European Journal of Business and Management
ISSN 2222-1905 (Paper) ISSN 2222-2839 (Online)
Vol.5, No.13, 2013

Topic: Financing A Tertiary Level Health Facility In Kumasi - Ghana

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ABSTRCT
The researchers sought to study the revenue and expenditure policy in the health sector. The study was conducted at the Komfo Anokye Teaching Hospital. Health institutions are financed through either private expenditure or public expenditure. Non-probability sampling technique was used in order to achieve the objectives set for the research. And also, financial statements of the hospital for 2008, 2009, 2010 and 2011 were used. The study revealed that the main sources of funding for the Komfo Anokye Teaching Hospital were from the Internally Generated Funds (IGF), Government of Ghana subventions (GoG) and the Donor Pool Fund (DPF). With regards to percentage contribution to revenue in terms of cash IGF, DPF and GoG contributes 88%, 3.35% and 8.97% respectively to the total cash revenue of the health sector. Thus, IGF is the main source of funding in the health sector with very little contributions from the other sources. Expenditure items in the health sector are broadly categorized into four categories namely; personnel emolument, administration, service delivery and investment. The analyses of these expenditure items revealed that expenditure on service delivery (service and drugs) constitute the biggest expenditure item. This was followed by personnel emoluments, administration and investment respectively. Since IGF is now the most reliable source of revenue in the health sector, policies, strategies and controls must be put in place in order to enhance revenue mobilization in the health sector.
KEY WORDS: Financing; Healthcare; Expenditure

1.0 INTRODUCTION

According to Teddy (2007) healthcare financing in the world over has been of great concern to both developed and developing countries. Thus, policies on how to finance and provide healthcare to an entire nation to include formal and informal sectors, rural and urban areas in low and middle income countries is a huge challenge for most developing countries. However, in Sub-Saharan Africa Countries, healthcare financing policies has been in crisis mainly because of the frequent occurrence of political instability coupled with severe economic constraints and lack of good governance. The prominence of these setbacks in financing healthcare among Sub-Saharan African Countries has led to policies developed on health care spending to be strategized around various transitory national objectives.

Mensah (2001) laments that, the rising cost of providing healthcare has become an albatross hanging over the heads of most nations both developed and developing and Ghana is no exception. He noted that, while most countries adopted the World Health Organization (WHO) goal of "Health for all by the year 2000 AD", there were no clear guidelines or models on how this would translate into health services delivery, and whether such services would be affordable. Year 2000 has come and gone and "health for all" has become an illusion.

None other than a former Minister of Health, Dr. Eunice Brookman-Amissah (1998), had dismissed as too idealistic and out of tune with nature the hope of attaining a disease free nation come the year 2000. Decrying what she termed as the simplistic view of Ghanaians on the concept, she said, "The slogan health for all was a means to register the world health organization (WHO) dissatisfaction with the inequity in access to healthcare. It is meant to ensure that good health is not the preserve of a few but something enjoyed by all", she added.

According to her, over the past years, healthcare has been inaccessible to most Ghanaians resulting from the collapse of the public health services. There has also been reported an acute shortage of doctors in the country despite the country having two medical schools and a good number of nursing training colleges.

From the Ministry of Health's (MoH) National Health Policy document (2007), total funds available for healthcare have been increasing in the last ten years from improvements in the following factors:

- Positive macro economic climate

- Increased allocation from government to the health sector
- Increased donor inflows
- Introduction of the national health insurance scheme (NHIS)
- Improved collection and management of internally generated funds.

However, the financing is still a major challenge. The increase in funding to the health sector has gone mainly into the payments of personal emoluments rather than to support service delivery. At the same time the increase in personal emoluments have not risen to the point where the salaries in the sector can match those of developed countries. The Ministry of Health has been reforming its financing strategies in two main areas, that is, pooling of funds and the development of a formula for resource allocation. The National Health Insurance Fund established under the National Health Insurance Programme pools funds collected from the National Health Insurance Levy and 2.5% of the Social Security contribution of all workers (National Health Insurance Act 2003, Act 650).

