial | 14,000 |
| 63 | Benzatropine Inj,1mg/ml (2ml) | 2ml | 50,000 |
| 64 | BenzatropineTab,2mg | Cap/tab | 350 |
| 65 | Benzoic Acid+Salicylic Acid Oint,6%+3% | 15G | 6,000 |
| 66 | BenzoylPeroxide Soln,10% | 15G | |
| 67 | BenzoylPeroxide Soln,5% (gel) | 15G | |
| 68 | Benzyl Benzoate Lotion, 25% 125mls | ml | 10,400 |
| 69 | Benzyl Penicillin Inj,1MU | Vial | 2,000 |
| 70 | Benzyl Penicillin Inj,5MU | Vial | 2000-8500 |
| 71 | Betaxolol HCL Eye Drops,0.5% | 5ml | 45,000 |
| 72 | Biperiden Inj,5mg/ml | 1ml | |
| 73 | Biperiden Tabs,2mg | Cap/tab | |
| 74 | Bisacodyl Tab,5mg | Cap/tab | 200 |
| 75 | Bromocriptine Tabs,2.5mg | Cap/tab | 10,000 |
| 76 | Budesonide Inhaler,200mcg/metered dose | 200doses | 195,000 |
| 77 | Budesonide Inhaler,50mcg/metered dose | 200doses | 195,000 |
| 78 | Bupivacaine+Glucose Inj, (5mg+80mg)/ml | 5ml | 45,000 |
| 79 | Bupivacaine Inj,2.5mg/ml (10ml) | 10ml | |
| 80 | Bupivacaine Inj,5mg/ml (4ml) | 4ml | 35,000 |
| 81 | Calamine Cream,15% | 15G | 8,000 |
| 82 | Calamine Lotion,15% 250mls | 100ml | 10,000 |
| 83 | Calciferol Tab,10000U | Cap/tab | 660 |
| 84 | Calcium Carbonate Tab,500mg | Tab | |
| 85 | Calcium Gluconate Inj,100mg/ml in 10ml | 10ml | 27,000 |
| 86 | Calcium with Vitamin D Tab, (97mg+10mcg | Tab | 160 |
| 87 | Carbamazipine Tab,200mg | Cap/tab | 800 |
| 88 | Carbimazole Tab 5mg | Tab | 1,900 |
| 89 | Carbimazole Tab 5mg | Cap/tab | |
| 90 | Cefotaxime Inj,1g | Vial | 41,000 |
| 91 | Cefotaxime Inj 500mg | Vial | 24,000 |
| 92 | Ceftriaxone Inj 1g | Vial | 50,000 |
| 93 | Ceftriaxone Inj 250mg | Vial | 30,000 |
| 94 | Cefuroxime Inj 1.5g | Vial | 76,000 |
| 95 | Cefuroxime Inj 750mg | Vial | 40,000 |

| No. | Generic Name, Dosage Form and Strength | Unit of pricing | Proposed Prices |
|---|---|---|---|
| 96 | Cefuroxime Susp, 125mg/70mls | 100ml | 60,000 |
| 97 | CefuroximeTab,125mg | Cap/tab | 3,500 |
| 98 | Cefuroxime Tab 250mg | Cap/tab | 8,000 |
| 99 | Cetrizine Tab,10mg | Cap/tab | 800 |
| 100 | Cetrimide Soln 125mls, 250mls. | ml | |
| 101 | Cetrimide Soln 40% | ml | |
| 102 | Chloramphenicol Cap,250mg | Cap/tab | 120 |
| 103 | Chloramphenicol Eye Drops,1% (10ml) | 10ml | 4,000 |
| 104 | Chloramphenicol Eye Oint, 1% (5G) | 5G | 4,500 |
| 105 | Chloramphenicol Inj,1g | Vial | 7,000 |
| 106 | Chloramphenicol Susp,250mg/5ml | 100ml | 7,000 |
| 107 | Chlorhexidine Cream,1% | 15G | 3,000 |
| 108 | Chlorhexidine Mouthwash, 0.2% | 300ml | 50,000 |
| 109 | Chlorhexidine Soln,4% in detergent base | ml | |
| 110 | Chlorhexidine Soln,5% | ml | |
| 111 | Chlorhexidine Soln,5% | ml | |
| 112 | Chloroquine Phosphate Syrup,10mg/ml (60ml) | 60ml | |
| 113 | Chloroquine Phosphate Injection | 5ml | |
| 114 | Chloroquine Phosphate Tab,250mg | Cap/tab | |
| 115 | Chloropheniramine Syrup, 2mg/5ml | 125mls | 7,000 |
| 116 | Chlorpheniramine Tab 4mg | Cap/tab | 50 |
| 117 | Chlorpromazine Inj,25mg/ml in 2mls | 2ml | 1,900 |
| 118 | Chlorpromazine Tab,100mg | Cap/tab | 200 |
| 119 | Chlorpromazine Tab, 25mg | Cap/tab | 500 |
| 120 | Chlorpromazine Tab, 50mg | Cap/tab | 120 |
| 121 | Chlorpropramide Tab,100mg | Cap/tab | 250 |
| 122 | Chlorpropramide Tab,250mg | Cap/tab | 420 |
| 123 | Cholera Replacement Fluid Inj,(5:4:1) | 500ml | 13,000 |
| 124 | Ciprofloxacine 2mg/ml Inj,100ml | 100ml | 12,600 |
| 125 | Ciprofloxacine Tab,250mg | Cap/tab | 1,000 |
| 126 | Ciprofloxacine Tab,500mg | Cap/tab | 1,200 |
| 127 | Clarithromycin Cap,250mg | Cap/tab | 12,000 |
| 128 | Clarithromycin Cap,500mg | Tab | 6,000 |
| 129 | Clarithromycin Susp,125mg/5ml (100ml) | 100ml | 235,000 |
| 130 | Clindamycin Caps,150mg | Cap/tab | 6,000 |
| 131 | Clindamycin Soln,1% | 30ml | 120,000 |
| 132 | Clindamycin Susp,75mg/5ml | 100ml | 100,000 |
| 133 | Clobetasol Propionate Cream,0.05% | 15G | 62,000 |
| 134 | Clomifene Tab,50mg | Cap/tab | 5,500 |
| 135 | Clotrimazole+Hydrocortisone Cream,2%+1% | 15G | 32,000 |
| 136 | Clotrimazole Cream,2% | 15G | 15,000 |
| 137 | Clotrimazole Pessary,100mg | Pessary | 4,000 |
| 138 | Clotrimazole Pessary,200mg | Pessary | 7,000 |
| 139 | Clotrimazole Pessary,500mg | Pessary | 7,000 |
| 140 | Cloxacillin Caps,250mg | Cap/tab | 250 |
| 141 | Cloxacillin Inj,500mg | Vial | 4,500 |
| 142 | Codeine Tab,30mg | Tab | 450 |
| 143 | Conjugated Oestrogen + Norgesterol Tab,625mcg+150mcg | Tab | 7,000 |
| 144 | Conjugated Oestrogen Tab,625mcg | Tab | 4,125 |
| 145 | Conjugated Oestrogen VaginalCream,625mcg | 15G | 70,000 |
| 146 | Corticosteroid+Antibiotic Eye Drops | 5ml | 15,000 |
| 147 | Corticosteriod+Antibiotic Eye Ointment | 5G | 13,000 |

| No. | Generic Name, Dosage Form and Strength | Unit of pricing | Proposed Prices |
|---|---|---|---|
| 148 | Cotrimoxazoloe Susp,(200+40)mg/5ml | 100ml | 5,000 |
| 149 | Cotrimoxazole Tab,(400+80)mg | Cap/tab | 125 |
| 150 | Cyclopentolate Eye Drops,1% | 5ml | 95,000 |
| 151 | Danazol Tab,200mg | Cap/tab | 8,500 |
| 152 | Darrow's Soln I.V Infusion, Half strength 250ml | 250ml | 8,000 |
| 154 | Dexamethasone Eye Oint,1% | 5G | 25,000 |
| 155 | Dexamethasone Inj,4mg/ml | 1ml | 2,500 |
| 156 | Dexamethasone Tabs,500mcg | Tab | 200 |
| 157 | Dextrose in Sodium Chloride I.V Infusion,10% in 0.18% 250ml | 250ml | 8,500 |
| 158 | Dextrose in Sodium Chloride I.V Infusion,4.3% in 0.18% 250ml | 250ml | 8,000 |
| 159 | Dextrose in Sodium Chloride I.V Infusion,5% in 0.9% 500ml | 500ml | 11,000 |
| 160 | Dextrose Infusion 5% 500ml | 500ml | 11,500 |
| 161 | Dextrose Infusion 50%,50ml | 50ml | 2,700 |
| 162 | Dextrose Infusion 10%,250ml | 250ml | 11,000 |
| 163 | Dextrose Infusion 10%,500ml | 500ml | 12,000 |
| 164 | Dextrose Infusion 20% 250ml | 250ml | |
| 165 | Dextrose Infusion 5%,250ml | 250ml | 8,500 |
| 166 | Diagnostic Strips-Glucose | strip | 10,000 |
| 167 | Diazepam Inj,5mg/ml in 2ml | 2ml | 3,000 |
| 168 | Diazepam Rectal Tubes,2mg/ml | 1ml | |
| 169 | Diazepam Tab,10mg | Cap/tab | 60 |
| 170 | Diazepam Tab, 5mg | Cap/tab | 50 |
| 171 | Diclofenac Inj,25mg/ml in 3ml | 3ml | 2,500 |
| 172 | Diclofenac Supp,100mg | Supp | 5,000 |
| 173 | Diclofenac Supp,50mg | Supp | 4,000 |
| 174 | Diclofenac Tab,25mg | Cap/tab | 500 |
| 175 | Diclofenac Tab,50mg | Cap/tab | 350 |
| 176 | Diethylcarbamazine Tab,50mg | Cap/tab | 400 |
| 177 | Diethylstilboestrol Tab,1mg | Cap/tab | 15,000 |
| 178 | Diethylstilboestrol Tab,5mg | Cap/tab | 18,000 |
| 179 | Digoxin Elixir,50mcg/ml | 50ml | 99,000 |
| 180 | Digoxin Inj,250mcg/ml | 1ml | 18,000 |
| 181 | DigoxinTab,125mcg(62.5mcg) | Tab | 120 |
| 182 | Digoxin Tab,125mcg | Cap/tab | 110 |
| 183 | Digoxin Tab,250mcg | Cap/tab | 200 |
| 184 | Dihydrocodeine Tab,30mg | Cap/tab | 800 |
| 185 | Diphenhydramine Tab,25mg | Cap/tab | |
| 186 | Disopyramide Cap,100mg | Cap/tab | 3,500 |
| 187 | Disopyramide Phosphate Inj 10mg/ml | 1ml | |
| 188 | Dopamine Inj 40mg/ml in 5ml | 5ml | 72,000 |
| 189 | Doxapram Inj,20mg/ml in 5ml | 5ml | |
| 190 | Doxycycline Caps,100mg | Cap/tab | 400 |
| 191 | Econazole Eye Drops,1% | 5ml | |
| 192 | Ephedrine HCL Inj,30mg/ml | 1ml | 40,000 |
| 193 | Ergometrine Injection | ml | 2,000 |
| 194 | Ergometrine Tabs,0.5mg | Cap/tab | 350 |
| 195 | Ergotamine Tabs,2mg | Cap/tab | 3,700 |
| 196 | Erythromycin Eye Oint,0.5% | 5G | |
| 197 | Erythromycin Inj,1g | v | |
| 198 | Erythromycin Inj,500mg | v | 86,000 |
| 199 | Erythromycin Syrup,125mg/5ml | 100ml | 10,000 |
| 200 | Erythromycin Tab,250mg | Cap/tab | 650 |

