



REPUBLIC OF GHANA



2015 GHANA HEALTH FINANCING STRATEGY



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ACRONYMS / ABBREVIATIONS

WHA	World Health Assembly
WHO	World Health Organisation
AFRO	Africa Regional Office
GDP	Gross Domestic Product
LMIC	Lower Middle Income Country
UHC	Universal Health Coverage
DMHIS	District Mutual Health Insurance Schemes
NHIL	National Health Insurance Levy
VAT	Value Added Tax
SSNIT	Social Security and National Insurance Trust
GOG	Government of Ghana
NHIC	National Health Insurance Council
NHIF	National Health Insurance Fund
NHIS	National Health Insurance Scheme
FDA	Food and Drug Authority
GGHE	Total Government Health Expenditure
GGE	Total Government Spending
OOPS	Out-of-Pocket Payments
MOH	Ministry of Health
DRGs	Diagnostic-Related Groups

FFS	Fee-for-Service
G-DRG	Ghana Diagnostic Related Group
GHS	Ghana Health Services
CHAG	Christian Health Association
CHPS	Community-Based Health Planning & Services
PFM	Public finance management
M&E	Monitoring and Evaluation
MOF	Ministry of Finance
IMCI	Integrated Management of Childhood Illnesses
PHC	Primary Health care

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EXECUTIVE SUMMARY

CHAPTER ONE: Introduction

In May 2005, the fifty-eighth World Health Assembly (WHA) adopted resolution WHA 58.33 on sustainable health financing, universal coverage and social health insurance that urges member states including Ghana to ensure that health financing systems include a method for prepayment of financial contributions for health care. It is aimed at sharing risk among the population and avoiding catastrophic health care expenditure and impoverishment of care-seeking individuals. The resolution also encourages planned transition to universal coverage and ensured, managed and organized external funds for specific health programs or activities which contribute to the development of sustainable financing mechanisms for the health system as a whole. In line with WHA 58.33, WHO/AFRO in

2006 through its regional committee adopted a report “Health Financing: A Strategy for the African Region” under AFR/RC56/10 reinforcing the resolution and how to practically implement in the African region.

Achieving the health system goals of improving health outcomes, providing financial risk protection and increasing system responsiveness to consumers requires direct contributions from health financing and clear relationships to other health systems functions. As an activity in the Health Sector Medium-Term Development Plan 2010-2013, the Ghana Health Financing Strategy elaborates how health financing in Ghana will contribute to health system goals and objectives. It is based upon the three health financing functions of revenue collection, pooling and purchasing.

CHAPTER TWO: Vision, Values, Guiding Principles, Goals and Objectives

The vision of the Ghana Health Financing Strategy is moving towards universal health coverage. It is a long journey and the strategy is intended to enable Ghana to continuously make progress on the road to universal health coverage (UHC) rather than arrive at the destination by a predetermined date. The vision is comprehensive including all types of public and private financing. It balances revenue increases and improved expenditure management including efficiency gains to extend coverage and increase sustainability together with direct links to desired service delivery and quality improvements.

CHAPTER THREE: Country Context and Current Situation

Values

The MOH will incorporate the following values into all aspects of Health Financing Strategy implementation:

- Good governance (transparency, accountability, participation, rule of law)

- High quality health care services
- Innovation in resource mobilization
- Importance of financial risk protection and equity with special focus on the poor and vulnerable
- Performance-based and value for money

Guiding Principles

The guiding principles below are principles, standards and expectations that have been considered in the development of the Health Financing Strategy:

- Commitment to global initiatives (Paris, Abuja, Ouagadougou declarations)
- Reducing individual and household risks for out-of-pocket payment for health care at the point of service delivery
- Consistency with decentralization fiscal and administrative context
- Cost containment
- Gradual shift from narrow program or scheme financing to broad system financing
- Strengthen inter-sectoral approach



Goal

The goal of the Ghana Health Financing Strategy is equitable, efficient, effective, transparent and sustainable health financing mechanisms contribute to achieving improved health outcomes, financial risk protection and consumer responsiveness.

Objectives


The objectives of the Ghana Health Financing Strategy are:

- Improve resource mobilization to ensure sufficient and predictable revenue
- Promote equity in the distribution of health resources and use of health services and reduce financial barriers to access to health care
- Efficient allocation and use of health sector resources
- Motivate and stimulate service delivery and quality improvement and increase population satisfaction and involvement in their own health

- Strengthen governance, transparency and accountability

CHAPTER THREE: Country Context and Current Situation

During the colonial era, curative services in Ghana were on a fee-paying basis. The policy, which dated back to the 1880s, was abolished after independence in 1957 when the new government chose the socialist path for the country's development strategy and made health care free. In 1992 another change in health care financing led to what popularly became known as the 'cash and carry' system which was a full cost recovery policy. A large percentage of the population of Ghana did not have the financial ability to pay for medical treatment at the point of use as required by the cash and carry system. Ghana's National Health Insurance Scheme (NHIS) was therefore introduced in 2003 with the aim of removing previous barriers created by the user fees financing system and ultimately providing equitable access to



basic health care services for the entire populace. The NHIS was subsequently implemented in 2005.

Health revenue has seen increases in absolute terms in recent years although the health sector is losing ground as measured by percentage of GDP. The proportion of funding from public funds, private funds and international funds has changed dramatically over the last five years and can generally be characterized as a shift from international funds to Ghana public funds. There are many new actors and changing financing structures with less donor financing of the health system and the NHIS becoming the main financing agent. The fiscal space outlook combines many factors including fiscal capacity, deficits, debt, prioritization of health and declining donor funding. The picture for large increases in public spending on health is not that bright, however, gradual and continuous increases in GOG revenues for health are envisioned. Concerning pooling and purchasing arrangements, the MOH provides services which are largely vertical service delivery programs and benefits which are the NHIS population entitlement. A wide variety of both input and output-based provider payment systems are currently in use. In summary,

the current situation argues for gradual revenue increases combined with a focus on expenditure management, efficiency gains and better cost containment to enable coverage expansion and move towards UHC.

CHAPTER FOUR: Main Challenges

To achieve the basic health system goals of improving health outcomes, financial protection and consumer responsiveness in an equitable and efficient manner, Ghana's Health Financing Strategy needs to address several major challenges. The current situation in public revenue for health is driven by Ghana's relatively low fiscal capacity combined with its slightly greater than average health prioritization reflecting GOG commitment to health. The situation supports the general conclusion that there will not be much scope for large increases in overall public spending in the foreseeable future, although gradual increases in GOG revenues are envisioned. The challenge is determining how best to increase health revenue through maintaining and gradually increasing GOG revenue for MOH including general revenue health budget and NHI levies; better NHIS premium



specification and exemption targeting; innovative resource mobilization; improving relationships between public and private financing; and mitigating the impact of declining donor funding.

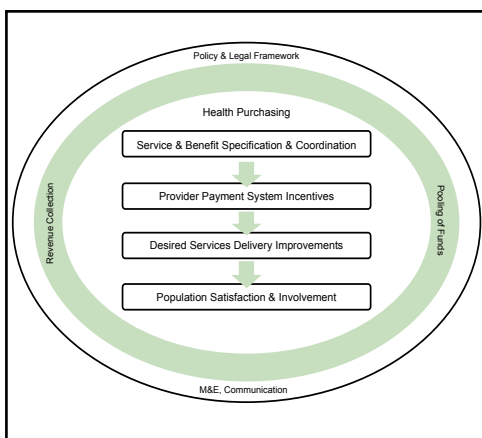
GOG and MOH should make the best choices or trade-offs for Ghana in the proportion of the population to be covered (breadth), the range of services or benefits to be made available (scope), and the proportion of the total costs to be met or alternatively the amount of cost sharing from the population (depth). Provider payment systems purchasing health services require continuous refinement to adapt to changing environments and provider behavior. MOF and MOH including NHIS payment system choices to date may have been appropriate at the time they were introduced but now need to be refined as the environment has evolved. The challenge for the MOH, NHIA and development partners is selecting the best refinements to their payment systems to attain the efficiency gains necessary to continue moving toward UHC. Health Financing

Strategy implementation will bring its own set of challenges including how institutional structure, roles and relationships should evolve, how to build institutional and human capacity, what implementation sequencing is most likely to accomplish objectives and how to improve health sector coordination. Improving monitoring and evaluation is also a challenge and improvements are required to monitor implementation and feed information back into policy dialogue.

CHAPTER FIVE: Health Financing Strategy Dynamic Framework

The Health Financing Strategy is a vehicle to enable Ghana to realize the vision of moving towards universal health coverage. Achieving the goals and objectives stated above requires converting theory to practice through an overall approach and implementation sequencing reflecting the nature of the Ghana context and environment. A dynamic framework illustrating the relationships and action inherent in the Health Financing Strategy is shown in

the chart below. It encompasses the entire Health Financing Strategy and portrays the relationships between the fifteen specific strategies. The dynamic framework enables addressing challenges and connecting goals and objectives to specific activities. It is based on the three health financing functions and includes all sources of funding as well as all institutions and stakeholders involved in health financing.