Health institutions are financed through either private expenditure or public expenditure. The differences are subtle but become very important when developing countries are searching for ways to maintain or increase health service spending, while the international monetary Fund and/or the World Bank are watching closely to make sure, as a condition of their help, that the public sector pays its way without borrowing, which could be inflationary. Put at its simplest, where tax revenue are used to pay for services or compulsory health insurance contribution, by either employers or insured persons or both, this counts as public expenditure. Voluntary payments by individuals or employers are private expenditure. The ownership of the facilities used, whether by government, social insurance agencies, non-profit organizations, private companies or individuals is not relevant in this connection. Any of these facilities are financed by either public expenditure or private expenditure (Akin et al, 1987).

Financing of healthcare has become extremely expensive compared to the free health care of the first republic. The sustainability of this form of financing has become questionable as the economy has shown signs of decline and increased competing demands. The increase in the population coupled with demand for better healthcare in recent times has put intense pressure on the healthcare facilities. It is therefore necessary for the expansion and improvement of the existing facilities to meet the increasing demand. This needs massive investment activities to be done in the sector. It is against this background that the researchers want to identify the main sources of funds and main expenditure items of a Tertiary Level Health Facility in Ghana.

2.0 LITERATURE REVIEW

2.1 GOVERNMENT POLICY ON HEALTH CARE FINANCING

Financing health care has gone through a chequered history in Ghana. Immediately after independence, health care provided to the people was “free” in public health facilities. This meant that there was no direct out of pocket payment at the point of consumption of health care in public health facilities. Financing of health in the public sector was therefore entirely through tax revenue. The sustainability of this form of financing became questionable as the economy began to show signs of decline and there were competing demands on the same source. What is important to note was that the general tax revenue did not allow for a percentage earmarked for health as we now have in the case of a percentage of VAT funds earmarked for education (National Health Policy Framework, 2007).

By 1969, the realities of the continued economic decline had compelled the government to introduce nominal out-of-pocket contributions to health care services and the Hospital’s Fees Decree, 1969 (NLCD 260) was passed. This situation continued until 1985 when the Government introduced the user fees for all medical conditions except certain specified communicable diseases. The free health care policy was badly implemented in the country. For example, although communicable diseases were supposed to have been exempted, in practice nobody enjoyed this facility. In addition, a guideline for implementation was not provided and no conscious system was designed to prevent possible financial leakage. In the ensuing years, the standard of health care provision fell drastically. There was acute shortage of essential drugs in all public health facilities. Most importantly, the introduction of the user fees resulted in the first observed decline in utilization of health services in the country (National Health Policy Framework, 2007). In spite of this, the government went ahead to institute full cost recovery for drugs as a way of generating revenue to address the shortage of drugs. The payment mechanism put in place was termed “Cash and Carry”. The implementation of the ‘cash and carry’ compounded the utilization problems by creating a financial barrier to health care access especially for the poor. It is estimated that out of the 18% of the population who require health care at any given time, only 20% of them are able to access it, implying that about 80% of Ghanaians who need health care cannot afford it.

2.2 Donor Pool Fund (DPF)

Donor Pooled Fund (DPF), also known as "The Health Fund", was launched in 1997. Two partners, Department for International Development (DFID) and Danish International Development Agency (DANIDA) started disbursement to this account in 1997 with the World Bank, European Union and Netherlands Embassy joining in 1998-9. As of early 2001, the same five partners contributed to the Fund although some problems have emerged. The contributing partners make an annual commitment to the fund. This commitment is made based on the annual programme of work and budget. Ideally, funds are disbursed in regular quarterly tranches at the beginning of each quarter, although not all partners have been able to comply with this. Funds are held in the Donor Pooled Account to which MoH and the Controller and Accountant General are signatories. The fund is allocated on a quarterly basis (subject to adequate in-flow of donor funds) to the various levels of BMCs: national level, tertiary, regional and district. Sub district funds are presently held by districts, as they are not yet full BMCs. Whilst the Health Fund is disbursed separately from GoG funds, it is budgeted for and reported on in an integrated way (budgets and financial reports are based on a combination of Health Fund, GoG funds and Internally Generated Funds) (Govindaraj et al, 2001).