| No. | Generic Name, Dosage Form and Strength | Unit of pricing | Proposed Prices |
|---|---|---|---|
| 201 | Ethanolamine Oleate Soln,5% | ml | |
| 202 | Ethosuximide Syrup,250mg/5ml (250ml) | 250ml | 1,600,000 |
| 203 | Ethosuximide Capsules 250mg | Cap/tab | 14,000 |
| 204 | Fentanyl Citrate Inj,50mcg/ml,2ml | 2ml | 8,000 |
| 205 | Ferric Ammonium Citrate (FAC) | 1ml | 50 |
| 206 | Ferrous Fumarate Tabs,(100mg Iron) | Cap/tab | 50 |
| 207 | Ferrous Gluconate Tab,(35mg iron) | Cap/tab | 50 |
| 208 | Ferrous Sulphate (BPC) Syrup,60mg/ml | 200ml | 22,000 |
| 209 | Ferrous Sulphate +Folic Acid,50mg iron+400mcgfolic | Tab | |
| 210 | Ferrous Sulphate Tab,60mg elemental iron | Cap/tab | 50 |
| 211 | Finasteride Tab,5mg | Cap/tab | 32,000 |
| 212 | Flucloxacillin Cap,250mg | Cap/tab | 800 |
| 213 | Flucloxacillin Inj,250mg | ml | 5,000 |
| 214 | Flucloxacillin Inj,500mg | ml | 7,000 |
| 215 | Flucloxacillin Susp,125mg/5ml | 100ml | 11,000 |
| 216 | Fluconazole Cap,150mg | Cap/tab | 25,000 |
| 217 | Fluconazole Cap,200mg | Tab | 50,000 |
| 218 | Fluconazole Cap,50mg | Cap/tab | 27,000 |
| 219 | Fludrocortisone Tab,100mcg | Cap/tab | 1,500 |
| 220 | Fluorescein Soln,2% | 15ml | 125,000 |
| 221 | Fluorescein Strips | strip | 2,500 |
| 222 | Fluoxetine Cap,20mg | Cap/tab | 4,000 |
| 223 | Fluphenazine Deconoate Inj,25mg/ml | ml | 28,000 |
| 224 | Flutamide Tab,250mg | Cap/tab | 9,200 |
| 225 | Fluticasone Propionate Inh,125mcg/meterd dose | 200doses | 170,000 |
| 226 | Fluticasone Propionate Inh,250mcg/meterd dose | 200doses | 420,000 |
| 227 | Fluticasone Propionate Inh,50mcg/meterd dose | 200doses | 205,000 |
| 228 | Fluvastatin Cap,20mg | Tab | 14,500 |
| 229 | Folic Acid Tab,5mg | Cap/tab | 50 |
| 230 | Furosemide Inj 10mg/ml in 2ml | 2ml | 1,200 |
| 231 | Furosemide Tab,40mg | Cap/tab | 80 |
| 232 | Gelatin Inf (succinylated gelatin) | 500ml | 291,200 |
| 233 | Gentamycin Eye Drops 0.3% | 5ml | 6,000 |
| 234 | Gentamycin Eye Oint,0.3% | 5G | 6,500 |
| 235 | Gentamycin Inj,40mg/ml in 2ml | 2ml | 1,000 |
| 236 | Gentian Violet Paint,1% | ml | 100 |
| 237 | Glibenclamide Tab,5mg | Cap/tab | 200 |
| 238 | Gliclazide Tab,80mg | Cap/tab | 810 |
| 239 | Glucagon Inj,1mg vial | Vial | 689,000 |
| 240 | Glyceryl Trinitrate Sublingual Tab,500mcg | Cap/tab | 350 |
| 241 | Glycopyrronium Inj,200mcg | Vial | |
| | Granistron 1mg | Tab | 125,000 |
| 242 | Griseofulvin Tab,125mg | Cap/tab | 120 |
| 243 | Griseofulvin Tab,500mg | Cap/tab | 800 |
| 244 | Haemacel (Polygeline) | 500ml | 278,500 |
| 245 | Haloperidol Inj,5mg/ml | ml | 4,200 |
| 246 | Haloperidol Tab,10mg | Cap/tab | 400 |
| 247 | Haloperidol Tab,5mg | Cap/tab | 250 |
| 248 | Halothane Inh | 250ml | 400,000 |
| 249 | Heparin (Low molecular weight) Inj,4000units/ml | ml | 100,000 |
| 250 | Heparin Inj,1000units/ml | 5ml | 49,000 |
| 251 | Heparin Inj,5000units/ml | 5ml | 37,000 |

| No. | Generic Name, Dosage Form and Strength | Unit of pricing | Proposed Prices |
|---|---|---|---|
| 252 | Heparin Inj,5000units/0.2ml | 1ml | |
| 253 | Hepatitis B Vaccine Inj | Vial | 300,000 |
| 254 | Homatropine Eye Drops,2% | 5ml | 45,000 |
| 255 | Hydralazine Inj,20mg/ | Vial | 24,000 |
| 256 | Hydralazine Tab,25mg | Cap/tab | 1,200 |
| 257 | Hydrocortisone Cream,1% (TOP),15G | 15G | 20,000 |
| 258 | Hydrocortisone Eye Drops,1% | 5ml | 22,000 |
| 259 | Hydrocortisone Eye Oint,1% | 5G | 22,000 |
| 260 | Hydrocortisone Sodium Succinate Inj,100mg | Vial | 6,000 |
| 261 | Hydrocortisone Tab,25mg | Cap/tab | 1,900 |
| 262 | Hydroxocobalamine Inj,1mg/ml | ml | 3,000 |
| 263 | Hyoscine Butylbromide Inj,20mg/ml | 2ml | 2,500 |
| 264 | Hyoscine Butylbromide Tab,10mg | Cap/tab | 400 |
| 265 | Ibuprofen Susp,100mg/5ml | 100ml | 9,000 |
| 266 | Ibuprofen Tab,200mg | Cap/tab | 60 |
| 267 | Ibuprofen Tab,400mg | Cap/tab | 150 |
| 268 | Imipramine Tab,25mg | Cap/tab | 400 |
| 269 | Insulin pre-mixed (30/70)HM Inj,100units/ml | 10ml | 192,000 |
| 270 | Insulin Soluble Inj (HM),100units/ml in 10ml | 10ml | 192,000 |
| 271 | Insulin Zinc Susp,(Lente) Inj,100units/ml in 10ml | 10ml | 192,000 |
| 272 | Intra Lipid Soln | ml | |
| 273 | Iodine +Patassium Iodide Solution | 100ml | 10,250 |
| 274 | Ipecachuana Emetic Mixture BP | ml | 1,000 |
| 275 | Iron+Folic Acid Tab,60mg+250mcg | Cap/tab | |
| 276 | Iron Dextran Inj, 100mg/2ml | 2ml | 7,000 |
| 277 | Iron Dextran Inj,250mg/5ml (100mg/2ml) | 5ml | 10,000 |
| 278 | Isoflurane Inh | 250ml | 1,032,000 |
| 279 | Isophane Insulin Inj (HM),100units/ml in 10ml | 10ml | 192,000 |
| 280 | Isosorbide Dinitrate Sublingual Tab,5mg | 100/pack | 19,000 |
| 281 | Isosorbide Dinitrate Tab,10mg | Cap/tab | 1,000 |
| 282 | Ivermectin Tab, 6mg | Tab | pd |
| 283 | Ketamine Inj,10mg/ml in 20ml | 20ml | 68,000 |
| 284 | Ketamine Inj,50mg/ml in 10ml | 10ml | 20,000 |
| 285 | Ketoconazole Tab,200mg | Cap/tab | 3,000 |
| 286 | Labetalol Inj,5mg/ml in 20ml | 20ml | 70,292 |
| 287 | Labetalol Tab, 100mg | Cap/tab | 2,900 |
| 288 | Labetalol Tab,200mg | Cap/tab | 3,600 |
| 289 | Lactulose Liquide 3.1-3.7gm/5ml (120ml, PO) | 120ml | 120,000 |
| 290 | Levothyroxine Sodium Tab,100mcg | Cap/tab | 350 |
| 291 | Levothyroxine Sodium Tab,150mcg | Cap/tab | 450 |
| 292 | Lidocaine+Adrenaline Cartrige,20mg/ml+(1:80,000/1:100,000) | ml | 2,100 |
| 293 | Lidocaine Cream,2-4%,20G | 15G | 18,500 |
| 294 | Lidocaine Gel,4% | 15G | 34,000 |
| 295 | Lidocaine Inj,1% | 20ml | 4,400 |
| 296 | Lidocaine Inj,2% in 20ml | 20ml | 13,000 |
| 297 | Lidocaine Inj,20mg/ml | 5ml | 60,000 |
| 298 | Lidocaine Inj,20mg/ml in 5ml | ml | 6,000 |
| 299 | Lidocaine Spray,10%, in 50ml | 50ml | 108,000 |
| 300 | Lidocaine+Adrenaline Inj, 10mg+5mcg/ml | 20ml | 32,500 |
| 301 | Lidocaine+Adrenaline Inj, 20mg+5mcg/ml | 20ml | 49,800 |
| 302 | Lindane Lotion 1% | 200ml | |
| 303 | Lisinopril Tab,10mg | Cap/tab | 2,000 |