A health financing policy and monitoring and evaluation (M&E) feedback loop is shown in the outside circle of the dynamic framework and represents Strategies 1, 14 and 15. The health financing functions of revenue collection and pooling of funds are shown in the next circle of the dynamic framework

chart. Revenue collection is Strategies 2-4 and pooling of funds Strategy 5. Health purchasing represents Strategies 6-12, and is portrayed in the middle of the dynamic framework with a focus on services and benefits specification and coordination, injecting appropriate financial incentives and creating efficiency gains by refining provider payment systems and stimulating desired service delivery improvements and population involvement. Although encompassed in revenue collection, pooling and purchasing functions, the relationship between public and private financing is Strategy 13 to reflect the key nature of this relationship in moving towards universal health coverage.

The dynamic framework portrays both an overall approach and the critical path to realizing the vision of moving towards universal health coverage. The critical path is increasing health revenue; better service and benefit specification and coordination; provider payment systems with incentives for cost containment and efficiency gains; and strengthening the relationship between health financing and desired service delivery improvements and population involvement in their own health. In summary, the dynamic framework is comprehensive and frames relationships



between the specific strategies described below. The inherent dynamics create opportunities enabling step-by-step health financing improvements, obtaining efficiency gains, better targeting and incentives for priority service delivery improvements, and improving management and use of information at all levels of the system.

CHAPTER SIX: Specific Health Financing Strategies

Strategy 1 is developing health financing policy and legal and regulatory framework. The specific objectives or aims of policy development and legal and regulatory framework are improved policy, increased stakeholder participation, clear and executed laws and regulations, and public accountability.

Revenue collection strategies are intended to ensure sustainable financing in moving towards UHC. Specific objectives or aims of revenue collection and resource mobilization are stable and predictable revenue together with

gradual increases in revenues as the health sector should benefit at least proportionally from any GOG revenue increases. Strategy 2 is increase GOG revenue allocated to the health sector. Strategy 3 is continually refine NHIS premium specification and improve means-testing to better target NHIS exemptions to poor and vulnerable populations. Strategy 4 is innovative resource mobilization and coordination of health revenues.

Strategy 5 is improve pooling of funds. The specific objectives or aims of pooling of funds are to increase redistributive capacity of prepaid funds and align different revenue sources for complementarity. Pooling of funds or the accumulation of prepaid revenues on behalf of a population has a direct relationship to equity and financial risk protection and enables health purchasing improving efficiency, quality and transparency.

Health purchasing is the most complex health financing function and includes both what to purchase or coverage

and benefits and how to purchase it or provider payment systems. Strategy 6 is improve breadth, scope and depth of services and benefits. Strategy 7 is coordination of MOH services and benefits including prioritization of preventive and primary health care services. Strategy 8 is improving health worker motivation and performance. Strategy 9 is improving and harmonizing provider payment systems for variable costs of direct patient care. Strategy 10 is improving capital purchasing. Strategy 11 is strengthening public finance management (PFM) and information systems supporting health purchasing. Strategy 12 is ensuring that health purchasing stimulates desired service delivery and quality improvements.

Strategy 13 contributes to improving relationships and coordination between public and private financing. The Health Financing Strategy includes all types of health financing and private financing is inherent in the three health financing functions. However, the relationship between public and private financing is key to moving toward UHC such that coordination of public and private financing across all health financing functions is an explicit strategy. Strategy 14 is strengthening monitoring and evaluation (M&E) and

monitoring Health Financing Strategy implementation. It includes a variety of M&E interventions and their feedback of evidence-based information into next generation policy dialogue. Improving M&E for all aspects of the Ghana Health Financing Strategy is critical to guide continuous refinement of interventions, institutionalization and increased ownership at all levels of the health system. Strategy 15 is develop and implement a communications strategy.

CHAPTER SEVEN: Health Financing Strategy Implementation

The Health Financing Strategy states the “what” as defined by the fifteen specific strategies to improve health financing. Implementation mechanisms and processes determine “how” Ghana will implement the strategy to fulfill its vision and achieve its goal and objectives. Implementation mechanisms and processes are not elaborated in great detail in the strategy as they will evolve based on progress, changes in the environment, identification of barriers, and accumulation of experience, lessons learned and evidence to guide subsequent decisions. To realize the specific health financing strategies, implementation is categorized into four elements:



implementation plans, prioritization and sequencing; clear institutional structure, roles and relationships; building human and institutional capacity; and strengthened health sector coordination.



CHAPTERS



CHAPTER ONE


1. Introduction

In May 2005, the fifty-eighth World Health Assembly (WHA) adopted resolution WHA 58.33 on sustainable health financing, universal coverage and social health insurance that urges member states including Ghana to ensure that health financing systems include a method for prepayment of financial contributions for health care. It is aimed at sharing risk among the population and avoiding catastrophic health care expenditure and impoverishment of care-seeking individuals. The resolution also encourages planned transition to universal coverage and ensured, managed and organized external funds for specific health programs or activities which contribute to the development of sustainable financing mechanisms for the health system as a whole. In line with WHA 58.33, WHO/AFRO in 2006 through

its regional committee adopted a report “Health Financing: A Strategy for the African Region” under AFR/RC56/10 reinforcing the resolution and how to practically implement in the African region.

Ghana’s estimated population was 24,658,823 in 2010 with a growth rate of 2.5% and population density increasing from 79 in 2000 to 103 in 2010. The adult population consisting of people above the age of 18 years stands at 13.6 million, while dependent population, comprising people less than 15 years and above 65 years is pegged at 10.6 million. The total fertility rate is 4.0 and about half the population lives in rural areas. Life expectancy has increased from 58 years to 63.8 years in the last decade. Ghana’s gross domestic product (GDP) was estimated at 44,799 million Ghana cedi in 2010 (\$31,548.40 million USD) which moved the country

¹ 1.42 Ghana cedi = 1USD



into lower middle income country (LMIC) status with GDP per capita of 1,872.07 Ghana cedi (\$1,318 USD).¹

Achieving the health system goals of improving health outcomes, providing financial risk protection and increasing system responsiveness to consumers requires direct contributions from health financing and clear relationships to other health systems functions. As an activity in the Health Sector Medium-Term Development Plan 2010-2013, the Ghana Health Financing Strategy elaborates how health financing in Ghana will contribute to health system goals and objectives. It is based upon the three health financing functions of revenue collection, pooling and purchasing. Revenue collection is the

source and level of funds, pooling is the accumulation of prepaid revenues on behalf of a population and purchasing is the transfer of pooled funds to providers on behalf of a population.²

The Ghana Health Financing Strategy provides a guide to improving health financing performance in the long-term. It is divided into seven sections. Following this introduction, Section 2 is vision, values, guiding principles, goals and objectives of the strategy; Section 3 is country context and current situation; Section 4 is the main challenges the strategy intends to address; Section 5 is the overall approach; Section 6 is specific strategies and main activities; and Section 7 is implementation mechanisms and processes.

² WHO/EURO/Joe Kutzin; *Health Financing Policy: A Guide for Decision-Makers*; 2008



CHAPTER TWO

2. Vision, Values, Guiding Principles, Goals and Objectives

2.1 Vision

The vision of the Ghana Health Financing Strategy is moving towards universal health coverage. It is a long journey and the strategy is intended to enable Ghana to continuously make progress on the road to universal health coverage (UHC) rather than arrive at the destination by a predetermined date. The vision is comprehensive including all types of public and private financing. It balances revenue increases and improved expenditure management. Expenditure management includes efficiency gains to extend coverage and increase sustainability together with direct links to desired service delivery and quality improvements.

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- Gradual shift from narrow program or scheme financing to broad system financing
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The goal of the Ghana Health Financing Strategy is equitable, efficient, effective, transparent and sustainable health financing mechanisms contribute

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- Efficient allocation and use of health sector resources
- Motivate and stimulate service delivery and quality improvement and increase population satisfaction and involvement in their own health
- Strengthen governance, transparency and accountability



CHAPTER THREE

2. Country Context and Current Situation

2.1 Revenue Collection Function

Historical Context

During the colonial era, curative services in Ghana were on a fee-paying basis. The policy, which dated back to the 1880s, was abolished after independence in 1957 when the new government chose the socialist path for the country's development strategy and made health care free (Asamoah-Baah, 1991). Medical services remained fee-free until 1971 when fees were introduced by the Hospital Fees Act of 1971 (Act 387). Though the rationale for instituting this policy was to recover cost, the fees charged were so low that it was regarded, to a large extent, as a token, and its effects on cost recovery became

insignificant as compared to the actual cost of delivering health care (Ministry of Health, 1971). As Ghana's economy began to decline in the mid-1970s to the early 1980s, an Economic Recovery Programme (ERP) was initiated in 1983 with the support of the World Bank and International Monetary Fund. This introduced the removal of subsidies and intensification of fee collection for health services and enforcement of the Hospital Fees Act. The Hospital Fees Regulation of 1985 required patients of public health facilities to pay fully for their drugs. The aim was to recover at least 15 percent of recurrent operating costs (Gyapong et al., 2007).