2.3 Internally Generated Fund (IGF)

Waddington et al, (1989) indicated that the source of internally generated funding (IGF) for public health is from user fees payments made by patients. This was preliminary received from out-of-pocket payments, until 2003 when the national health insurance scheme was introduced in Ghana to redress some of failures inherited in the out-of-pocket payment system in public health institutions, which is generally seen as regressive and therefore disadvantaged the poor. The IGF comprises revenue generated in services like consultation, laboratory services, mortuary, X-rays, in-patient feeding and accommodation, and other revenue like car park tolls, auction sales and others. These concerns are particularly important in view of the earlier findings made by Waddington and Enyimayew that, the 1985 increase in user fees in Ghana resulted in a sharp and significant reduction in the utilization of ambulatory care (Waddington et al, 1989).

2.4 Government of Ghana Subventions (GoG)

Government of Ghana (GoG) contributions also fell short of expectations, with the percentage of GoG expenditure allocated to health standing at an estimated 8.1% in 1999 as against a target of 11.0%. The 5 Year POW's aim to restore GoG recurrent spending back to 1991 levels (12%) by 2001 did not look on course to being achieved (MoH, 1999). The achievement of overall expenditure targets had been analyzed to be partly by means of commercial borrowing (not envisaged in the original POW) and partly by a contribution from IGF. However, as GoG funding to hospital has been dwindling over the years, the financing burden is strongly being shifted to IGF. This increase trend in percentage funding of hospitals through IGF (i.e. payments from user fees) has been identified as a possible source of concern in terms of burden of payments on the public. In 1985, the Hospital Fees Regulation was promulgated to stipulate the fees to be collected at government health facilities. The regulation set fees for out-patient attendance, laboratory and other investigations, medical, dental and surgical treatment, medical examinations, drugs, and hospital accommodation and catering. The regulation provided for a graduated fee structure with fees for outpatient consultation and delivery, increasing from rural health center and posts through district and regional hospitals to teaching hospitals.

However, as discussed above, overall resource allocation to Hospitals have been disappointing and the latest projections of likely GoG and donor contributions in the short to medium term are a cause for concern. This has led to a reconsideration of how IGF and indeed all monies received by hospitals should be controlled and managed (MoH, 1999).

Between 1983 and 1990, the administration of user fees evolved to allow individual institutions retain all revenue generated. At the beginning of the cost recovery program, all revenue generated by individual health facilities went into a central account controlled from national level. Subsequently, health institutions have been allowed to keep increasing percentages of revenue generated. Today, health institutions retain all revenue generated. The revenue is kept in two separate bank accounts: one for drugs, and a second for other revenue. The rationale is to use money from the drugs account solely for the purchase of drugs to ensure that there is always money for drugs. Funds from the other accounts can be used at the discretion of the local facility's manager to improve the quality of care provided (MoH, 1999).

2.5 Healthcare Expenditure

Gupta and Mitra (2004) undertook a cross country analysis of 56 countries. In their study they concluded that increasing public expenditure on health has the ability to reduce the mortality rates of infants and children in a

population. Toor and Butt (2005) in determining healthcare expenditure in Pakistan had shown that the share of health expenditure to the total public sector expenditure is the most important variable affecting health status of a country. Moreover, literacy rate and gross domestic product growth rate are also essential variables that had positive relationship with Health Care Expenditure.

Norman (1985) had observed that increasing government expenditure on health had been found to benefit the upper income class rather than the lower class. This is apparently because the upper income class possesses the ability to meet up with the cost of such health care provision.