| No. | Generic Name, Dosage Form and Strength | Unit of pricing | Proposed Prices |
|---|---|---|---|
| 304 | Lisinopril Tab,2.5mg | Cap/tab | 1,200 |
| 305 | Lisinopril Tab,20mg | Cap/tab | 4,200 |
| 306 | Lisinopril,5mg | Cap/tab | 1,500 |
| 307 | Lodoxamide Eye Drops,0.1% | 5ml | 80,000 |
| 308 | Lorazepam Inj,4mg/ml | ml | |
| 309 | Lorazepam Tab,1mg | Tab | 2,600 |
| 310 | Lorazepam Tab,2mg | Cap/tab | 1,600 |
| 311 | Losartan Tab, 100mg | Cap/tab | 2,500 |
| 312 | Losartan Tab,25mg | Cap/tab | 4,000 |
| 314 | Magnessium Sulphate Inj,20% | 20ml | 50,000 |
| 315 | Magnessium Sulphate Inj,25% | 20ml | 50,000 |
| 316 | Magnessium Sulphate Inj,50%, in 10ml | 20ml | 100,000 |
| 317 | Magnessiun sulphate Salt | G | |
| 318 | Magnessium Trisilicate Mixture | 200ml | 6,000 |
| 319 | Magnessium Trisilicate Tab,500mg | Cap/tab | 50 |
| 320 | Mannitol Inj,10% in 500ml | 500ml | 24,650 |
| 321 | Mannitol Inj,20% in 500ml | 500ml | 24,650 |
| 322 | Mebendazole Susp,100mg/5ml | 30ml | 4,500 |
| 323 | Mebendazole Tab,100mg | Cap/tab | 200 |
| 324 | Mebendazole Tab,500mg | Cap/tab | 3,000 |
| 325 | Mebeverine Inj,50mg/ml (as embolate) | ml | |
| 326 | Mebeverine Tab,135mg | Cap/tab | 3,000 |
| 327 | Medroxyprogesterone Acetate Tab,5mg | Cap/tab | 2,500 |
| 328 | Mercurochrome Soln | ml | 100 |
| 329 | Metformin Tab,500mg | Cap/tab | 500 |
| 330 | Metformin Tab,850mg | Cap/tab | 2,000 |
| 331 | Methylcellulose Eye Drops,0.3% | 5ml | 26,000 |
| 332 | Methylcellulose Eye Drops,1% | 5ml | |
| 333 | Methylcellulose Eye Drops,2% | 5ml | |
| 334 | Methyldopa Tab,250mg | Cap/tab | 800 |
| 335 | Metoclopramide Inj,5mg/ml in 2ml | 2ml | 8,000 |
| 336 | Metoclopramide Tab,10mg | Cap/tab | 1,200 |
| 337 | Metolazone Tab,5mg | Cap/tab | 5,000 |
| 338 | Mertronidazole Inj,5mg/ml in 100ml | 100ml | 8,800 |
| 339 | Metronidazole Rectal Supp,1G | supp | 10,150 |
| 340 | Metronidazole Supp,500mg | supp | 2,500 |
| 341 | Metronidazole Susp,100mg/5ml (as Benzoate) | 100ml | 6,000 |
| 342 | Metronidazole Susp,200mg/5ml (as Benzoate) | 100ml | 7,000 |
| 343 | Metronidazole Tab,200mg | Cap/tab | 100 |
| 344 | Metronidazole Tab,400mg | Cap/tab | 200 |
| 345 | Miconazole Oral Gel,15mg/ml | 15G | 85,000 |
| 346 | Midazolam Inj,15mg/3ml | ml | 50,000 |
| 347 | Midazolam Inj,5mg/ml in 3ml | 3ml | 29,200 |
| 348 | Misoprostol Vaginal Tab,200mcg | Tab | 6,000 |
| 349 | Morphine Inj,10mg/ml | ml | 9,000 |
| 350 | Morphine Inj,10mg/ml (preservative free) | ml | 3,000 |
| 351 | Morphine Sulphate Tab,30mg (Slow Release) | Cap/tab | 20,000 |
| 352 | Multivitamine Syrup | 100ml | 5,000 |
| 353 | Multivitamin Cap/Tab | Cap/tab | 50 |
| 354 | Naloxone Inj,200mcg/ml | ml | 16,000 |
| 355 | Naloxone Inj,400mcg/ml | ml | 17,000 |
| 356 | Neomycin Tab,500mg | Cap/tab | 1,300 |

| No. | Generic Name, Dosage Form and Strength | Unit of pricing | Proposed Prices |
|---|---|---|---|
| 357 | Neostigmine Inj,0.5mg | Vial | 3,600 |
| 358 | Neostigmine Inj,2.5mg | Vial | 4,800 |
| 359 | Niclosamine Tab,500mg | Cap/tab | 4,200 |
| 360 | Nifedipine Cap,10mg | Cap/tab | 1,100 |
| 361 | Nifedipine Cap,5mg | Cap/tab | 750 |
| 362 | Nifedipine Tab,10mg (Slow Release) | Cap/tab | 1,200 |
| 363 | Nifedipine Tab,20mg (Slow Release) | Cap/tab | 2,500 |
| 364 | Nifedipine Tab,30mg (GITS) | Tab | 2,600 |
| 365 | Nitrofurantion Tab,100mg | Cap/tab | 400 |
| 366 | Noresthisterone Depot Inj,200mg/ml | ml | 55,000 |
| 367 | Noresthisterone Tab,5mg | Cap/tab | 1,200 |
| 368 | Nystatin Pessaries100,000IU | pessary | 1,400 |
| 369 | Nystatin Skin Oint,100,000IU/ml | 15G | 10,700 |
| 370 | Nystatin Susp,100,000IU/ml | 30ml | 32,000 |
| 371 | Nystatin Tab,500,000IU | Cap/tab | 1,100 |
| 372 | Omeprazole Tab,20mg | Cap/tab | 1,700 |
| 373 | Ondansetron Inj,2mg/ml,in 4ml | 4ml | |
| 374 | Ondansetron Tab,4mg | Cap/tab | |
| 375 | Oral Rehydration Salts Powder, 1pack/1L | Packet | 1,500 |
| 376 | Oxytocin Inj,5units/ml | ml | 1,500 |
| 377 | Paracetamol Supp,100mg | supp | 3,700 |
| 378 | Paracetamol Supp,125mg | supp | 2,800 |
| 379 | Paracetamol Supp,250mg | supp | 3,500 |
| 380 | Paracetamol Supp,500mg | supp | 6,000 |
| 381 | Paracetamol Syrup,120mg/5ml | 100ml | 3,000 |
| 382 | Paracetamol Tab,500mg | Cap/tab | 50 |
| 383 | Paraffin Liq | ml | 150 |
| 384 | Pentamidine Isetionate Inj,300mg | Vial | |
| 385 | Pethidine Inj,50mg/ml in 2ml | 2ml | 6,000 |
| 386 | Phenobarbital Elixir 15mg/5ml | 100ml | 13,000 |
| 387 | Phenobarbital Inj,200mg/ml | Vial | 6,500 |
| 388 | Phenobarbital TAb, 30mg | Cap/tab | 180 |
| 389 | Phenobarbital Tab, 60mg | Cap/tab | 270 |
| 390 | Phenol 5% in Almond Oil Inj | ml | |
| 391 | Phenoxymethylpenicillin Tab,250mg | Cap/tab | 140 |
| 392 | Phenytoin Injection,50mg/ml | ml | 5,100 |
| 393 | Phenytoin Sodium Inj,100mg | Cap/tab | 600 |
| 394 | Phytomenadione Inj,10mg/ml | ml | 5,300 |
| | Pioglitazone 30mg | Tab | 9,500 |
| | Pioglitazone 15mg | Tab | 7,500 |
| 395 | Phytomenadione Inj,1mg/ml | ml | 4,600 |
| 396 | Pilocarpine Eye Drops,2% in 10ml | 10ml | 44,000 |
| 397 | Pilocarpine Eye Drops,4% in 10ml | 10ml | 60,000 |
| | Polyethyleneglycol | | 78,000 |
| 398 | Polymycin B+Bacitracin+Neomycin Oint | 15G | 22,000 |
| 399 | Polystyrene Sulphonate Resins Powder,300g | 15G | |
| | Pot Citrate Mixture | 200mls | 10,000 |
| 400 | Potassium Chloride Inj,20mEq/ml | 10ml | 9,200 |
| 401 | Potassium chloride Tab,600mg (enteric coated) | Cap/tab | 600 |
| 402 | Povidone Iodine (aq)Soln,10% | 100ml | 21,000 |
| 403 | Praziquantel Tab,600mg | Cap/tab | 2,800 |
| 404 | Prazosin Tab,500mcg | Cap/tab | |