In 1992 another change in health financing led to what popularly became known as the 'cash and carry' system which was a full cost recovery policy for drugs in public health facilities. Patients

also paid partially for consultation and examination, laboratory services and diagnostic procedures, medical, surgical and dental services, and hospital accommodation (Asenso-Okyere et al., 1998, Nyongator and Kutzin, 1999, Atim et al., 2001). In spite of the fact that the fees were nominal in relation to the cost of providing health services, they were considered high in relation to income levels of majority of the Ghanaian citizenry. With average per capita income of only US\$390 and a daily minimum wage of less than a dollar at the time, a large percentage of the population of Ghana did not have the financial ability to pay for medical treatment at the point of use as required by the 'cash and carry' system.

Ghana's National Health Insurance Scheme (NHIS) was therefore introduced in 2003 with the aim of removing previous barriers created by the user fees and ultimately providing equitable access to basic health care services for the entire population. NHIS was subsequently implemented in 2005. Implementing NHIS was a step towards universal health coverage that began by covering vulnerable groups and then significantly expanded enrolment using substantial resources earmarked to support the system.

Ghana's NHIS relies on a diversified set of funding sources, which has been an important factor in the stability and sustainability of health financing in a number of other countries. The country's approach pragmatically built on the existing system of district mutual health insurance schemes (DMHIS) and transitioned toward a uniform national system. NHIS membership has steadily increased from 1.4 million in 2005 to about 35 percent of the population, while outpatient visits have increased 23-fold, inpatient service use 29-fold, and expenditures by 40-fold.

Health Sector Revenue Sources and Trends

The health sector in Ghana is financed by traditional sources: public funds which are Government of Ghana (GOG) revenues, private funds from companies and households for both pre-paid voluntary premiums and out-of-pocket payments, and international funds from donors/development partners. GOG revenues can be sub-divided into general revenue for the health budget, targeted revenues for NHIS and local government revenue. The National Health Insurance Authority (NHIA) under the MOH manages the National Health Insurance Fund (NHIF) which has six



main sources of funding to operate the NHIS. The sources include;

- The National Health Insurance Levy (NHIL) which is a 2.5 percent value added tax (VAT) levied on selected goods and services
- 2.5 percent social security deductions from formal sector workers managed by the Social Security and National Insurance Trust (SSNIT)
- GOG annual budgetary allocations proposed and approved by parliament to the NHIF
- Accruals from investments of surplus funds held in the NHIF by the National Health Insurance Council (NHIC)
- Grants, gifts and donations made to the NHIF
- Premiums/contributions paid by NHIS subscribers

Total health expenditure in Ghana for 2005 was US\$680.55 million, rising to US\$964.68 million by 2010. This represented a 41.75 percent US dollar

increase in total health expenditure within the five year period. In 2005, Ghana spent 6.41 percent of its GDP on health. However, total health expenditure as a percentage of GDP in 2010 fell considerably to 3.28 percent. Thus, total health expenditure as a percentage of GDP was halved between 2005 and 2010. This result is related to the rebasing of the GDP in 2006 which showed that the economy in US dollars grew by over 200 percent within the five year period. The increase in the size of the economy was not matched by expansion in health expenditure which increased by about 40 percent (Ministry of Health, 2013).

Public funding for health increased sharply from US\$201.41 million in 2005 to US\$662.92 million in 2010. In 2005, GOG general revenue amounted to US\$180.66 million, constituting 89.7 percent of public funds. However by 2010, GOG general revenue decreased to 58.07 percent with a marked increase in NHIF levies in 2010 which had by then been in place for over five years. Public

funds from the NHIF increased from US\$20.75 million in 2005 to US\$277.94 million in 2010 (Ministry of Health, 2013).

Private funds were relatively constant between 2005 and 2010, rising slightly from US\$118.66 million in 2005 to US\$122.83 million in 2010. While private funds from companies increased from US\$4.97 million in 2005 to US\$10.19 million in 2010, private funds from households barely changed, decreasing from US\$113.68 million in 2005 to US\$112.64 million in 2010. This accounted for private funds being relatively constant in absolute terms between 2005 and 2010 (Ministry of Health, 2013). Under the NHIS (with funds from the NHIF), private funds from households (premiums) increased from US\$173,527 in 2005 to US\$12.35 million in 2010.

Between 2005 and 2010, donor funds fell significantly from US\$360.48 million to US\$178.93 million. There is a relationship between this declining donor funding and Ghana's entering LMIC status. Other types of health-

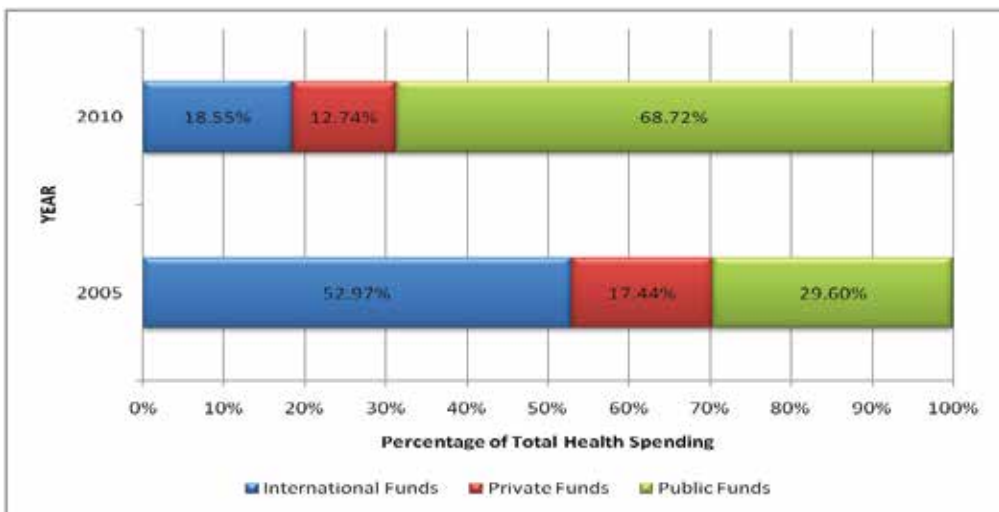
related revenues include other public (e.g. FDA fees) and a variety of private including foundations, company-related, and other donations.

In addition to the absolute figures stated above, from 2005 to 2010 significant changes occurred in the proportions of different types of revenue as shown in Figure 1 below. Public funding increased by 132%, moving from 29.6% to 68.72% of total financing; private funding decreased by 37%, moving from 17.44% to 12.74% of total financing; and international funding decreased by 65%, moving from 52.97% to 18.55% of total financing. Clearly public funding increases replaced declining international funding. The relationship between public and private funding is less clear, however, it appears that increased public funding particularly for NHIS is having an impact on the level of private funding.

Figure 2: Ghana Total Health Expenditure Breakdown by Financing Source, 2005 & 2010 (million US\$)



Figure 2: Ghana Total Health Expenditure Breakdown by Financing Source, 2005 & 2010 (million US\$)



Source: Ministry of Health 2013

In summary, financing has seen increases in absolute terms in recent years although the health sector is losing ground as measured by percentage of GDP. The proportion of funding from public funds, private funds and international funds has changed dramatically over the last five years and can generally be characterized as a shift from international funds to Ghana public funds. There are many new actors and changing financing structures

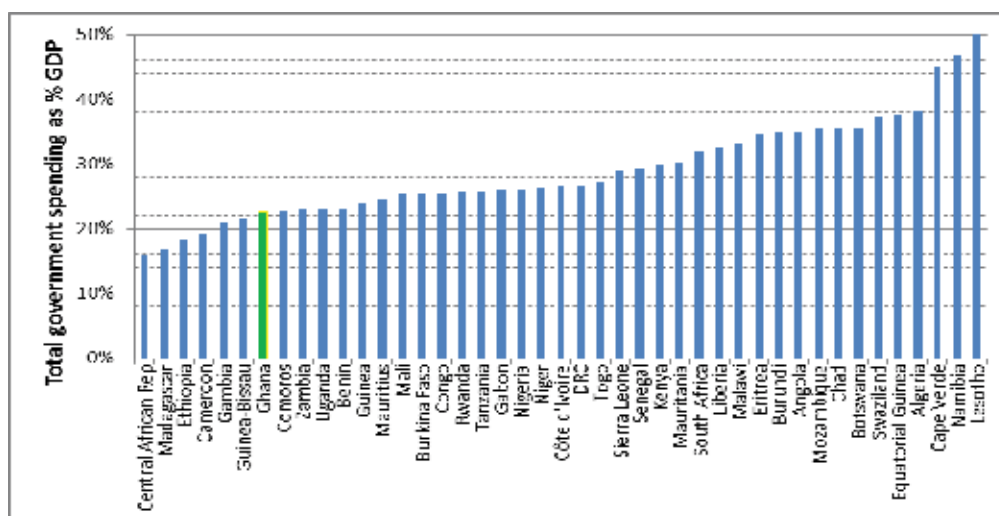
with less donor financing of the health system and the NHIS becoming the main financing agent.