Castro-Leal et al (2000) while analyzing curative care in several African countries also found that public sector spending on health favors mostly the better-off rather than the poor. This pro-rich public expenditure on heath was further observed by Hamid- et al (2003) while utilizing Benefit Incidence Approach (BIA) covering 56 countries found on the average a pro-rich spending on health in sub-Saharan African countries. While believing that health expenditure has the ability to improve health status of a population, it has also been evidently established that such expenditure had been pro-rich particularly, among African countries. Thus, the income elasticity of health care expenditure in African countries has been reported to be below unity.

Gerdtham (1992) used pooled cross section and time series data for 22 OECD countries including Turkey and compared different models (Static Equilibrium Model, Error correcting Model, Dynamic model, ARDL growth rate and partial adjustment model). The result indicated short-run income elasticity below unity and a long-run income elasticity of health care expenditure around unity in all their models estimated.

Moore (1992) specified a supply model for cross country examination where per capital Health Care Expenditure is a function of per capital income. The result shows that health is a necessity good (with elasticity below unity) in the short run and a luxury good in the long run.

Sogaard, Anderson and Jonsson (1992) investigated a similar relationship for 19 OECD countries using cross section data and generalized a model where Health Care Expenditure is a function of National Income, relative price of health care services, supplier induced demand, public financing, age distribution and urbanization. The result indicated that the income elasticity is greater than one. It remains yet to be established if the income elasticity of health care expenditure is unity or below unity is Ghana. The characteristic behavior of income elasticity on expenditure on health will determine the direction of budgetary flow and re-distribution of public expenditure in Ghana.

3.0 METHODOLOGY

Non-probability sampling technique was used in order to achieve the objectives set for the research. Both primary and secondary source were used for the research. The primary data used for this study dealt with information gathered from selected members of management of the hospital. This was achieved by the use of interview guide to solicit information from the Director of Finance. Secondary data comprise data that were originally collected for some other purpose. The secondary data used in this research included the documents received from the finance directorate and also financial statements of the hospital for 2008, 2009, 2010 and 2011. The data collected were examined, categorized, tabulated and analyzed to address the research objectives and the research questions. Information gathered were first edited and organized into tables. Some of the values were later converted into percentages to facilitate comparison between the responses.

4.0 RESULTS / DISCUSSION

4.1 Internally Generated Fund

The source of internally generated funding (IGF) for KATH is from user fees payments made by patients. This was preliminary received from out-of-pocket payments, until when the national health insurance scheme was introduced in Ghana to redress some of failures inherited in the out-of-pocket payment system in public health institutions. The IGF comprises revenue generated in services like consultation, laboratory services, mortuary, X-rays, in-patient feeding and accommodation, sale of medicine and other ancillary revenue such as car park tolls, auction sales and others.

Table 1 Total IGF Revenue Generated at Kath for the Period 2008 - 2011.

YEAR	REVENUE GENERATED GHS	PERCENTAGE CHANGE GHS
2008	7,521,414.08	-
2009	12,486,378.97	66%
2010	16,685,951.66	33,6%
2011	19,496,461.67	16.8%

Source: Income and Expenditure Report

From the table above, total revenue generated from this source amounted to GHS 7,521,414.08 in the year 2008. This figure increased by 66% to GHS 12,486,378.97 in 2009, to GHS 16,685,951.66 in 2010 indicating a 33.6% increase over the previous year's figure and to GHS 19,496,461.67 in 2011, thus an increase of 16.8% over the 2008 figure. The observed increase in IGF at KATH over the years under consideration can be attributed to the increase in patient attendance since the introduction of the national health insurance policy and also an increase in charges for services rendered by the hospital.