| No. | Generic Name, Dosage Form and Strength | Unit of pricing | Proposed Prices |
|---|---|---|---|
| 405 | Prednisolone Eye Drops,0.5% | 5ml | 55,000 |
| 406 | Prednisolone Eye Drops,1% | 5ml | 10,000 |
| 407 | Prednisolone Tab,5mg | Cap/tab | 100 |
| 408 | Prilocaine Inj,10mg/ml | ml | |
| 409 | Primidone Tab,250mg | Cap/tab | 1,000 |
| 410 | Procaine Penicillin Inj4MU | Vial | 3,800 |
| 411 | Promethazine HCl Elixir,5mg/5ml | ml | 100 |
| 412 | Promethazine HCl Inj,25mg/ml | 2ml | 1,500 |
| 413 | Promethazine Tab 25mg | Cap/tab | 50 |
| 414 | Promethazine Theocalate Tab, 25mg | Cap/tab | 120 |
| 415 | Propofol Inj,10mg/ml in 20ml | 20ml | 86,000 |
| 416 | Propranolol Inj,1mg/ml | ml | 37,000 |
| 417 | Propranolol Tab,10mg | Tab | |
| 418 | Propranolol Tab,40mg | Cap/tab | 150 |
| 419 | Propranolol Tab,80mg | Cap/tab | 500 |
| 420 | Propylthiouracil Tab,50mg | Cap/tab | 3,000 |
| 421 | Protamine Sulphate Inj,10mg/ml, in 5ml | 5ml | 60,000 |
| 422 | Quinine Inj ,300mg/ml in 2mls | 2ml | 4,000 |
| 423 | Quinine Tab,300mg | Cap/tab | 1,500 |
| 424 | Rabies Vaccine Inj | Vial | 403,600 |
| 425 | Ranitidine Inj,25mg/ml in 2ml | 2ml | 18,000 |
| 426 | Ranitidine Tab,150mg | Cap/tab | 1,300 |
| 427 | Reserpine Inj,1mg/ml | ml | 4,500 |
| 428 | Reserpine Tab,250mcg | Cap/tab | 150 |
| 429 | Retinol Soft Cap,100,000IU | Cap/tab | 850 |
| 430 | Retinol Soft Cap,200,000IU | Cap/tab | |
| 431 | Ringers Lactate I.V Inf,500ml | 500ml | 10,500 |
| 433 | Risperidone Tab,1mg | Tab | 3,300 |
| 434 | Resperidone Tab,2mg | Tab | 12,500 |
| 435 | Risperidone Tab,500mcg | Tab | 1,600 |
| 436 | Rocuronium Inj,10mg/ml | ml | |
| 437 | Rose Bengal Minims ,1% | ml | |
| 438 | Salbutamol Inh,100mcg/meterd dose, 200doses | 200doses | 46,000 |
| 439 | Salbutamol Nebuliser Soln,5mg/ml as Sulphate | 10ml | 9,000 |
| 440 | Salbutamol Nebuliser ,2.5MG Nbules | 10ml | 9,000 |
| 441 | Salbutamol Sulphate Inj,50mcg/ml | 1ml | 5,200 |
| 442 | Salbutamol Syrup,2mg/5ml | 100ml | 15,000 |
| 443 | Salbutamol Tab,2mg | Cap/tab | 100 |
| 444 | Salbutamol Tab,4mg | Cap/tab | 250 |
| 445 | Salicylic Acid Oint,2% | 1G | 280 |
| 446 | Selenium Sulphide Shampoo,2.5% | 100ml | 58,000 |
| 447 | Senna Tab,7.5g or Grannules | Cap/tab | 1,100 |
| 448 | Silver Sulphadiazine Cream,1% | 15G | 20,000 |
| | Simple Lintus Syrup (Adult) | 200mls | 10,000 |
| 449 | Simple Lintus Syrup (paediatric) | 100ml | 91,000 |
| 450 | Sodium Bicarbonate Inj,8.4% in 10ml | 10ml | |
| 451 | Sodium Chloride+Potassium Chloride Inj,(0.9%+20mmol),500ml | 500ml | 19,600 |
| 452 | Sodium Chloride in Dextrose Inj,(0.9%+5%) in 500ml | 500ml | 11,500 |
| 453 | Sodium Chloride Inj,0.45% in 250ml | 250ml | 9,300 |
| 454 | Sodium Chloride Inj,0.9% in 250ml | 250ml | 6,000 |
| 455 | Sodium Chloride Inj,0.9% in 500ml | 500ml | 11,500 |

| No. | Generic Name, Dosage Form and Strength | Unit of pricing | Proposed Prices |
|---|---|---|---|
| 456 | Sodium Chloride Nasal Drops,0.9% | 10ml | 8,000 |
| 457 | Sodium Valproate Cap,200mg | Cap/tab | 1,000 |
| 458 | Sodium Valproate Syrup,200mg/5ml | 5ml | |
| 459 | Soothing Agent+Local Anaesthetic+Steriod Oint | 15G | 46,600 |
| 460 | Soothing Agent+Local Anaesthetic+Steriod Supp | supp | 4,300 |
| 461 | Soothing Agent+Local Anaesthetic Oint | 15G | 46,600 |
| 462 | Soothing Agent+Local Anaesthetic Supp | supp | 4,300 |
| 463 | Spironolactone Tab,100mg | Cap/tab | 3,800 |
| 464 | Spironolactone Tab,25mg | Tab | 4,200 |
| 465 | Spironolactone Tab,50mg | Cap/tab | 2,400 |
| 466 | Sulfadoxine+Pyrimethamine Tab,525mg | Cap/tab | 1,000 |
| 467 | Sulfasalazine Tab,500mg | Cap/tab | 3,200 |
| 468 | Sulphacetamide Eye Drops,10% | 10ml | 3,500 |
| 469 | Sulphacetamide Eye Oint,10% | 5G | 5,000 |
| 470 | Suxamethonium Inj,100mg/2ml | 2ml | 160,000 |
| 471 | Tamoxifen Tab,10mg | Cap/tab | 1,300 |
| 473 | Tamsulosin Cap,400mcg | Cap/tab | 31,000 |
| 474 | Terazocin Tab,2mg | Cap/tab | 8,300 |
| 475 | Terazocin Tab,5mg | Cap/tab | 7,250 |
| 476 | Terbinafine HCL Tab,150mg | Cap/tab | 38,000 |
| 477 | Terbinafine HCL Tab,200mg | Tab | 114,500 |
| 478 | Testosterone Enantate Inj,250mg in 1ml Amp | 1ml | 7,300 |
| 479 | Tetanus Toxoid Inj,0.5ml | 1ml | |
| 480 | Tetanus Immunoglobulins Inj,250IU/ml | Vial | 4,000 |
| 481 | Tetanus Vaccine Inj,40IU/5ml | 5ml | 3,000 |
| 482 | Tetracaine Eye Drops,0.5% | 5ml | 95,000 |
| 483 | Tetracycline Eye Oint,1% | 5G | 3,000 |
| 484 | Tetracycline Cap,250mg | Cap/tab | 100 |
| 485 | Tetracycline Eye Drop,0.5% | 5ml | 18,000 |
| 486 | Theophyline Dry Syrup,60mg/5ml | 100ml | 12,500 |
| 487 | Theophyline Tab,200mg (Slow Release) | Cap/tab | 450 |
| 488 | Thiamine Inj,100mg | Vial | 2,400 |
| 489 | Thiamine Tab,25mg | tab | 1,100 |
| 490 | Thiopentone Sodium Inj,1gm | Vial | 30,000 |
| 491 | Thiopentone Sodium Inj,500mg | Vial | 9,800 |
| 492 | Tiabendazole Susp,50mg/ml | 20ml | 5,000 |
| 493 | Tiabendazole Tab,,500mg | Cap/tab | 1,200 |
| 494 | Timolol Maleate Eye Drops,0.5% | 5ml | 30,000 |
| 495 | Tolbutamide Tab,500mg | Cap/tab | 1,500 |
| 496 | Trifluoperazine,1mg | Tab | |
| 497 | Trifluoperazine,10mg | Cap/tab | 1,500 |
| 498 | Trifluoperazine 5mg | Tab | 240 |
| 499 | trihexyphenidyl Tab,2mg | Cap/tab | 800 |
| 500 | trihexyphenidyl Tab,5mg | Cap/tab | |
| 501 | Tropicamide Eye Drops,1% | 5ml | 36,000 |
| 502 | Vecuronium Bromide Inj,10mg/Vial | Vial | 144,000 |
| 503 | Warfarin Tab,1mg | Tab | 720 |
| 504 | Warfarin Tab,3mg | Cap/tab | 600 |
| 505 | Warfarin Tab,5mg (scored) | Cap/tab | 2,000 |
| 506 | Water for Inj,10ml | Ampoule | 600 |

# Appendix 2 – Suggested Services Pricing for GHS and CHAG

Proposed GHS and CHAG standardized fee schedule for 2006 /2007
Majorie Y

| | HC/CHPS/SC (No doctor) | Polyclinic /HC with doctor / Hospital | Regional Hospital |
|---|---|---|---|
| CONSULTATION, ADMINISTRATION, DOCUMENTATION AND PROCESSING | | | |
| Patient (general) | 11,000.00 | 20,000. 00 | 23,000.00 |
| Patient (special) | 20,000.00 | 23,000.00 | 28,000.00 |
| Medical Exams | | 50,000.00 not part of NHIC covered benefit package | 100,000.00 |
| Utilities to be charged – only for institutions to be paid for by HI which utility bills are not paid for by GoG already | 10,000.00 | 10,000.00 | 10,000.00 |
| Patient Folder | 12,500.00 | 12,500.00 | 12,500.00 |
| Referral Forms to be absorbed by documentation | | | |
| Police form – not covered by NHIS | | 50,000.00 | 50,000.00 |
| FOLLOW UP VISIT - Review | | | |
| Patient (general) | 2,500.00 | 6,000.00 | 7,500.00 |
| Patient (special) | 5,000.00 | 7,500.00 | 10,000.00 |
| ACCOMMODATION (Daily fee) | | | |
| Children | 5,000.00 | 15,000.00 | 20,000.00 |
| Gen. Side Ward | 5,000.00 | 15,000.00 | 20,000.00 |
| Gen. Ward | 5,000.00 | 15,000.00 | 20,000.00 |
| Maternity | 5,000.00 | 15,000.00 | 20,000.00 |
| VIP – not covered by NHIS | | 150,000.00 | 150,000.00 |
| FEEDING | | | |
| Adult | | 25,000.00 | 25,000.00 |
| Children | | 25,000.00 | 25,000 |
| Side ward (not covered by NHIS) | | 50,000.00 | 50,000.00 |
| VIP (not covered by NHIS) | | 100,000.00 | 100,000.00 |
| SANITATION /CLEANING MATERIALS – one flat rate out patients charged once only | To be added to the consultation fee and the separate column to be removed | - | - |
| X-RAY /RADIOLOGY / and Imaging | | | |

| | HC/CHPS/SC (No doctor) | Polyclinic /HC with doctor / Hospital | Regional Hospital |
|---|---|---|---|
| X-Ray to be revisited against size of x-ray film: | | | |
| Small size | | 50,000 | 50,000 |
| Medium size | | 75,000 | 75,000 |
| Large size | | 100,000 | 100,000 |
| ECG | | - | 60,000.00 |
| Ultrasound Scan | | 50,000.00 | 50,000.00 |
| Abdomen | | 50,000.00 | 50,000.00 |
| Angiogram: Carotid (excldg cont) | To be flagged for additional cost information | | 20,000.00 |
| Barium Enema | | - | 20,000.00 |
| Barium meal & follow through | | - | 20,000.00 |
| Cholecystogram | | - | - |
| Dental | | 30,000.00 | 30,000.00 |
| Ductogram | | - | - |
| Femoral Arteriogram | | - | - |
| HSG | | - | 250,000.00 |
| Image Intensifier | | - | - |
| IVP | To be clarified | - | 500,000.00? |
| Mammography | | - | - |
| Myelogram | To be clarified | - | 20,000.00 |
| Phlebogram | | - | 20,000.00 |
| Retrograde (excluding contrast) | | - | - |
| Sialogram | | - | - |
| Urethrogram | | - | - |
| USG | | 60,000.00 | 60,000.00 |
| LABORATORY | Not discussed in detail | | |
| HAEMOTOLOGY | | | |
| A P T T | | - | 35,000.00 |
| ANC +G6PD | | - | 55,000.00 |
| ANC +G6PD + MPS | | 65,000.00 | 65,000.00 |
| B/F | 10,000.00 | 10,000.00 | 10,000.00 |
| Bleeding | | - | 20,000.00 |
| Bleeding/Clotting Time | | - | - |
| Blood Group | 10,000.00 | 10,000.00 | 10,000.00 |
| Clotting Time | | - | 20,000.00 |
| D/C | | 10,000.00 | 20,000.00 |
| ESR | | 10,000.00 | 10,000.00 |
| FBC | 30,000.00 | 30,000.00 | 30,000.00 |
| FBC+BF+Sickling | | - | - |
| FBS+BF | | - | - |
| Film Comment | | - | 15,000.00 |
| G6PD | 15,000.00 | 15,000.00 | 15,000.00 |
| HB | | 10,000.00 | 10,000.00 |