Health Expenditure Patterns and International Comparison

Indicators showing an international comparison of health expenditure patterns are portrayed and described below.

Fiscal Capacity: Total government spending (GGE) as percentage of GDP measures the size of the state in the economy (GGE/GDP). Figure 2 shows a snapshot of how Ghana compares to other countries in the region on this indicator. As can be seen, Ghana has lower than average fiscal capacity (relative to the size of its overall economy) than most African countries.

Figure 2: Ghana Fiscal Capacity as Measured by GGE/GDP

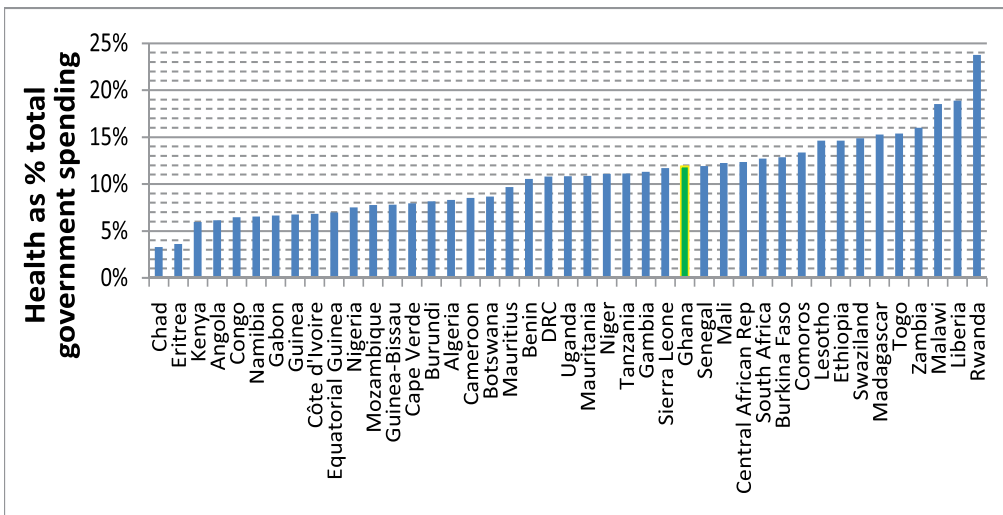


Source: WHO 2011

Priority of Health: This is total government health expenditure (GGHE) as a percentage of total government spending (GGE), and reflects the allocation share of total expenditure that GOG made to health. The numerator and denominator include not only central and local governments, but also social security contributions (SSNIT) in Ghana. It is the Abuja target variable or the commitment that it should be at least 15%. As shown in Figure 3, it was about 12% in Ghana in 2011 which is slightly higher than the average of most African countries.



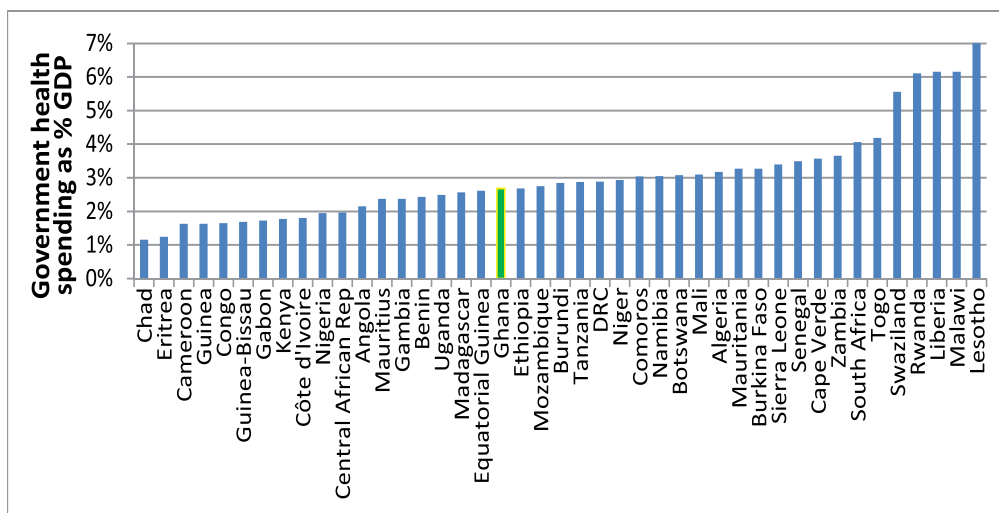
Figure 3: Ghana Priority of Health as Measured by GGHE/GGE



Source: WHO 2011

Together, the product of these two variables (fiscal capacity times prioritization for health) is government health spending as a share of GDP ($GGE/GDP \times GGHE/GGE = GGHE/GDP$). As shown in Figure 4, Ghana’s relatively low fiscal capacity combined with its slightly greater than average health prioritization resulted in a GGHE/GDP of 2.7% in 2011, somewhat below average for the region

Figure 4: Ghana Priority of Health as Measured by GGHE/GGE

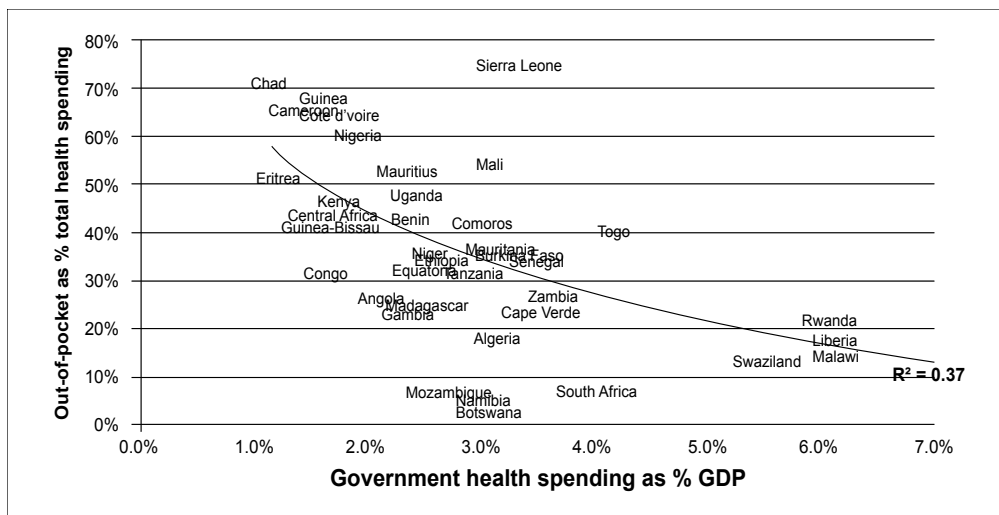


Source: WHO 2011

In turn, cross-country evidence shows that that this indicator is inversely related to the dependence of health systems on out-of-pocket payments (OOPS). This held for African countries as well in 2011. As shown in Figure 5, in Ghana OOPS represented just under 30% of total health spending, somewhat below the share that would be expected for its level of overall government health spending.



Figure 5: Out-of-Pocket Comparison



Source: WHO 2011

The fiscal space outlook combines many factors including fiscal capacity, deficits, debt, prioritization of health and declining donor funding. The picture for large increases in public spending on health is not that bright, however, gradual and continuous increases in GOG revenues for health are envisioned. In summary, the current situation argues for gradual revenue increases combined with a focus on expenditure

management, efficiency gains and better cost containment to enable coverage expansion.

NHIS Premiums and Exemptions

NHIS is a mixed funding system with the vast majority consisting of GOG revenue and the remainder from premium contributions. Enrollment is contingent on payment of premiums

and registration fees with exemptions for certain population categories. The premiums for informal sector workers, who make up more than 70 percent of the labour force and 29 percent of NHIS members are low (GH¢7.2-GH¢48 depending on socioeconomic status). As of 2009, premium revenue accounted for just 3.8% of NHIF contributions. Of the approximately two-thirds of NHIS enrollees who are exempt from NHIS premium payments, more than 30% are in the top two wealth quintiles of the population and could afford to pay premiums or higher registration fees (Schieber et al., 2012). No country has a NHIS that is fully supported by premiums. The point is whether the combination of VAT revenues, SSNIT payments and voluntary premiums is sufficient, and if not how to combine revenue increases and efficiency gains to increase sustainability. Two countries that have achieved high levels of coverage with a strong “voluntary” prepayment element are China and Rwanda. In each case, the premiums are set on the grounds of affordability, not by some actuarial rate, and they are heavily subsidized.