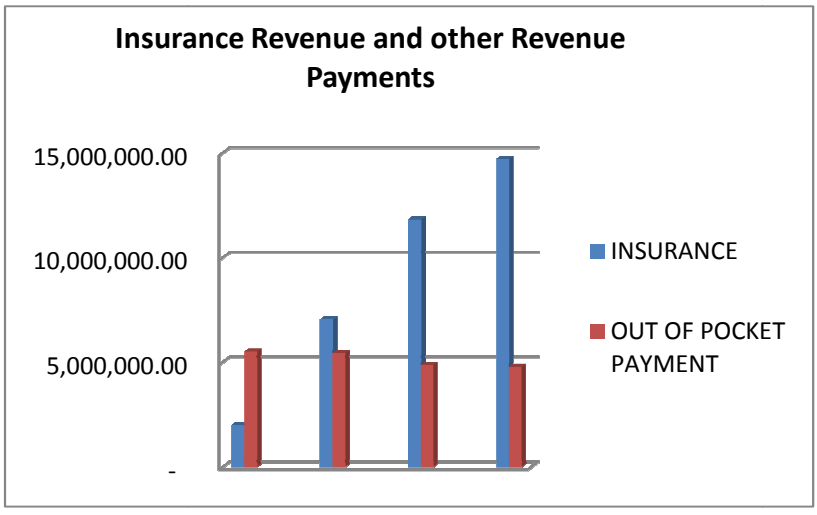
Table 2 Drug and Service Revenue for 2008 to 2011

AMOUNT/ YEAR	SERVICE GHS	PERCENTAGE CHANGE (%)	DRUGS GHS	PERCENTAGE CHANGE (%)
2008	5,332,138.13	_	2,118,041.15	_
2009	8,013,188.88	50.3	4,345,444.84	105.2
2010	11,363,016.40	41.8	5,111,570.26	17.6
2011	12,872,826.92	13.3	6,476,015.31	26.7

Source: Income and expenditure report

From the above table 2, revenue generated in the course of providing service to patients increased by 50.3%, 41.8% and 13.3% in 2009, 2010 and 2011 respectively. For the same period, revenue generated from the sale of drugs increased by 105.2%, 17.6% and 26.7% in 2009, 2010 and 2011 respectively. The observed increases in service and drug revenue over the period resulted in an increase in total IGF revenue over the period. This means real annual growth in revenue of the hospital over the period.

Figure 4.1 Breakdown of IGF into Insurance and other Revenue Payments



Source: Field Data

From the graph, other revenue payments (out-of-pocket, corporate bills, social welfare, absconders and paupers) contributed more to IGF in the year 2008 but were overtaken by insurance payments thereafter. This trend is attributed to the fact that, as more people register to join the national health insurance scheme, the number of patients who visits the hospital on account of insurance increases compared to the other payment methods. Thus, as the coverage of the national health insurance scheme increases, a substantial part of IGF accruing to public health facilities would come from insurance payments. For example, the ratio of out-of-pocket payment to payments received from health insurance for the year 2011 was 3:7 respectively. That is, 70% of total IGF for the

year was from the NHIS. This continued trend tends to confirm the fact that revenue from health insurance constitutes a greater percentage of IGF revenue in public health institutions.

TABLE 4 TREND OF CLAIMS SUBMISSION FOR 2008-2011

YEAR/ MONTH	2008 GHS	2009 GHS	2010 GHS	2011 GHS
JANUARY	24,989.62	418,358.65	745,094.01	601,849.68
FEBRUARY	58,682.81	411,851.43	860,411.18	874,669.63
MARCH	68,747.94	399,954.88	704,670.72	1.282.946.71
APRIL	67,883.48	602,683.62	1,023,017.97	983,964.28
MAY	140,550.83	561.586.14	856,710.73	1,089,372.01
JUNE	108,201.05	634,429.36	1,422,045.66	1,444,246.06
JULY	171,230.57	568,519.11	1,516,273.88	1,275,734.38
AUGUST	210,530.78	730,517.61	648,076.82	1,297,410.77
SEPTEMBER	265,530.89	711,082.56	1,130,643.62	1,436,835.73
OCTOBER	312,430.24	666,607.87	1,253,964.87	1,388,088.28
NOVEMBER	295,126.07	692,204.63	967,143.44	1,559,233.63
DECEMBER	291,909.16	646,393.16	697,073.08	1,405,115.27
TOTAL	**2,015,813.44**	**7,044,189.02**	**11,819,088.81**	**14,639,466.43**