| | HC/CHPS/SC (No doctor) | Polyclinic /HC with doctor / Hospital | Regional Hospital |
|---|---|---|---|
| HB Electrophoresis | | 20,000.00 | 20,000.00 |
| HB/BF | | 10,000.00 | 10,000.00 |
| HbsAg | | 15,000.00 | 15,000.00 |
| Platelet Count | | - | 10,000.00 |
| Pregnosticon | 20,000.00 | 20,000.00 | 20,000.00 |
| Prothrombin Time & INR | | - | 40,000.00 |
| Sickling | 10,000.00 | 10,000.00 | 10,000.00 |
| WBC | 10,000.00 | 10,000.00 | 10,000.00 |
| WBC/Differential | 20,000.00 | 20,000.00 | 20,000.00 |
| | | | |
| PARASITOLOGY | | | |
| Amylase | | - | 10,000.00 |
| HVS R/E | | 15,000.00 | 15,000.00 |
| Microfilaria | | 15,000.00 | 20,000.00 |
| MPs | 10,000.00 | 10,000.00 | 10,000.00 |
| Skin Scrapping | | 15,000.00 | 15,000.00 |
| Skin Snip | 15,000.00 | 15,000.00 | 15,000.00 |
| Stool R/E | 10,000.00 | 10,000.00 | 10,000.00 |
| Urethral Smear for Gram | | 20,000.00 | 20,000.00 |
| Urine Protein | | 10,000.00 | 15,000.00 |
| Urine R/E | 10,000.00 | 10,000.00 | 10,000.00 |
| | | | |
| CHEMICAL PATHOLOGY | | | |
| GLUCOSE TEST | | | |
| FBS | 15,000.00 | 15,000.00 | 15,000.00 |
| FBS and Urine Sugar | 20,000.00 | 20,000.00 | 20,000.00 |
| Glucose Monitoring | | - | 10,000.00 |
| RBS | 10,000.00 | 10,000.00 | 10,000.00 |
| Urine Sugar | 10,000.00 | 10,000.00 | 10,000.00 |
| | | | |
| NON-DIABETICS | | | |
| Calcium | | 20,000.00 | 20,000.00 |
| Cardiac Enzymes | | - | - |
| FBS | | 10,000.00 | 10,000.00 |
| Ketone | 5,000.00 | 10,000.00 | 20,000.00 |
| Phosphorus | | - | - |
| RBS | | 10,000.00 | 10,000.00 |
| RFT | | - | - |
| | | | |
| LIVER FUNCTION TEST | | | |
| Albumin | | 20,000.00 | 20,000.00 |
| Alkaline Phos | | 20,000.00 | 20,000.00 |
| Direct Bilirubin | | 20,000.00 | 20,000.00 |
| GAT | | 20,000.00 | 20,000.00 |
| Indirect Bilirubin | | 20,000.00 | 20,000.00 |

| | HC/CHPS/SC (No doctor) | Polyclinic /HC with doctor / Hospital | Regional Hospital |
|---|---|---|---|
| LFT | | 55,000.00 | 60,000.00 |
| SGOT | | 20,000.00 | 20,000.00 |
| SGPT | | 20,000.00 | 20,000.00 |
| Total Bilirubin | | 20,000.00 | 20,000.00 |
| Total Proteins | | 20,000.00 | 20,000.00 |
| | | | |
| KIDNEY FUNCTION TEST | | | |
| BUE | | 50,000.00 | 50,000.00 |
| BUE & CR | | 80,000.00 | 80,000.00 |
| Chloride | | 15,000.00 | 15,000.00 |
| CO2 | | - | 15,000.00 |
| Creatinine | | - | 20,000.00 |
| Electrolytes | | - | 50,000.00 |
| HDL | | - | 20,000.00 |
| K+ | | 15,000.00 | 15,000.00 |
| LDL | | - | 20,000.00 |
| Lipid Profile | | 60,000.00 | 60,000.00 |
| NA+ | | 15,000.00 | 15,000.00 |
| Total Cholesterol | | 20,000.00 | 20,000.00 |
| triglycerides | | - | 20,000.00 |
| Urea | | 20,000.00 | 20,000.00 |
| Urea Creatinine | | - | 40,000.00 |
| Uric Acid | | 25,000.00 | 25,000.00 |
| | | | |
| HORMONES | | | |
| Free T3 | | - | 70,000.00 |
| Free T4 | | - | 70,000.00 |
| FSH | | - | 70,000.00 |
| LH | | - | 70,000.00 |
| Oestrogen | | - | 70,000.00 |
| Progesterone | | - | 70,000.00 |
| Prolactine | | - | 70,000.00 |
| T3, T4, TSH | | - | 210,000.00 |
| Testosterone | | - | 70,000.00 |
| Thyroid Function Test (TFT) | | - | 210,000.00 |
| TSH | | - | 70,000.00 |
| | | | |
| BLOOD BANK / SEROLOGY | To be flagged for further comments | | |
| Direct Coombs Test | | - | 20,000.00 |
| Grouping / X' match | | - | 30,000.00 |
| Hephatitis B | | - | 30,000.00 |
| HIV | | - | 10,000.00 |
| Indirect Coombs Test | | - | - |
| Pregnancy Test | 15,000.00 | - | 20,000.00 |

| | HC/CHPS/SC (No doctor) | Polyclinic /HC with doctor / Hospital | Regional Hospital |
|---|---|---|---|
| Processing Fee (1) Unit | | - | 130,000-150,000 |
| Processing Fee (2) Units | | - | 220,000-270,000 |
| Processing Fee (3) Units | | - | 310,000-390,000 |
| Processing Fee (4) Units | | - | 400,000-510,000 |
| Processing Fee (5) Units | | - | 490,000-600,000 |
| Rhematoid Factor | | - | 20,000.00 |
| VDRL | 10,000.00 | - | 10,000.00 |
| WIDAL | 20,000.00 | - | 20,000.00 |
| | | | |
| MICROBIOLOGY | | | |
| Bacteriology | | - | - |
| Blood C/S | | - | 30,000.00 |
| CSF Biochemistry | | - | 30,000.00 |
| Endocervical Smear for C/S | | - | 40,000.00 |
| HVS RE/CS | | - | 30,000.00 |
| MICROSCOPY | | | |
| Nasal Swab C/S | | - | 30,000.00 |
| Semen Analysis | | - | 50,000.00 |
| Sputum | | - | 20,000.00 |
| Stool C/S + RE | | - | 40,000.00 |
| Throat Swab C/S | | - | 30,000.00 |
| Urine RE/CS | | - | 40,000.00 |
| Wound Swab | | - | 30,000.00 |
| | | | |
| EYE mainly data from Ridge Hospital as there was no other data available – perhaps HC prices to be removed | | | |
| Chalazion I & D | 100,000.00 | - | 100,000.00 |
| Complicated Corneal | | - | 800,000.00 |
| Corneal Foreign Body Removal | 15,000.00 | - | 50,000.00 |
| Corneal Laceration (simple) repair | | - | 500,000.00 |
| Demoid Cyst Excision | 25,000.00 | - | 500,000.00 |
| ECCE + 10L | | - | 1,200,000.00 |
| Entropion & Ectropion repair | 500,000.00 | - | 500,000.00 |
| Enucleation | | - | 800,000.00 |
| EUA | 50,000.00 | - | 50,000.00 |
| Evisceration | 500,000.00 | - | 500,000.00 |
| ICCE | | - | 900,000.00 |
| ICCE + 10L | | - | 1,000,000.00 |
| Insertion of Prothesis | 250,000.00 | - | 250,000.00 |
| Corneal Laceration & washout (AC) | | - | 800,000.00 |
| Lid Lacration | 200,000.00 | - | 300,000.00 |

| | HC/CHPS/SC (No doctor) | Polyclinic /HC with doctor / Hospital | Regional Hospital |
|---|---|---|---|
| Paracentesis | 400,000.00 | - | 400,000.00 |
| Probing | 10,000.00 | - | 100,000.00 |
| Pterygium Excision | 30,000.00 | - | 300,000.00 |
| Refraction | 20,000.00 | - | 20,000.00 |
| Retrobulbar Alcohol | 5,000.00 | - | 50,000.00 |
| Rodding | 20,000.00 | - | 20,000.00 |
| Squit Correction (G.A.) | | - | 1,200,000.00 |
| Sub Conjunctival Injection | 20,000.00 | - | 20,000.00 |
| Tarsal Foreign Body | 15,000.00 | - | 15,000.00 |
| Trabeculectomy | | - | 900,000.00 |
| DENTISTRY | Left – again similar to eye: specialist care at some few places only<br><br>To call up national dental council for further suggestions / considerations | | |
| a. Root Canal Therapy | | 300,000.00 | 400,000.00 |
| b. Amalgam Filling | | 100,000.00 | 150,000-200,000 |
| c. Composite Filling | | 100,000.00 | 180,000-300,000 |
| Complete denture | | - | - |
| d. Galaronmon Filling | | 100,000.00 | - |
| Denture repair | | - | - |
| Extraction | | 70,000.00 | 60,000-100,000 |
| Extraction (A1 Veolectomy) | | - | - |
| Extraction (complicated | | 100,000.00 | - |
| Filling: | | | - |
| Gengivectomy | | - | - |
| Minor oral Surgery | | - | 200,000.00 |
| Partial denture (1st tooth) | | - | - |
| Partial denture (additional tooth) | | - | - |
| Periodontal Curetage (Blind)/quarant | | 20,000.00 | - |
| Scaling Polishing | | 100,000.00 | 150,000-250,000 |
| Splinting | | - | - |
| Surgical Extraction | | - | 200,000.00 |
| PHYSIOTHERAPY | | | |
| FIRST VISIT | | | |
| Adult - Foreigner | | - | 60,000.00 |
| Adult - Ghanaian | | - | 30,000.00 |
| Children - Foreign | | - | 34,000.00 |
| Children - Ghanaian | | - | 30,000.00 |
| SUBSEQUENT VISITS | | | |