3.2 Pooling of Funds Function

General revenue is allocated to the MOH through the health budget. These

funds are pooled at the national level and distributed to health facilities at all administrative levels through MOH programs and services. Local governments may also include health funding in their budgets pooled at the local government level. NHIS revenues from VAT, SSNIT, any GOG annual budgetary allocations, returns on investments of surplus funds and grants, gifts and donations made to NHIF are pooled at the national level. Voluntary contributions/premiums paid by NHIS subscribers to the various district mutual health insurance schemes (DMHIS) vary among the DMHIS. These contributions were pooled at the district level for claims payment and administrative support at that level (Ghana National Health Insurance Authority, 2008) but procedures will evolve as implementation of the National Health Insurance Act 2012 (Act 852) progresses. GOG general revenue allocated to health budget and NHIF levies are not pooled. There may be significant ramifications to pooling these funds (e.g. status of health in the public sector) such that complete pooling of these funds is not likely in the short-term. The vast majority of private funding remains out-of-pocket payments with no pooling of these funds. Of US\$122.83 million in private



funding in 2010, only US\$12.35 million or ten percent consisted of premiums whose pre-payment increased pooling of private funding.

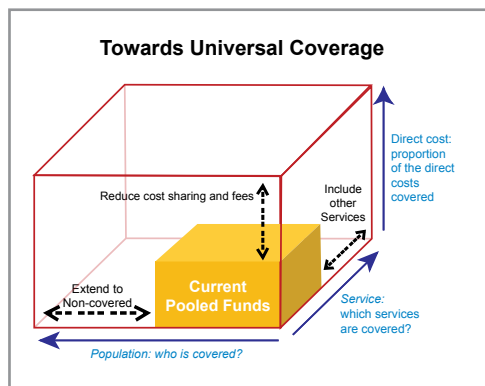
3.3 Health Purchasing Function

3.3.1 What to Purchase: Coverage and Benefits

The cube in Figure 6 from the WHO 2010 World Health Report has three dimensions: the proportion of the population to be covered (breadth), the range of services to be made available (scope), and the proportion of the total costs to be met (depth).

MOH delivers programs, services or benefits some of which cover the entire population of Ghana. All Ghana residents except military and police are eligible to enroll in NHIS. NHIS enrollment has increased steadily since 2005. As of 2011, coverage of the NHIS stood at 33.4 percent of the entire populace with the Upper West region having the highest coverage of

Figure 6: Three Dimensions to Consider When Moving Towards Universal Coverage



Source: The World Health Report—Health Systems Financing: the Path to Universal Coverage. Geneva: World Health Organization; 2010.

53.3 percent, followed by the Brong Ahafo and Ashanti regions with 42.8 percent and 41.8 percent respectively. The region with the lowest registration coverage was the Greater Accra region with 24 percent. The scheme had a membership of 8,302,411 comprising children under 18 years (47.7 percent), the informal sector (31.8 percent), pregnant women (8.6 percent), the

aged (5.4 percent), SSNIT contributors (4.7 percent), indigents (1.4 percent) and SSNIT pensioners (0.4 percent) (Ministry of Health, 2011).

The extensive basic benefits package marketed as covering 95% of the disease burden with no cost sharing may not be sustainable given the rapid expansion of enrollment unless increasing cost is brought under control (Saleh, 2013). The NHIS benefits package is heavily weighted towards specialized curative care while other MOH programs and services are more oriented toward preventive and primary health care. Although the benefits package is comprehensive, it does not necessarily allow for a balance of cost-effective interventions, health promotion and preventive services. Treatment costs, especially for non-communicable diseases, can be reduced considerably if the population regularly avails itself of preventive care and screening services. Paying for preventive services (such as screening for chronic diseases), family planning, and possibly even nonmedical prevention (such as insecticide-treated nets for malaria) could generate savings by reducing demand for more expensive services and medications (Smith and Fairbank, 2008). Thus, the NHIS benefits

package may need to be modified to reflect more balanced service provision (Saleh, 2013).

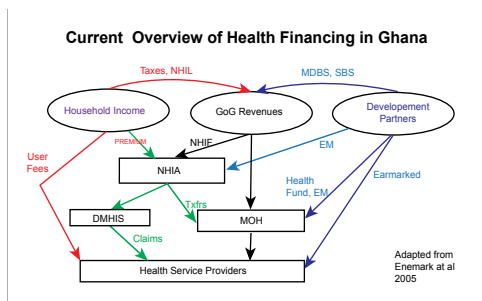
The new National Health Insurance Act of 2012 (Act 852) Section 30 Benefits states that “(1) The Minister shall prescribe the healthcare benefits package including any relevant family planning package to be provided under the National Health Insurance Scheme; (2) The Authority shall provide information at the point of member registration, about the benefits package, rights and responsibilities of members and complaints and dispute resolution mechanisms under the Scheme; and (3) The Authority’ shall assess the healthcare benefits package provided under the Scheme every six months and advise the Minister accordingly.” This revision of the law should provide the NHIA and MOH flexibility in benefits package specification.

3.3.2 How to Purchase: Provider Payment Systems

Funds flow in the health sector is portrayed in the chart below. The arrows from the health purchasers MOH and NHIA and also development partners to the health service providers



reflect the funds flowing through provider payment systems.



A number of different provider payment systems are used to purchase health services in Ghana. They tend to be organized or differentiated by the expense categories from the Ghana economic classification which are aggregated into three main groups or line items: compensation, goods and services, and capital. Health workers salaries are in the compensation economic classification and paid through an input-based line-item budget payment system. They can be seen as health purchasing glue holding provision of all MOH programs including

services and NHIS benefits together or helping ensure they don't fragment to the extent that UHC is jeopardized. A wide variety of both input and output-based provider payment systems are currently in use for the variable costs of direct patient care contained in the goods and services economic classification. Health providers are paid by MOH for variable costs of direct patient care using an input-based line-item budget provider payment system. Health providers are paid by NHIS for variable costs of direct patient care using a combination of output-based provider payment systems including fee-for-service (FFS) for drugs, diagnostic-related groups (DRGs) for both inpatient and outpatient services, and capitated rate (Ashanti pilot). Donor contributions also represent a substantial portion of payment for goods and services for the variable costs of direct patient care and they also use a variety of different provider payment systems.

The NHIS payment mechanism for drugs has effectively increased the availability



of drugs at health facilities, with fewer shortages. However, the price of drugs has increased dramatically and continues to increase. Pharmaceutical reimbursement costs represent about half of total NHIS claims reimbursed (variable costs for direct patient care). Prices for the same drug tend to vary around the country. The private sector tends to charge higher prices, but price differentials exist even within the public sector. As a result, current pricing and cost structures capture the inefficiencies of the market. The average drug prices in Ghana are several-fold above international reference pricing. The MOH through NHIA has not been able to effectively use its market share and dominant position to leverage provider payment incentives to lower prices for medicines dispensed in the scheme or stimulate more rational use of drugs. This could be done by creating a NHIS pricing list that strictly adheres to drug pricing policies and markups (Saleh, 2013) or by bundling drugs into more output-based provider payment systems.

Under the Ghana Diagnostic Related Group (G-DRG) payment system, the NHIS pays hospitals and outpatient departments a flat rate for each treated case depending on the diagnosis.

Although it is an improvement over the previous traditional fee-for-service payment system, it is still based on fees rather than budget neutral relative weights, with limited bundling and no hard caps leaving the health purchasing carrying the majority of risk. Consequently, utilisation and total claims have continued to increase at unsustainable rates, with no mechanism to contain costs or ensure that funding is allocated in the most cost-effective way. There are also major concerns of inappropriate categorisation of conditions and diseases, up-coding, over-billing and deliberate misinformation and fraudulent practices among managers of schemes and service providers. Most of these have been put down to weak capacity and supervision (Seddoh et al., 2011). The MOH through NHIA has started centralising claims management and piloting a capitation payment mechanism. It is assumed that primary health care capitation and hospital reimbursement bundling or ceilings will streamline and ensure efficient use of financial resources by curtailing supplier-induced demand and lengthy hospital stays.

In addition to the variable costs of direct patient care, the goods and services




economic classification contains other costs that encompassed in health purchasing. Fixed or recurrent costs such as utilities should be considered. Public health costs not related to individual health services and medical education costs are also included in this category.