Source: Health Insurance Unit 2011 Performance Review

From the table above, revenue received from health insurance increased from GHS 2,015,813.44 in 2008 to GHS 7,044,189.02 in 2009 representing a 249.5% increase over the year 2008 figure. In year 2010, an amount of GHS 11,819,088.81 was realized from health insurance which was an increase of 67.8% over what was realized in 2009. Revenue realized from health insurance in 2011 was GHS 14,639,466.43. That is an increase of approximately 24% over the 2010 figure.

TABLE 5 BREAKDOWN OF HEALTH INSURANCE DEBT PORTFOLIO

ITEM/ YEAR	SERVICES GHS	DRUGS GHS	TOTAL GHS
2008	173.37	63.04	**236.41**
2009	93,760.70	42,101.81	**135,862.51**
2010	269,518.23	126,715.46	**396,233.69**
2011	3,885,434.27	2,268,305.53	**6,153,739.80**
TOTAL	**4,248,886.57**	**2,437,185.84**	**6,686,072.41**

Source: Health Insurance Unit 2011 Performance Review

In spite of the fact that revenue received from health insurance forms a substantial part of IGF which happens to be the main source of revenue for the hospital, the hospital has not been able to collect all the money owed by the mutual health insurance schemes. From table 5 above, total indebtedness by the mutual health insurance schemes to the hospital stood at GHS 236.41 in 2008. In 2009, total indebtedness by the mutual health insurance schemes increased to GHS 135,862.51. This trend continued in 2010 with an outstanding debt of GHS 396,233.69 owed by the schemes. The situation was worse in year 2011 with a whooping GHS 6,153,739.80 being debt outstanding. The continuous indebtedness by the mutual health schemes to the hospital poses a financial problem to the hospital since cash needed to procure essential consumables for the running of the hospital may not be available.

IGF expenditure

In hospitals setup, expenditure is classified and coded according to accounting activities. The classification of accounting structure within a hospital is classified into four main categories namely Item 1 which deals with personnel emoluments, Item 2 which takes care of administrative expenses, Item 3 made up of expenditure for

service delivery and Item 4 which is expenditure for investment activities.

Table 6 Total IGF expenditure

YEAR	TOTAL EXPENDITURE GHS	PERCENTAGE CHANGE %
2008	6,795,148.83	_
2009	10,920,632.32	61%
2010	15,567,945.12	43%
2011	16,749,682.92	8%

Source: Field Data

As illustrated in the table above, expenses incurred in generating revenue internally amounted to GHS6, 795,148.83 in 2008. This expense rose to GHS10, 920,632.32 in 2009. That is, an increase of 61% over the 2008 figure. It rose further to GHS15, 567,945.12 in 2010, registering a 43% increase and to GHS16, 749,682.92 in 2011 which was an increase of 8% over the 2010 figure. The observed increase is generally attributed to an increase in patient attendance to the hospital and general rises in the prices of goods and services in the country.

Table 7 IGF Revenue and Expenditure Compared

YEAR	TOTAL REVENUE	TOTAL EXPENDITURE	SURPUS / DEF
2008	7,521,414.08	6,795,148.83	726,265.25
2009	12,486,378.97	10,920,632.32	1,565,746.65
2010	16,685,951.66	15,567,945.12	1,118,006.54
2011	19,496,461.67	16,749,682.92	2,746,778.75

Source: Income and Expenditure Report

From the above table, it could be seen that revenue generated internally at KATH exceeded its expenditure over the years. This phenomenon is due to the modified accrual accounting concept used by the Ministry of Health (MoH, Accounting, Treasury and Financing Reporting). Thus, in terms of revenue reporting, it is strictly based on billed revenue. This means any revenue earned is recorded irrespective of it being received or not. But on expenditure reporting, cash accounting is the basis used (that is, expenditure is recorded only when cash is paid for that expense). These accounting concepts used tend to constraint the comparison between revenue and expenditure because the bases for their recordings are not the same. For the successive years, 2008, 2009, 2010 and 2011 it is clear that IGF revenue has consistently exceeded IGF expenditure which meant that the hospital is generating more from IGF than it is spending out of IGF.