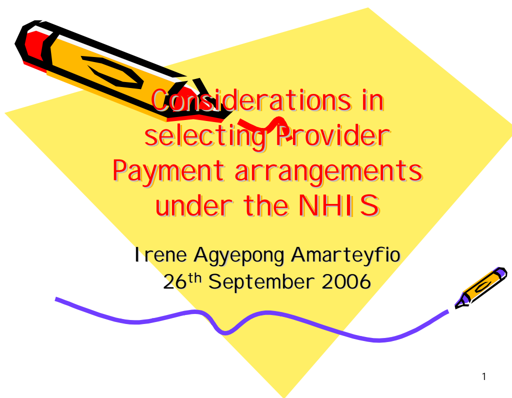
| | HC/CHPS/SC (No doctor) | Polyclinic /HC with doctor / Hospital | Regional Hospital |
|---|---|---|---|
| Adult - Foreigner | | - | 48,000.00 |
| Adult - Ghanaian | | - | 24,000.00 |
| Children - Foreign | | - | 24,000.00 |
| Children - Ghanaian | | - | 12,000.00 |
| | | | |
| WARD CASES | | | |
| Adult | | - | 5,000.00 |
| Children | | - | 4,000.00 |
| | | | |
| THEATRE | | | |
| | | | |
| To define: | | | |
| three groups:<br>Minor<br>Medium<br>Major | At<br>400,000.00<br>600,000.00 – 800,000<br>1,000,000 - 1,500,000.00 | | |
| | | | |
| Others including<br>circumcision,<br>IND,<br>EOU,<br>Excision (lipoma)<br>& those currently under 400,000.00 to be left as mentioned below | <br>150,000.00<br>200,000.00<br>400,000.00<br>250,000.00 | | |
| | | | |
| + General anaesthesia | 30% mark up | | |
| | | | |
| DISINFECTION flag it – to be put to consumables | | | |
| C/S Delivery | | - | 300,000.00 |
| Disinfectant | | - | 15,000.00 |
| Methylated Spirit | | - | 5,000.00 |
| Normal delivery | 50,000.00 | 60,000.00 | 70,000.00 |
| Sanitation & Laundry | | - | 12,000.00 |
| Urine or Drainage Bag | | - | 8,000.00 |
| | | | |
| ANAESTHESIA CHARGES (to be added as percentage of surgical procedure) | | | |
| | | | |
| 10 cc | | - | 2,000.00 |
| 2 cc | | - | 1,000.00 |
| 5 cc | | - | 1,000.00 |
| Anaesthesia B/A (Major) | | - | - |
| ANAESTHESIA B/A (Minor) | | - | - |
| Endotracheal tubes | | - | 15,000.00 |
| Giving Sets | | - | 5,000.00 |
| I V Cannul | | - | 10,000.00 |

| | HC/CHPS/SC (No doctor) | Polyclinic /HC with doctor / Hospital | Regional Hospital |
|---|---|---|---|
| Ryles tubes | | - | 10,000.00 |
| Spine Needles | | - | 20,000.00 |
| Suction Catheter | | - | 10,000.00 |
| | | | |
| CONSUMABLES (Ward/Theatre) | | | |
| Abdominal sponge | 50,000 | - | 50,000.00 |
| Bandage | 2,500 | - | 5,000.00 |
| Bandage P. O. 15 cm | 0 | - | - |
| Bandage P. O. 7.5 cm | 0 | - | - |
| Blood giving set | 0 | - | 10,000.00 |
| Bulb syringe (for suction) | | | |
| Butterfly Needle (adult) | 5,000 | - | 5,000.00 |
| Cannular | 0 | - | 20,000.00 |
| Catheter -Foley | 10,000 | - | 10,000.00 |
| Chomic Catgut | 12,000 | - | 10,000.00 |
| Cord Clamps | 5,000 | - | 6,000.00 |
| Cord dressing | 0 | - | 7,000.00 |
| Cotton Wool | 15,000 | - | 15,000.00 |
| Cotton Wool absorbent 500g | 0 | - | 31,000.00 |
| Cotton Wool/ball | 0 | - | - |
| Crepe bandage | 10,000 | - | 10,000.00 |
| D. Syringe & Needle 10 ml | 1,000 | - | 2,000.00 |
| D. Syringe & Needle 5 ml | 10,000 | - | 2,000.00 |
| Disp. Face mask | 5,000 | - | 5,000.00 |
| Disposable syringes & needles 2 ml | 0 | - | - |
| Examination gloves | 2,000 | - | 2,000.00 |
| Gauze Absorbent 100 yds | 0 | - | 10,000.00 |
| Gauze bandage | 0 | - | - |
| Gauze Swab non-sterile 16 PL | 0 | - | - |
| Infusion giving set | 0 | - | 7,000.00 |
| Insulin syringe 1ml 40/80 unit | 1,000 | - | 1,000.00 |
| Irrigation syringe & needle | 5,000 | - | 5,000.00 |
| Maternity gloves | 20,000 | - | 30,000.00 |
| Nasal Cannula | 40,000 | - | 40,000.00 |
| Neltron Catheter | 10,000 | - | 10,000.00 |
| Nylon (various) doz. | 12,000 | - | 12,000.00 |
| Pad | 0 | - | - |
| Paraffin gauze | 0 | - | - |
| Plain (various) doz. | 12,000 | - | 15,000.00 |
| Plaster | 2000-4000 | - | 3,000.00 |
| Plaster zinc oxide 10cm | 0 | - | - |
| R. tubes | 10,000 | - | 10,000.00 |
| S. Tulle | 7,000 | - | 10,000.00 |

| | HC/CHPS/SC (No doctor) | Polyclinic /HC with doctor / Hospital | Regional Hospital |
|---|---|---|---|
| Scalp Vein needle (chn) | 5,000 | - | 15,000.00 |
| Silk (various) doz. | 12,000 | - | 12,000.00 |
| Spirit | 1000-5000 | - | 5,000.00 |
| Surgical blade | 2,000 | - | 3,000.00 |
| Surgical gloves | 5,000 | - | 10,000.00 |
| Syringes & Needles | 2,000 | - | 2,000.00 |
| Syringes/Needles 20ml | 2,000 | - | 3,000.00 |
| Syringes/Needles 50ml | 5,000 | - | 5,000.00 |
| Triangular bandage | 0 | - | - |
| Wrist band | 5,000 | - | 5,000.00 |

# Appendix 3- Presentation slides

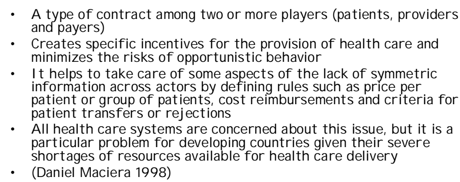
## *2.1 Considerations in selecting provider payment rates*




1

### Provider payment mechanisms

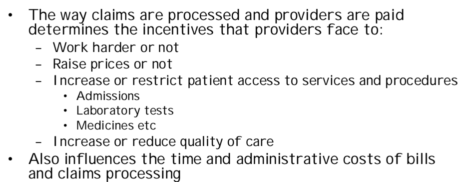
- A type of contract among two or more players (patients, providers and payers)
- Creates specific incentives for the provision of health care and minimizes the risks of opportunistic behavior
- It helps to take care of some aspects of the lack of symmetric information across actors by defining rules such as price per patient or group of patients, cost reimbursements and criteria for patient transfers or rejections
- All health care systems are concerned about this issue, but it is a particular problem for developing countries given their severe shortages of resources available for health care delivery
- (Daniel Maciera 1998)



2

### Provider payment mechanisms

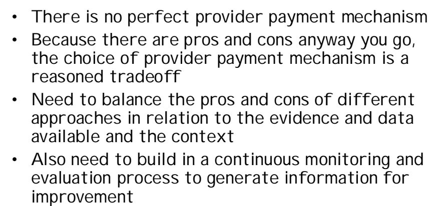
- The way claims are processed and providers are paid determines the incentives that providers face to:
  - Work harder or not
  - Raise prices or not
  - Increase or restrict patient access to services and procedures
    - Admissions
    - Laboratory tests
    - Medicines etc
  - Increase or reduce quality of care
- Also influences the time and administrative costs of bills and claims processing



3

### Provider payment mechanisms

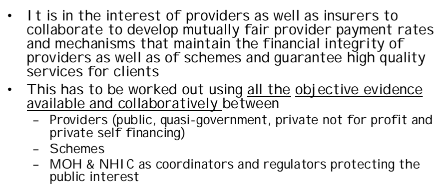
- There is no perfect provider payment mechanism
- Because there are pros and cons anyway you go, the choice of provider payment mechanism is a reasoned tradeoff
- Need to balance the pros and cons of different approaches in relation to the evidence and data available and the context
- Also need to build in a continuous monitoring and evaluation process to generate information for improvement



4

### Provider payment mechanisms

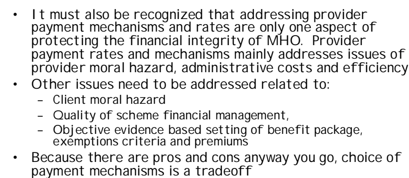
- It is in the interest of providers as well as insurers to collaborate to develop mutually fair provider payment rates and mechanisms that maintain the financial integrity of providers as well as of schemes and guarantee high quality services for clients
- This has to be worked out using <u>all the objective evidence available and collaboratively</u> between
  - Providers (public, quasi-government, private not for profit and private self financing)
  - Schemes
  - MOH & NHIC as coordinators and regulators protecting the public interest



5

### Provider payment mechanisms

- It must also be recognized that addressing provider payment mechanisms and rates are only one aspect of protecting the financial integrity of MHO. Provider payment rates and mechanisms mainly addresses issues of provider moral hazard, administrative costs and efficiency
- Other issues need to be addressed related to:
  - Client moral hazard
  - Quality of scheme financial management,
  - Objective evidence based setting of benefit package, exemptions criteria and premiums
- Because there are pros and cons anyway you go, choice of payment mechanisms is a tradeoff



6

## Payment mechanisms

- Already in place in Ghana
  - Fee for service
  - Line item budgets (GOG service & admin, investments etc)
  - Global budgets (DPF)
- Worth examining
  - Case based payments
    - Flat fee per episode or contact
    - Diagnosis related payment
    - Per diem
  - Capitation