The third aggregated economic classification or budget line item is capital costs. GHS providers are paid for capital from MOH using input-based line-item budget payment system. CHAG and private providers are paid for capital from NHIA using output-based provider payment systems. There are three main capital issues – capital investment planning, capital maintenance costs and leveling the playing field among types of health providers. MOH is responsible for capital planning and investment. Issues arising include capital investments outside of MOH planning processes that could be contributing to cost increases and concentration of hospital-based care in urban centers rather

than strengthening of the periphery of the health system and delays and other problems with planned capital investments. Capital maintenance costs are not well planned or incorporated into payment systems which fuels less than optimal return on capital investments.

Private health care providers rely heavily on out-of-pocket payments for operating costs. They depend on their savings and credit for investment purposes. Larger private ventures, such as private hospitals have easier access to credit than smaller health providers. Thus, lack of access to credit and financing has been a major constraint in the expansion of the private sector. Furthermore, several private health care providers are unable to upgrade their facilities to meet NHIS accreditation standards. Those that are accredited are challenged by delays in claims reimbursements. Consequently, some private providers are reluctant to register with the NHIS (Saleh, 2013).



The relationship between health purchasing and service delivery is critical to the achievement of both health financing and overall health sector goals and objectives. A key question is whether the financial incentives in provider payment systems stimulate desired service delivery results. There is a need to strengthen district health and sub-district health systems, with a focus on primary care (Schieber et al., 2012). To date, prioritization and financial incentives contained in provider payment systems have not sufficiently stimulated improved infrastructure and functioning of CHPS community-based health planning & services (CHPS) and health centers representing the periphery of the health delivery system and providing PHC services to the population. The capitation pilot in Ashanti region was intended to begin addressing some of these issues.

Initial results of the capitation pilot are being assessed after which capitation payment system scale-up plans will be developed. Implementation of priority service delivery programs focusing on prevention, improving quality and more rational use of drugs have also not been adequately stimulated by payment system financial incentives.

Public finance management (PFM) and other health management systems together with health information systems provide the foundation of supporting systems enabling health purchasing operations. Weakness in management exists at all levels of the health system which health purchasing has not yet helped address whether by increasing provider autonomy or encouraging improvements in management systems and processes.



CHAPTER FOUR


4. Main Challenges

To achieve the basic health system goals of improving health outcomes, financial protection and consumer responsiveness in an equitable and efficient manner, Ghana's health financing policy needs to address several major challenges.

The current situation in public revenue for health is driven by Ghana's relatively low fiscal capacity combined with its slightly greater than average health prioritization reflecting GOG commitment to health. The situation described above supports the general conclusion that there will not be much scope for large increases in overall public spending in the foreseeable future, although gradual increases in GOG revenues are envisioned. The challenge is determining how best to increase health revenue through maintaining and gradually increasing

GOG revenue for MOH including general revenue health budget and NHI levies; better NHIS premium specification and exemption targeting; innovative resource mobilization; improving relationships between public and private financing; and mitigating the impact of declining donor funding.

Specific pooling challenges include relationship between GOG general revenue for health budget and NHI levies, finding the best balance between pooling and decentralization in order to maintain and increase equity and financial risk protection, and including donor funding in pooling arrangements to the extent possible. Improving health purchasing for all MOH programs including preventive services and NHIS curative benefits is key to obtaining the cost containment and efficiency gains necessary to continue to move towards UHC while also ensuring sustainable health financing.



A challenge for GOG and MOH is to make the best choices or trade-offs for Ghana in the proportion of the population to be covered (breadth), the range of services or benefits to be made available (scope), and the proportion of the total costs to be met or alternatively the amount of cost sharing from the population (depth). How can the MOH ensure rationale and consistent breadth, scope and depth decisions across all MOH programs including NHIS? As expenditures are increasing faster than revenue generation, it can be argued that NHIS is not financially sustainable under its existing design and operational policies including coverage rules, benefit package, and provider payment systems. Despite efforts to increase enrollment and therefore population coverage, estimates show that NHIS enrollment remains at about 34%. Can Ghana afford to increase NHIS population coverage and maintain a benefits package covering 95% of the disease burden and oriented towards curative not preventive care with no population cost sharing? How to ensure that vulnerable populations represent a high proportion of the population covered under NHIS?

Provider payment systems purchasing health services require continuous


refinement to adapt to changing environments and provider behavior. MOF and MOH including NHIS payment system choices to date may have been appropriate at the time they were introduced but now need to be refined as the environment has evolved. For example, FFS might have been one of the few payment systems options to begin reforming health purchasing and it contributed to the objective of increasing service utilization. However as programs mature, the nature of the current input and output-based provider payment systems as well as the potential for conflicting incentives between the mix of systems could be substantially contributing to cost increases and inefficiencies. FFS for drugs can drive both price increases and supplier-induced demand or unnecessary utilization. DRGs based on fees rather than inherently budget neutral relative weights or hard caps could have the same impact. The relationship between input-based line-item payment systems for some goods and services could create conflicting incentives with output-based provider payment systems (e.g. FFS, DRGs, capitated rate) for variable costs of direct patient care resulting in unintended consequences and system inefficiencies.



The challenge for the MOH, NHIA and development partners is selecting the best refinements to their payment systems to attain the efficiency gains necessary to continue moving toward UHC. Can the capitation pilot be rolled-out in a way that strengthens PHC and provider networks to contribute to cost containment, efficiency, quality improvement and patient satisfaction? Is it time to consolidate or bundle payment systems to create financial incentives to increase efficiency and improve service delivery and quality? Does FFS for drugs undermine the incentives for efficiency in either the DRG or capitated rate payment system such that drugs should be incorporated into DRGs and the capitated rate? Is it likely that the financial incentives stimulate demand for inpatient rather than outpatient care, or curative care over preventive care, or quantity rather than quality of service delivery? Domestically financed public investment projects are not based on careful cost benefit analysis and the computation of financial, social and economic returns.

How to improve capital planning and investment? How to strengthen systems supporting health purchasing including PFM and health information systems? How to improve funds flow to avoid delays in payment which contribute to management problems and undermine provider and population trust? Answering these questions arising from the current situation is at the core of specific health purchasing strategies.

Health Financing Strategy implementation will bring its own set of challenges including how institutional structure, roles and relationships should evolve, how to build institutional and human capacity, what implementation sequencing is most likely to accomplish objectives and how to improve health sector coordination. Improving monitoring and evaluation is also a challenge and improvements are required to monitor implementation and feed information back into policy dialogue. Regular and comprehensive reviews of public health expenditure



from an effectiveness, efficiency and sustainability perspective is lacking. Therefore, transparency, executive accountability and oversight of public financial management are weak (Schieber et al., 2012). Better expenditure tracking, review and analysis will enable appropriate adjustments and improve responsiveness of the system.



CHAPTER FIVE

5. Health Financing Strategy Approach

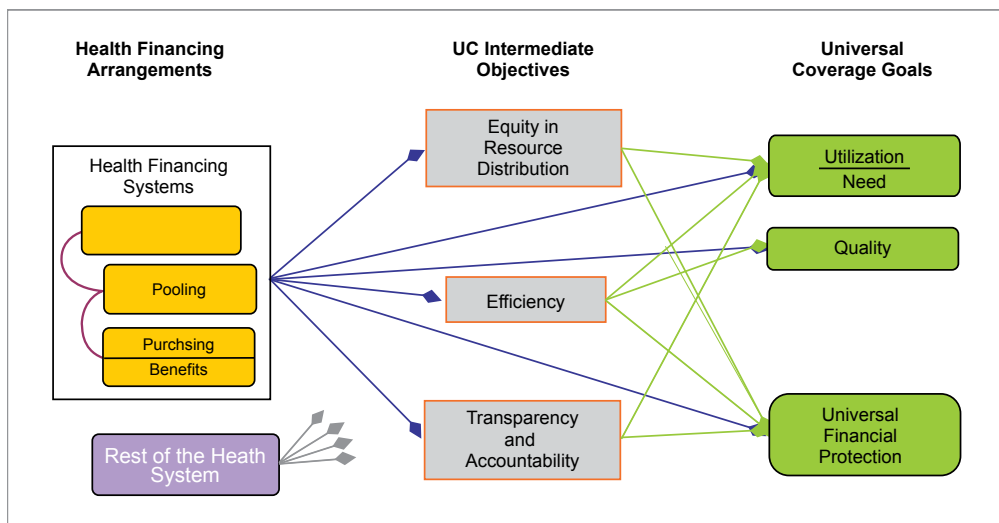
5.1 International Concepts and Experience

International health concepts and experiences over the last few years have raised the visibility of the goal of attaining UHC. The World Health Report 2010 states that financing systems need to be specifically designed to provide all people with access to needed health services (including prevention, promotion, treatment and rehabilitation) of sufficient quality to be effective and ensure that the use of these services does not expose the user to financial hardship. UHC goals embedded in the definition include equity in service use or utilization based on need, quality and universal financial protection.