4.3 Donor Pooled fund

Donor Pooled Fund (DPF), also known as "The Health Fund", was launched in 1997. Two partners, Department for International Development (DFID) and Danish International Development Agency (DANIDA) started disbursement to this account in 1997 with the World Bank, European Union and Netherlands Embassy joining in 1998-9. The contributing partners make an annual commitment to the fund. This commitment is made based on the annual programme of work and budget. Ideally, funds are disbursed in regular quarterly tranches by the Ministry of Health at the beginning of each quarter, although not all partners have been able to comply with this. In 2008, KATH received a total amount of GHS 870,907.31 from this fund as budgetary support from the Ministry of Health. 42.5% of this amount was used to support the administrative activities of the hospital, 33.3% was used in the delivery of services at the hospital whilst the remaining 24.2% went into investment in new projects at the hospital (Income and Expenditure Report 2007). In 2009, DPF shifted from their previous financial support to budgetary support. Because of this new policy shift of DPF to budgetary support since 2007, amounts received from that period onwards were mainly for ongoing projects such as the construction of doctors flats among others.

In 2009, there was no budgetary allocation from DPF; however, the hospital received some funds for specific projects and activities the details of which are stated below:

Project/Activity	**Funds Received (GHS)**
Construction of Doctors flat	188,940.10
Purchase of computers	100,000.00
Fellowship	125,000.00
Polyclinic rehabilitation	101,302.00
CAN 2008 Training	12,012.00
Total	**527,254.00**

Source: KATH Annual Report 2011.

In year 2010 also, there was no budgetary allocation from DPF, but the hospital again received funds for some specific projects and other activities details of which are presented below:

Project/Activity	**Funds Received (GHS)**
Fellowship	145,825.00
CAN 2008 Training	74,411.22
Other project funding	90,128.13
Total	**310,364.35**

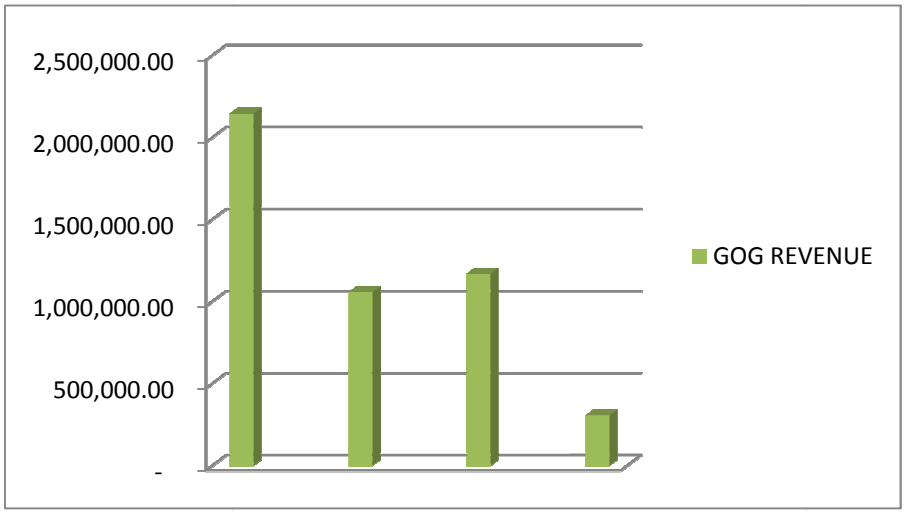
Source: KATH Annual Report 2011

Significantly, in the year 2011, no DPF revenue was received by KATH. These therefore indicate that the hospital is heavily dependent on IGF.