7

## Terminology clarification

- PROSPECTIVE PAYMENT – the payment rate for a package of health care services is negotiated and agreed upon before the treatment takes place e.g. case based payments, capita based payments
  - Tends to increase the incentive for provider efficiency because the provider faces higher financial risks
  - However that same exposure of the provider to higher financial risk can depending on the circumstances provide an incentive for the provide to reduce patient care inputs and possibly quality depending on how essential or not the inputs reduced are. However the reduced inputs may actually be better
  - Example of reduction of injection use for insured patients in Dodowa under the flat fee per contact system

8

## Terminology clarification

- RETROSPECTIVE PAYMENT – the payment rate is selected during or after the service has been rendered. Also known as cost based reimbursement. Classical example is itemized fee for service
  - Tends to be cost escalating rather than cost reducing
  - Although prices for each service may be set in advance, providers are not limited by a predetermined agreement on types and numbers of services rendered
  - However interesting case of Germany where fee for service has not necessarily led to cost escalation because of other control mechanisms such as moral pressure on physicians and regulatory interventions. Still this is the exception rather than the rule

9

## Fee for service

- A specified payment for each unit of service provided.
  - Itemized fee for service (a set menu of prices for every possible component that goes into service provision with the cost of each contact being calculated based on the different components that went into service delivery during that contact)
  - After each contact, the components are individually costed and added up
- In theory should give better quality of care. In practice could lead to provision of unnecessary services and procedures

10

## Rationalizing fee for service

- Price standardization – reduce arbitrariness in billing under FFS
- Relative value scales (complicated to work out)
  - Used to standardize and bring order to itemized fee schedules
  - Each service is given a point value
  - A common service e.g. uncomplicated OPD visit is given a weight of one point and used as the reference
  - The point value is given a monetary value that is used to calculate the fee due based on the number of points assigned any given service

11

## Case based payment

- Diagnosis related groups – payment is determined by the diagnosis
- Flat rates e.g. fixed rate per OPD contact at a defined level of facility (HC, CHPS etc)

12

## Capitation

- Capitation – a set payment per client per time period e.g. per month regardless of the number of units of service provided to that client
- Paid in advance (prospective)
- Provider bears financial risks in case of inefficiency or inadequate calculation of rates
- Risk could be shifted to patient in the form of reduction of services. However these could be unnecessary or unneeded services. They could however also be needed services

13

## Provider payment mechanisms and possible effects

| | Possible incentives /effects on provider behavior, quality and admin costs | | | | |
|---|---|---|---|---|---|
| | Workload | Bills | Services | Quality | Admin |
| FFS | Increase* | Increase per case | Increase services per client | ?? | High |
| Case based payments e.g. flat FFS, DRG | Increase* | Stable per case but 'creeping' when DRG used | Reduce services per case but increase no of cases | ?? | Medium |

14

## Provider payment mechanisms and possible effects

| | Possible incentives /effects on provider behavior, quality and admin costs | | | | |
|---|---|---|---|---|---|
| | Workload | Bills | Services | Quality | Admin |
| Capitation | Reduce | stable | Reduce services per case | ??? | Low |
| Per diem (IP) | Increase | Could increase | Reduce per case daily but increase days | ??? | Low |

15

## *2.2 Conclusions from summary data on costs under NHIS and fee for service from BAR and ER*

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## *2.3 Presentation of results of costing study*

### Costing of Hospital Services

Ghana – Dutch Collaborative Study

Dan Osei
Deputy Director, PPMED-GHS

### Outline

- Why develop Service Costs
- Results
- Methodology

### Why Unit Costing

- What are the objectives & reasons this study?
  - To provide best estimate of cost of facility outputs including share of direct/ indirect and administrative overheads
  - To provide cost estimates for benchmarking and contracting of services to improve **efficiency**

### Methodology – Absorption Costing

- Key Features
  - Focus on Patient Related Services rather than inputs
  - Link cost to volume of services
- Focus on Expenditure not income
- Focus on all sources
- Basis of Apportionment using cost pools and cost drivers

### Interpretation of Results

- To provide the evidence base for decisions on pricing of services
- Tool for comparing performance
- Simple average price schedules - single charge for broad category of services – Flat Fees

### Interpretation of Results - 2

- Does not provide unit cost of diseases
  - e.g. Malaria,
- Does not differentiate between severity of diseases
  - Simple and complicated malaria
- Does not differentiate different levels of services
  - e.g. Child & Adult Registration & Consultation

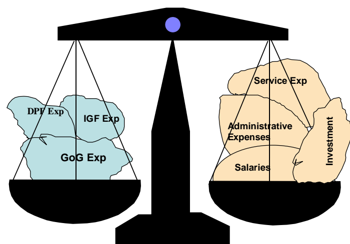
- Policy decisions are required to transform results into practice
  - Markups for drugs and consumables
  - Subsidy due to government budget

# Results

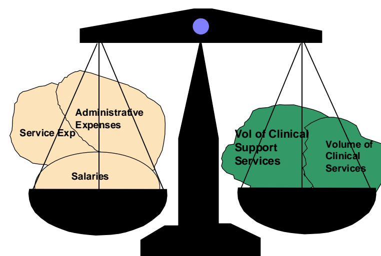
| Facilities | Average Cost Per Visit |
|---|---|
| Regional Hospital Sunyani | 75,000 |
| Effia Nkwanta Regional Hospital | 59,000 |
| Tetteh Quarshie Memorial Hospital | 65,000 |
| Sogakope District Hospital | 69,000 |
| Tema General Hospital | 56,000 |
| Zebilla District Hospital | 55,000 |
| Yendi Gov't District Hospital | 49,000 |
| La General Hospital | 47,000 |
| Kwesimintim Polyclinic | 34,000 |
| Bunsu Health Centre | 27,000 |
| Gara | 27,000 |
| Adukrom Health Centre | 26,000 |
| Sang Health Clinic | 23,000 |
| Kpotame Health Centre | 17,000 |

**Average Cost includes Registration, Consultation, Laboratory and Drugs (where available)**

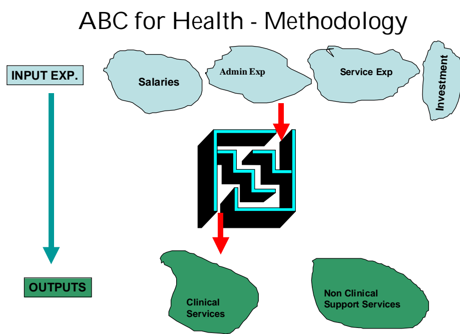
ABC for Health - Methodology

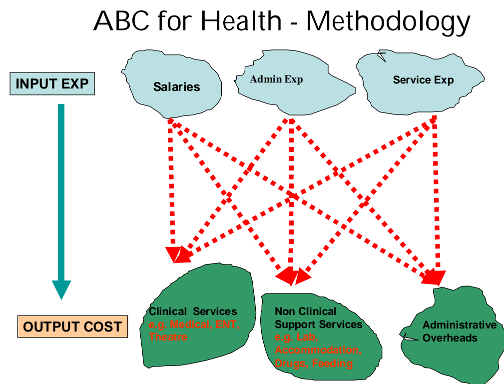


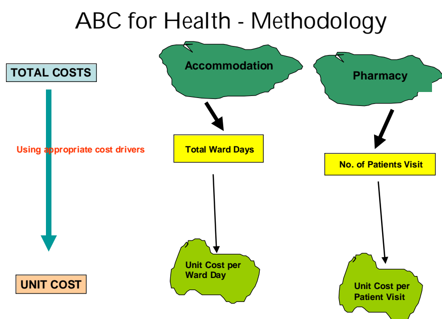

ABC for Health - Methodology

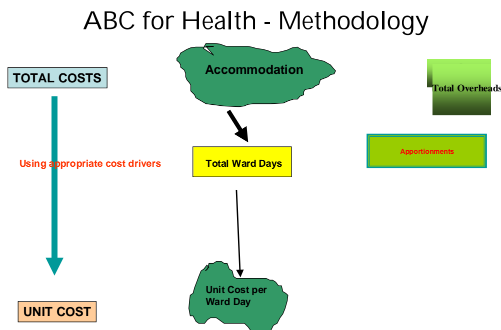


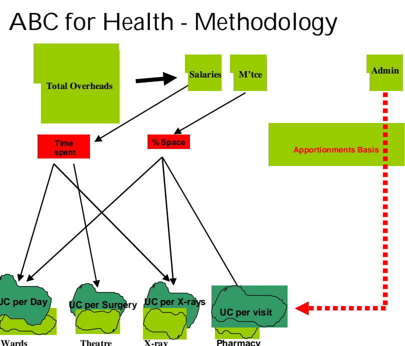

Total Expenditure = Total Utilisation


ABC for Health - Methodology
INPUT EXP.
Salaries
Admin Exp
Service Exp
Investment
OUTPUTS
Clinical Services
Non Clinical Support Services

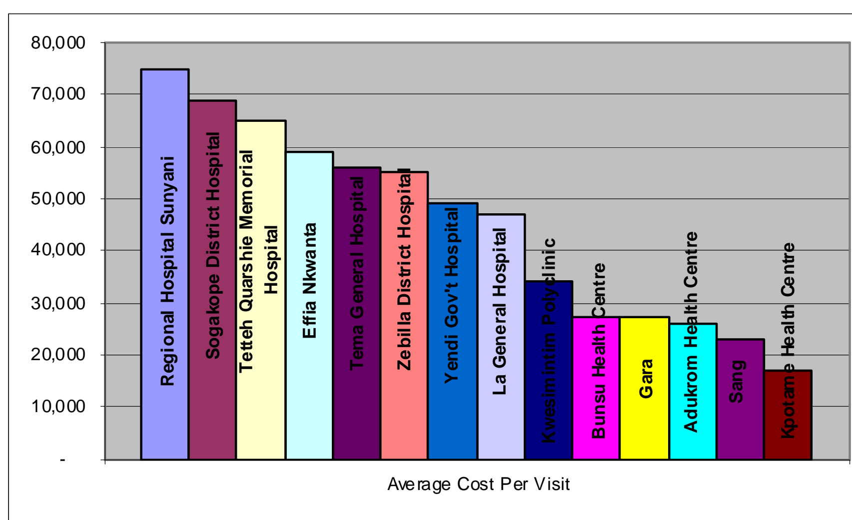

ABC for Health - Methodology
INPUT EXP
Salaries
Admin Exp
Service Exp
OUTPUT COST
Clinical Services
e.g. Medical, ENT, Theatre
Non Clinical Support Services
e.g. Lab, Accommodation, Drugs, Feeding
Administrative Overheads


