



# WORLD HEALTH ORGANIZATION

**FIFTY-SECOND WORLD HEALTH ASSEMBLY**  
**Provisional agenda item 5**

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## **Ministerial round table**

### **Investment in hospitals: dilemmas facing ministers**

#### **THE ISSUES**

1. Health infrastructure, often too sophisticated and inappropriate, is concentrated in large cities, disproportionately benefiting relatively well-to-do urban households. Health facilities for the rural poor are often too few, not easily accessible, understaffed, and characterized by basic equipment that is poorly maintained.
2. Hospitals normally are built to endure and, once built, are extremely difficult to close - for political reasons and because they are a source of employment. Poor capital investment decisions or weak project execution can therefore have serious financial repercussions for decades. Inadequate needs assessment, uncoordinated activities of various stakeholders, and a lack of norms, standards and locally adapted methodologies often lead to inappropriate location and design of facilities, substandard construction and unduly high unit costs.
3. Efficiency losses from poor selection, acquisition and maintenance of equipment can also be very heavy. Purchasing sophisticated equipment without proper assessment causes persistent problems for managers in ensuring its adequate use and maintenance. In some countries, less than half the available equipment is usable at any time, representing in some instances a loss of several thousand million dollars. Because of poor operating and maintenance skills and extremely low maintenance budgets (about 1% of the value of capital stock, whereas 7% to 8% is considered optimal), equipment fails frequently and its active life is considerably shortened. Lack of maintenance leads to additional costs of 20% to 40%, and lack of inventory increases the cost of use and service by 60% to 80%. Inappropriate choice of technology may result in significant increases in the cost of care.

#### **STRENGTHENING MANAGEMENT AND IMPROVING EFFICIENCY**

4. Managerial expertise in finances, drugs and consumables, facilities and equipment, and clinical practice is essential to run a modern hospital. Such expertise often is not available, and special training methods must be developed to provide managers with the required skills. But investment in such training is fully useful only in a policy environment in which hospital management has the decision-making power and authority.
5. Greater hospital autonomy has been advocated in recent years, but this is not a panacea and will not improve cost management and quality of care unless it is tailored to specific managerial functions and capacities. Moreover, most would agree that hospitals should not be free to redefine their roles in the health system, but should continue to be guided by public policy oriented towards achieving overall policy objectives

set by the ministry of health. With increasing hospital autonomy, however, questions of governance, the role of the providers, and accountability to the community must be addressed.

## **APPROPRIATE INVESTMENT AND USE**

6. The fundamental dilemma in rationalizing and restructuring hospitals relates to the need for overall cost-effectiveness of sectoral investment linked with health outcomes. A better-balanced portfolio of hospitals and more efficient pattern of their use are needed in order to provide the intended services to the intended population. Both public and private hospitals as well as those run by other sectors - such as those for military personnel - must be incorporated in overall service planning. Purchasing should be based on the entire population rather than just the public sector, and resources should be used to provide the best services for a defined population, irrespective of the provider.

7. Reorganization of functions and reallocation of resources for facilities can provide great scope for improving cost-effectiveness of overall service delivery. Hospital costs are mainly fixed costs, so eliminating a few beds in all hospitals will not free many resources. Purchasing services rather than funding facilities could reduce excess costs. Costing systems should be put in place to identify and possibly recoup subsidies on the various “amenity” services that hospitals provide.

8. An obvious way to reduce spending without sacrificing health gains is to make full use of existing lower-level facilities, and to encourage users to follow the desired referral pattern. Incentives could include raising user fees for non-urgent patients seeking primary care at the hospital, provided they have a feasible primary care provider. Referral from the primary care facility should be mandatory for access to all specialized services. Rough estimates suggest that if just 33% of patients could be shifted from upper-level to lower-level facilities, the total savings would be 5% of the total government health expenditure and 10% of hospital expenditure. Reliability, quality and responsiveness of services at lower-level facilities would first need to be improved, however. A critical prerequisite for this shift is improvement in procurement, supply and maintenance systems and in the provision of high-quality care by appropriately trained and compassionate health-care workers.

9. To ensure high-quality care and an appropriate work attitude, job satisfaction for the health worker is essential. This calls for investments in suitable training, adequate remuneration and the granting of incentives for good performance. Improvements in health equipment and supplies can be ensured if investments in medical equipment are rationalized by controlling the purchase of expensive, sophisticated equipment and declining donations that do not fit established plans.

10. Purchasing decisions should be based on macro-assessment of needs, life-cycle cost analysis, available support capacity, and long-term effects of acquired technology on the health system. Such decisions should also accord with a defined essential-technology package for different types of facilities and should link technologies to essential clinical procedures. Recurrent cost implications should be fully understood and adequate budget provisions ensured for operation and maintenance. Certain procedures must be decentralized and cost-recovery mechanisms established to partly finance maintenance services at facility level. Cost-effective allocations of resources tend to be those that give priority to improved maintenance over purchase of new equipment, and development of in-house services for routine maintenance and repair, rather than contracting these out.

11. Hospitals are experiencing major changes. New types of health care institutions are emerging to replace some existing ones. Medical technology has more than ever broadened its base, and rapid development of telecommunications is introducing revolutionary changes in concepts and ways of practising medicine. The dimensions of the hospital sector are multifaceted, and a range of issues is involved in hospital rationalization and restructuring. These include changing policies, roles and relationships of institutions, labour forces and interest groups; identification of the opportunities and challenges of architectural and technological advances; and the integration and networking of health care institutions.

12. Investment in hospitals increasingly requires sophisticated analysis and planning. Gone are the days when a well-wisher's offer to donate a hospital to a country could be accepted with thanks and without a second thought. If hospitals are to contribute to health, their siting, planning, organization, management and the services they provide compared to the priority needs of the community must be seriously taken into account if they are not to become white elephants and voracious consumers of scarce resources.

### **Discussion points**

- C Should ministries of health divest themselves of hospitals and develop systems to purchase services on contract from the public and/or private sectors?
- C Who should manage hospitals: professional managers on performance-based contracts or medically qualified managers?
- C Should ministries regulate the total number of public and private hospital beds in a given community?
- C Should countries invest in regional (between countries) tertiary-care treatment and training centres rather than build their own?
- C Should there be catastrophic insurance for public hospital use? If so, under what circumstances?

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