As shown in Figure 7, there is a strong and direct relationship between health financing strategy and UHC goals and objectives. This conceptual relationship is also practical and country-specific as it's based on the three health financing functions of revenue collection, pooling of funds and health purchasing which allows formulation of country-specific strategies and action steps in each function and also linking the functions together consistent with country environment and context. Countries can't simply spend their way to UHC such that getting beneath commonly used labels such as "tax-funded systems" or "social health insurance", moving from schemes to systems, not compromising equity, and prioritizing strategic health purchasing as the main health financing instrument for promoting efficiency in the use of funds are gaining prominence in pathways to

UHC.³ This emerging international experience and consensus is consistent with GOG policy on UHC and serves as the foundation of the Ghana Health Financing Strategy.

Figure 7: Relationship between Health Financing Functions and Arrangements and Universal Health Coverage Goals and Objectives



Source: WHO

5.2 Ghana Health Financing Dynamic Framework

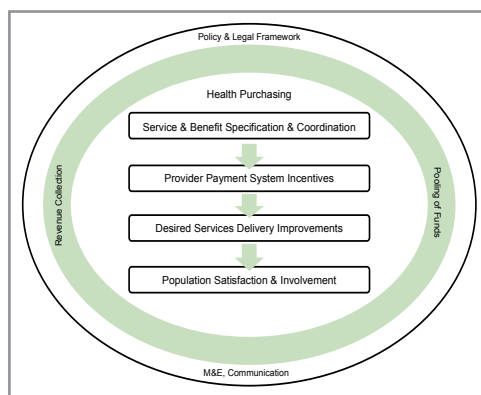
The Health Financing Strategy is a vehicle to enable Ghana to realize the vision of moving towards universal health coverage. Achieving the goals and objectives stated above requires converting theory to practice through an overall approach and implementation sequencing reflecting the nature of

the Ghana context and environment. A dynamic framework illustrating the relationships and action inherent in the Health Financing Strategy is shown in the chart in Figure 8. It encompasses the entire Health Financing Strategy and portrays the relationships between the fifteen specific strategies contained in Section 6. The dynamic framework enables addressing challenges and connecting goals and objectives to

³ Kutzin, Joe, *Bulletin of the World Health Organization* 2012; 90:867-868. doi: 10.2471/BLT.12.113654

specific activities. It is based on the three health financing functions and includes all sources of funding as well as all institutions and stakeholders involved in health financing.


Figure 8: Ghana Health Financing Strategy Dynamic Framework



A health financing policy and monitoring and evaluation (M&E) feedback loop is shown in the outside circle of the dynamic framework and represents Strategies 1, 14 and 15. The health financing functions of revenue collection and pooling of funds are

shown in the next circle of the dynamic framework chart. Revenue collection is Strategies 2-4 and pooling of funds Strategy 5. Health purchasing is the most complex of the three health financing functions, represents Strategies 6-12, and is portrayed in the middle of the dynamic framework with a focus on services and benefits specification and coordination, injecting appropriate financial incentives and creating efficiency gains by refining provider payment systems and stimulating desired service delivery improvements and population involvement. Although encompassed in revenue collection, pooling and purchasing functions, the relationship between public and private financing is Strategy 13 to reflect the key nature of this relationship in moving towards universal health coverage.

The dynamic framework portrays both an overall approach and the critical path to realizing the vision of moving towards universal health coverage. The critical path is increasing health



revenue; better service and benefit specification and coordination; provider payment systems with incentives for cost containment and efficiency gains; and strengthening the relationship between health financing and desired service delivery improvements and population involvement in their own health. In summary, the dynamic framework is comprehensive and

frames relationships between the specific strategies described below. The inherent dynamics create opportunities enabling step-by-step health financing improvements, obtaining efficiency gains, better targeting and incentives for priority service delivery improvements, and improving management and use of information at all levels of the system.



CHAPTER SIX

6. Specific Health Financing Strategies and Major Activities

Specific health financing strategies and major activities are described in the subsections below categorized by policy and legal and regulatory framework, revenue collection, pooling of funds, health purchasing, and M&E and communication. The Health Financing Strategy consists of fifteen specific strategies with corresponding major activities.

6.1 Health Financing Policy and Legal and Regulatory Framework

Strategy 1 is developing health financing policy and legal and regulatory framework. The specific objectives or aims of policy development and legal and regulatory framework are

improved policy, increased stakeholder participation, clear and executed laws and regulations, and public accountability. Health financing policy will be consistent with Ghana country development strategies, Health Sector Medium-Term Development Plan 2010-2013 and other GOG and Ministry of Health (MOH) strategies and plans. The legal and regulatory framework will be amended as required by evolving policy and operational experience.

Major policy development and legal and regulatory framework activities include:

- Strengthen health financing policy dialogue mechanisms and processes to ensure open, transparent and participatory dialogue
- Policy dialogue, decisions and refinements on major policy issues

- Amend and implement legal and regulatory framework to codify health financing policy decisions
- Incorporate feedback from M&E into evidence-based policy dialogue

6.2 Revenue Collection and Resource Mobilization

Revenue collection strategies are intended to ensure sustainable financing in moving towards UHC. Specific objectives or aims of revenue collection and resource mobilization are stable and predictable revenue together with gradual increases in revenues as the health sector should at least benefit proportionally from any GOG revenue increases. It could be argued that the share should increase slightly, given the moderate share of GDP and the government budget that Ghana currently spends on health as well as the significant expansions of coverage envisioned.⁴

Specific strategies are classified as GOG revenue (Strategy 2), refining NHIS premiums and exemptions (Strategy 3), and mobilization and coordination

of additional health revenues (Strategy 4). Population copayments are directly related to benefit package specification and discussed in section 6.4.1 health purchasing/benefits package.

Strategy 2 is increase GOG revenue allocated to the health sector. Basic options include a greater proportion of general revenue allocated to health (including oil and gas revenue), increasing the 2.5% VAT or National Health Insurance Levy (either increase VAT or increase proportion allocated to health), increasing the 2.5% SSNIT contribution to health from the 18.5% SSNIT tax, and earmarking revenues from current or increased cigarette and alcohol excises taxes to health (“sin taxes”). The Health Financing Strategy does not make specific proposals for GOG health revenue increases, rather the MOH will engage in policy dialogue with Government and MOF on options and advocate for gradual increases. Evidence of results is important to resource mobilization as revenue collection usually requires action beyond the health sector.

⁴ Schieber, George, Cheryl Cashin, Karima Saleh, and Rouselle Lavado. 2012. *Health Financing in Ghana*. Washington, DC: World Bank.



Major GOG revenue activities include:

- Develop options, analyses and evidence to engage in dialogue with Parliament, Government and MOF on level and source of GOG revenue allocated to health
- Advocacy and systems strengthening to help ensure timely and complete collection and transfer of GOG revenue
- Engage in multi-sectoral advocacy and promotion of results to contribute to increasing revenue and mobilizing resources

Strategy 3 is continually refine NHIS premium specification and improve means-testing to better target NHIS exemptions to poor and vulnerable populations. Given that almost the entire population of Ghana is eligible for NHIS, increasing population enrollment/coverage significantly beyond the current 34% may require revenue side increases in addition to efficiency gains. This does not imply that premiums need to be actuarially determined as

the key is whether the combination of VAT revenues, SSNIT payments and the small amount of voluntary premiums is sufficient, and whether health purchasing levers are being used to attain budget neutrality or match all NHIS revenues and expenses. It does mean that premium and exemption policies should be continuously improved in order to help ensure that NHIS remains on sound financial footing through a combination of contributions and subsidies appropriate, understood and accepted in Ghana.

NHIS premium refinements will be driven by balancing NHIS enrollment to increase financial access for the poor and sick with sustainability and shared population responsibility. Premium refinements could include either substantial revision or continuous small improvements such as recalibrating the premium ranges which have not been updated in ten years although the minimum wage has increased during this time period. Ghana could also develop creative ways to increase NHIS

premium payments and encourage informal sector participation including: 1) engaging local government or civil society to promote enrollment possibly with explicit incentives; and 2) publicizing subsidy links so that it will be clear to the population that the value of their potential benefit is much greater than the value of the contribution they are asked to make. The idea is that for a small contribution you buy into a big program. Improving means-testing to better target exemption policy and ensure that a high proportion of vulnerable populations enroll in NHIS as well as developing common targeting across sectors and programs will be a priority.