Government of Ghana subventions

Government of Ghana subventions to the health sector has fallen short of expectations in recent times. This is evident in the decreasing trend in the amount of Government subvention received by KATH from 2008 to 2011. The chart below depicts the amount and trend of GoG flow to KATH. However, it must be emphasized that majority of the staff at the hospital and major investment activities at the hospital are paid for and financed directly by the government. Therefore the information below excludes these payments by the government.

Fig. 2 GoG received by KATH over the period



Source: Field Data

From the graph above, the amount of Government of Ghana (GoG) subvention to KATH has generally been decreasing over the period. Thus, from its 2008 figure of GHS 2,154,992.89, it fell to GHS 1,055,581.91 and GHS 1,169,963.52 in 2009 and 2010 respectively. In 2011, it fell further to GHS 305,911.57. Thus GoG contributions have fallen short of expectations and as GoG funding to the hospital is dwindling over the years, the financing burden is strongly being shifted to IGF.

Table 8 GoG expenditure for 2008-2011

ITEM	2008 GHS	2009 GHS	2010 GHS	2011 GHS
PERSONNEL EMOLUMENTS	1,903,106.80	624,303.18	944,574.15	289,090.42
ADMINISTRATION	164,200.53	262,165.74	231,779.83	201,192.91
SERVICE DELIVERY	30,417.39	583,941.18	13.418.00	9,022.50
INVESTMENT	29,737.90	64,562.63	2,523,709.00	0

Source: Income and Expenditure Report

Part of GoG support for items 1 and 4 i.e. personnel emoluments and Investments respectively are retained and disbursed from Accra as is normally the case. For example staffs on the Controller and Accountant Generals Department payroll are paid directly from Accra as well as other investment projects such as the maternity block which is still under construction. Therefore, the amounts shown on the above table for items 1 and 4 represents commitments made against GoG for staff that are paid internally and investment projects that are paid for internally. From table above, in spite of the fact that a substantial number of staff are paid from the CAGD, a greater percentage of GoG is spent on personnel emoluments. For the year 2008, personnel emoluments accounted for 89.5% of total GoG expenditure, whilst 7.7% was spent on administration with 1.4% each going into service delivery and investment respectively. In 2009, out of a total of GHS 1,534,972.73 received from GoG, GHS 624,303.18 representing 40.7% was spent on personnel emoluments with 17.1%, 38% and 4.2% going into administration, service delivery and investments respectively. However, in 2010, a substantial amount of GHS 2,523,709.42 representing 68% of GoG received for the year was used for investment activities with 25%, 6% and 1% going into personnel emoluments, administration and service delivery respectively. Significantly in the year 2011, out of a total of GHS 499,305.83 received for the year, nothing was spent on investment activities.

5.0 CONCLUSION

From the above analysis, the following conclusions can be drawn with respect to revenue and expenditure policy in the health sector Ghana. It must be emphasized that the under mentioned conclusions were based on the case study at KATH. However, the conclusion can apply to KATH in particular and the health sector of Ghana in general. This is because apart from the strategic location of KATH, it is also the second largest hospital in Ghana. In terms of sources of funding to the health sector, it can be concluded that IGF, GoG and DPF are the major sources of funds to the health sector, whilst DPF and GoG are increasingly declining; IGF is increasing at an increasing rate. 70% of IGF is in the form of health insurance revenue which normally takes a long time to be paid to the health institutions. This therefore, poses a serious threat to the liquidity of the hospitals. Expenditure items in the health sector are broadly categorized into four categories namely: personnel emolument, administration, service and investment. From the analysis done in chapter four, it can be concluded that service delivery is the highest category of expenditure in the hospital, followed by personnel emoluments, administration and investment. It can therefore be concluded that the health sector spend more on salaries and service related expenditure than on investment expenditure. Based on the above it is recommended that policies, strategies and controls must be put in place in order to enhance revenue mobilization in the health sector since IGF is now the most reliable source of revenue.

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