ABC for Health - Methodology
TOTAL COSTS
Accommodation
Pharmacy
Using appropriate cost drivers
Total Ward Days
No. of Patients Visit
Unit Cost per Ward Day
Unit Cost per Patient Visit
UNIT COST


ABC for Health - Methodology
TOTAL COSTS
Accommodation
Total Overheads
Using appropriate cost drivers
Total Ward Days
Apportionments
Unit Cost per Ward Day
UNIT COST


ABC for Health - Methodology
Total Overheads
Salaries
M'tce
Admin
Time spent
% Space
Apportionments Basis
UC per Day
UC per Surgery
UC per X-rays
UC per visit
Wards
Theatre
X-ray
Pharmacy

# Results – Unit Cost




# Results – Unit Cost

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|---|---:|
| Regional Hospital Sunyani | 75,000 |
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| Effia Nkwanta Regional Hospital | 59,000 |
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| Bunsu Health Centre | 27,000 |
| Gara | 27,000 |
| Adukrom Health Centre | 26,000 |
| Sang | 23,000 |
| Kpotame Health Centre | 17,000 |

**Average Cost includes Registration, Consultation, Laboratory and Drugs (where available)**

## *2.4 Factors affecting enrollment in the NHIS – A Study from the Ho Municipality*

FACTORS INFLUENCING THE ENROLLMENT OF THE INFORMAL SECTOR IN THE HO MUNICIPAL HEALTH INSURANCE SCHEME

**ROBERT K. ADATSI [1]**
**IRENE A. AGYEPONG [2]**
**KARIM SHAKOOR [3]**

1

### STATEMENT OF THE PROBLEM

- Currently the Ho municipal scheme records show that it has only achieved about 5% percent registration of Ho Municipal population
- Only 0.6% of registered members comprise informal sector workers.
- The low participation of the informal sector is of much concern to the Ho Municipal MHIS and other stakeholders.

2

### GENERAL OBJECTIVES OF THE STUDY

- To describe the factors contributing to the low enrollment of the informal sector in the Ho Municipal MHIS, their relative importance and how they contribute to the net observed result of low enrollment in the Municipal MHIS.

3

### SPECIFIC OBJECTIVES

- To describe the factors influencing willingness of the informal sector to voluntarily pay premium for the enrolment in the HO Municipal MHIS.
- To describe geographical access to insured health services in the Ho Municipality by mapping out service availability and geographical distribution of facilities providing services to insured clients.
- To make recommendations as to the validity of the starting problem analysis diagram and provide information on the factors and variables that needs to be assessed in any following quantitative study.

4

### STUDY AREA

- Ho Municipality is one of the fifteen (15) political/administrative districts in the Volta Region.
- The population of the Municipality stood at 253,732 as at 2004 [**estimated figure from the 2000 population census]**. This represented about 14.4% of the total population of the Volta Region.
- Females constituted 51.8% (**i.e. 131,433)** while the males constituted 48.2% (122,299**)** of the total Municipal population.

5

### STUDY AREA -2 **Health Institutions**

| No | Category | Number |
|---|---|---|
| 1 | Regional Hospital | 1 |
| 2 | Municipal Hospital | 1 |
| 3 | Polyclinic | 1 |
| 4 | Health Centers | 39 |
| 5 | RCH/FP Static Clinics | 3 |
| 6 | Quasi Government Institutions | 1 |
| 7 | Christian Health Association Clinics | 2 |
| 8 | Private Maternity Homes | 5 |
| 9 | Private Clinics | 3 |
| | **Total** | 56 |

6

## HO MUNICIPALITY MAP

HO MUNICIPALITY MAP



## METHODOLOGY

- Descriptive cross sectional study
- The study population consisted of informal sector workers in the Ho-Shia, Kpedze-Vane and Abutia Sub-Municipalities.
- Fifteen (15) FGDs were conducted in total.
- Seven in-depth interviews were conducted in which 7 people participated.
- Five to fifteen (5-15) participants were in each group.
- A total of 141 participants took part in the study.



## METHODOLOGY cont'n

- Ho-Shia, Kpedze-Vane and Abutia Sub-Municipalities were purposely selected as the study sites.
- Purposive sampling was used to choose 12 communities in the three Sub- Municipalities selected for the study.
- All informal sector workers defined as non SSNIT registered who were above eighteen (18) years and in the Ho Municipality were eligible for selection into the study.
  - Insured FGD participants were selected systematically using community insurance register.
  - Uninsured FGD participants were selected systematically using community household register



## DATA COLLECTION TECHNIQUE

- Three data collection methods were used in the study.
  - FGD for uninsured & insured informal sector workers.
  - In-depth interviews.
  - Facility and service mapping.
- Data was analyzed manually



## RESULTS

- In presenting the results relevant quotes from the respondents were used to illustrate and support the observations made.
- The results will be presented by the specific objectives.



## Occupation of Respondents

OCCUPATION OF RESPONDENTS

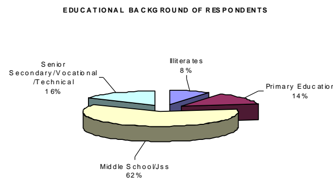
Not Specific 3%

Artisan 29%

Farmers 38%

Traders 30%

## Educational Background of Respondents




13

## WILLINGNESS TO PAY PREMIUM BY INFORMAL SECTOR

- The following were mentioned as factors influencing willingness to pay.
  - Lack of awareness & understanding of health insurance.
  - Number of dependants
  - Premium and schedule of payment.
  - Benefit package.
  - Registration arrangements
  - Financial barriers.
  - Quality of service.
  - Time of issue of ID cards.
  - Initial over politicization of NHIS policy
- Points are illustrated in next slides with quotes

14

## LACK OF AWARENESS

- Board chairman with a serious look said;

*"But the intensity of education is not sustained because of pressure of work. Even Ho Township has little or no information about the scheme. The unit communities could also be used for awareness creation but they lack motivation. So logistic and motivation must be provided for the scheme themselves, such as motorbikes and bicycles for the agents. Dissemination of information could be done through community durbars, house to house campaigns like its done during political campaigning,posters,TV Radio information are not enough since it not everybody who can read or have TV and radio."*

15

## PREMIUM AND SCHEDULE OF PAYMENT

- An elderly woman in a sober mood said,

*"After paying my children school fees, what I am left with is only for food."*

- *A 73 years old woman in a sad mood commented,*

*"Enye ya evi gba va wum alegbegbe" meaning, "as for me I am over burdened with dependants."*

- *A young lady trader remarked;*

*"Payment should be done monthly as being done to formal sector workers."*

16

## REGISTRATION ARRANGEMENTS

- A 45 years old man with a frown face said,

*"Cost of traveling is high and we have to travel a long distance to registration points. It is better and of lesser cost to us if the registration point would be located in the community to sell registration forms and take photographs."*

17

## BENEFIT PACKAGE

- *A 50 years old Chief said,*

  *"The fact that all diseases are not covered is not good. This could lead to low registration since people don't know which illness that will attack and kill them".*

- The market Queen said with a frown on her face,

  *"When I went to the hospital the first time, I was given all the drugs but later when I went I was told that the drugs I need are not covered by the scheme. Because of this I don't use my card again. I think if the drug list is not reviewed, it will discourage some of us. Therefore, I will not encourage anybody, to join the scheme especially **diabetic patients**".*

18

## QUALITY OF SERVICE

- A disappointed looking 58 years old man said angrily;

  *"My wife went to the Hospital but stayed long overdue. When I asked her she said, at the hospital the card bearers were separated from the cash and carry clients. The cash and carry clients were treated first before the insured clients. In fact she blamed the Nurses at post and regretted for joining the scheme"*

- *An angry young woman said,*

  *"When it is night, the Nurse will tell you, she is not going to treat you."*

  *"Don4r ate `u aku 5aa elabena nye ha mate `u aku" meaning, you the sick person can die free since I can also die.*

- The Municipal Chief Executive in a relaxed mood but with a stern looking face said,

  *"We expect the medical and paramedics at the facilities to change their attitude so that quality of care could improve. Today is a theatre day and so on, which affects OPD and hospital attendance".*

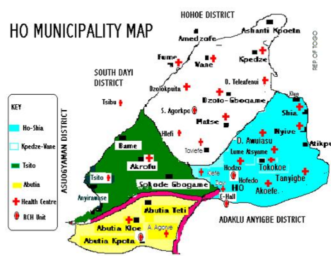
19

## GEOGRAPHICAL ACCESS TO INSURED SERVICES

- Overall 85% uninsured & 69% insured participants lived within a walking distance from a healthcare facility.
- Population ratio to healthcare facilities:
- Ho-Shia 1:3, 876
- Kpedze-Vane 1:7, 415
- Abutia 1:1, 3718

20

## FACILITY AND SERVICE AVAILABILITY MAPPING




21

## GEOGRAPHICAL ACCESS

- Most of these facilities were almost non-functional.
- Availability of services woefully inadequate.
- Participants had to travel long to distant towns such as Ho to access healthcare.
- Sometimes the total cost of travel and services was more than the minimum premium.

22

## CONCLUSION

- Enrollment of the informal sector in the Ho Municipal Health Insurance Scheme was influenced by two main factors:
  - (1) Willingness to pay premium and the factors influencing it already described.
    - Lack of awareness and understanding of health insurance.
    - High numbers of dependants.
    - Financial barriers.
    - Inappropriate registration arrangements.
  - (2) Poor level of service availability in the healthcare facilities in the study area.

23

## OTHER FINDINGS OF INTEREST AND CONCERN

- Inadequate knowledge of participants about the registration procedure, the minimum benefit package and its content, mode of payment and the approved time of issue of ID cards.
- Perceived poor quality of healthcare in the participating health facilities.
- Discrimination against insured clients.
- Initial over politicization of the NHIS policy and lack of sense of ownership.

24

## RECOMMENDATION

- Intensifying education and awareness creation, using methods of disseminating NHIS information that will facilitate the peoples understanding of key issues.
- Community health insurance committees should be established in all communities or reactivated where they already existed.
- Community registration points should be established, at least at sub-municipal capitals to handle some aspects of registration and collect premium.

25

## RECOMMENDTION cont'n

- Reorientation of health personnel about the NHIS. The thrust of this orientation must be on issues relating to quality of service provision (interpersonal relationship).
- Support for the poor through the provision of government subsidy to pay part of their premium.

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## Appendix 3 – Acknowledgements (Secretariat /Final report compilation)

Mrs. Cecelia Oppong Peprah
Mr. Alex Ntow
Mrs. Rebecca Lokko
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