Major NHIS premium and exemption refinement activities include:

- Refine NHIS premiums, strengthen premium collection systems, and develop creative ways to increase NHIS premium payments and encourage informal sector participation (e.g. engage local government or civil society to promote enrollment, publicize subsidization of premium contributions)
- Improve means-testing and better target NHIS exemptions to poor and

vulnerable populations including developing common targeting across sectors and programs

Strategy 4 is innovative resource mobilization and coordination of health revenues. This strategy envisions innovation and creativity in resource mobilization and leveraging private sector resources (e.g. public-private partnerships, foundations, corporate responsibility) as well as documentation, assessment of the impact and coordination of all existing health revenue. As a result of revisions to its GDP in 2010, Ghana was elevated to the ranks of lower-middle-income countries. Donor funding to Ghana is decreasing and increases in existing revenue sources and exploration of new revenue sources is needed to replace donor funds. Improving projections and planning for donor funding will help mitigate the impact of the transition. In addition, more active country and development partner coordination will contribute to maximizing impact and increasing sustainability of joint activities. Major innovative resource mobilization and health revenue coordination activities include:

- Explore, develop, and leverage innovative private resource

- 
- mobilization mechanisms
 - More active country and development partner coordination to maximize impact, increase sustainability and manage the transition including intensifying planning to fill gaps created by declining donor funding

6.3 Pooling of Funds

Strategy 5 is improve pooling of funds. The specific objectives or aims of pooling of funds are to increase redistributive capacity of prepaid funds and align different revenue sources for complementarity. Pooling of funds or the accumulation of prepaid revenues on behalf of a population has a direct relationship to equity and financial risk protection and enables health purchasing improving efficiency, quality and transparency. Further pooling of general revenue health budget and NHI levies is not envisioned in the short-term such that ensuring unification and coordination of these two revenue streams will be a health purchasing


priority. Health Financing Strategy implementation will further specify the nature of decentralization in the health sector in the context of the high priority of ensuring equal financial risk protection for all Ghana citizens, relationship with local government funding, and separation of the financing and management functions.

Major pooling of funds activities include:

- Continuously assess and to the extent possible improve pooling of funds related to both decentralization and the two MOH revenue streams of general revenue health budget and NHIS funding
- Assess geographic disparities in resource allocation and address by mechanisms such as further pooling of funds or geographic equalization formula.

6.4 Health Purchasing

As described above, the two main MOH funding streams are GOG



general revenue health budget and NHIF levies for NHIS administered by NHIA under MOH. Pooling of these two streams is not envisioned in the short-term, therefore, an overarching health purchasing priority is optimizing relationships between the funding streams to enable good expenditure management and efficiency gains. To differentiate types of MOH programs for health purchasing purposes, the Health Financing Strategy uses the following terminology: services to describe largely vertical service delivery programs under MOH and benefits to describe NHIS population entitlement.

6.4.1 What to Purchase: Coverage and Benefits

Strategy 6 is improve breadth, scope and depth of services and benefits. It is based on the cube portrayed above with three dimensions: the proportion of the population to be covered (breadth), the range of services to be made available (scope), and the proportion of the total costs to be met (depth). The specific objectives or aims are transparency and realism with regard to the entitlements and obligations of the population and effective communication such that people can completely understand their entitlements and obligations and

realize them in practice. Fiscal space considerations combined with rapidly increasing utilization and costs and growing inefficiencies make it hard to envision accomplishing both the provision of unlimited health services and benefits and financial sustainability.

As does every country in the world, Ghana will have to make policy choices and face trade-offs regarding the breadth, scope and depth of services and benefits. The Health Financing Strategy does not make a priori choices and the purpose of Strategy 6 is to frame questions and options, do assessments and analyses as necessary, engage in policy dialogue and stakeholder consultations, and make policy choices over the course of strategy implementation. How to move towards UHC in the context of health purchasing cost containment and efficiency gains ensuring financial sustainability of the system? Can Ghana cover the entire population with services and benefits? What are the trade-offs and next steps in expanding NHIS coverage from the current 34% level? What is included in MOH services and benefits? How are MOH services and benefits specified and how to ensure the specification process is flexible and can evolve and adapt over



time? Should the population pay a portion of the cost? The history of the “cash and carry” system is still fresh but population copayments could further prioritize selected services and benefits, encourage population behavior change in how services are accessed (e.g. PHC gatekeeper), and help ensure shared responsibility and financial sustainability.

Major breadth, scope and depth of services and benefits activities:

- Incorporate population choice payments into expansion of PHC capitation payment system and formation of PPNs including CHPS into which population will enroll
- Perform assessments and develop options and analyses to generate evidence informing policy dialogue and decisions on major policy issue of breadth, scope and depth of services and benefits in moving towards UHC

Strategy 7 is coordination of MOH services and benefits including

prioritization of preventive and primary health care services. It’s natural that the intersection of MOH priority program services and NHIS benefits would create some overlapping, duplication or inefficiencies. Family planning is often used as an example of a service or benefit “caught in the middle” resulting in lack of clarity and understanding for providers and the population. The Health Financing Strategy stakeholder consultation process identified a serious concern about coordination of more prevention-oriented services and more curative-oriented benefits especially given the decreasing proportion of the health budget allocated to goods and services and declining donor funding. Curative care cost increases squeezing out the most cost-effective prevention and primary health care services will undermine achievement of efficiency gains and moving towards UHC. In addition, if there’s any service or benefit duplication or lack of clarity it could contribute to inefficiencies, duplicating or overlapping payments to providers or population dissatisfaction with services.

Strategy 7 will work to better coordinate and reduce the separation of preventive and curative care to prioritize preventive and primary health care, improve the continuum of care, and contribute to seamless, holistic and patient-centered service delivery. Improved service and benefit coordination will improve expenditure management, increase efficiency, improve the quality of services and increase sustainability. Conceptually and practically, a unified framework specifying both services and benefits can be established to improve coordination of service delivery at health facility level and provide more clarity on entitlements for the population. It can be linked to ongoing implementation of National Health Insurance Act 2012 (Act 852). The unified service and benefit framework would move away from rigid separation of programs towards delivery system integration for UHC with high priority, seamless and well-coordinated services and continuum of care being the joint responsibility of all stakeholders.

Major coordination of MOH services and benefits activities include:


- **Prioritize, educate and facilitate improvements in coordination of**

MOH services and NHIS benefits arising from the critical path of expansion of PHC capitation payment system, formation of PPNs including CHPS, population choice payments, and integration of vertical programs.

- Depending on whether addressing major policy issues result in more pooling of general revenue health budget and NHIS funding, either develop and implement a unified service and benefits framework to contribute to improving MOH service and NHIS benefit coordination or refine NHIS benefits to incorporate MOH services.

6.4.2 How to Purchase: Provider Payment Systems

The specific objectives or aims of provider payment systems Strategies 8-12 below are efficient use of resources, improving transparency and accountability, improving staff motivation and productivity, ensuring that stated service and benefit priorities are matched by allocation mechanisms, and incentives aligning and stimulating provider service delivery and quality improvement. The strategies are framed consistent with Ghana expense categories or economic classification



aggregated into the three main line items of compensation, goods and services and capital. Other Ghana developments or reforms (e.g. program budgeting) can create opportunities empowering MOH to implement more strategic health purchasing. Development partners are in transition to output-based payment by 2017 such that donor funds could be added on top or incorporated into provider payment systems to increase efficiency and sustainability.


Strategy 8 is improving health worker motivation and performance. Payment to health workers can be portrayed as the trunk of a Ghana health purchasing tree growing toward UHC. This is because health worker salaries support both services and benefits thus anchoring the connection between revenue streams and institutions to help reduce the level of fragmentation in the system. Phased improvements to health worker payment is envisioned with an initial phase of refinements and then gradually over time including salary

payments in output-based provider payment systems. Incentives to improve human resources distribution especially in rural areas are also incorporated into Strategy 8.

Major activities improving health worker motivation and performance include:

- Support incremental implementation of MOH Human Resources for Health (HRH) policies, increases in productivity, and improving human resource distribution in rural and underserved areas
- Design and develop mechanisms and systems to gradually incorporate health worker salary payments into output-based provider payment systems

Strategy 9 is improving and harmonizing provider payment systems for variable costs of direct patient care. Priorities will be technical refinement of existing provider payment systems and better alignment between them



to avoid inefficiencies and conflicting financial incentives, addressing exploding drug costs, and scale-up of the capitated rate pilot. Ghana health purchasing mechanisms currently include many different types of provider payment systems for the variable costs of direct patient care. MOH uses line-item budget payment system, NHIS uses fee-for-service, DRGs and capitated rate payment systems, and donor funds also enter the health system under a variety of payment systems. The relationship between these five different payment systems or branches of the health purchasing tree can create inefficiencies and conflicting incentives.

The Health Financing Strategy does not differentiate between the terminology of output-based provider payment systems, results-based financing, pay-for-performance, performance-based budgeting or performance-based financing but rather implements comprehensive health purchasing improvements generally shifting toward output-based payment and encompassing all relevant tools to achieve objectives and improve performance and results. It also includes payment for other fixed operating costs (e.g. utilities) and

other health-related program costs such as population-based public health interventions, medical education and administration.

Major activities for provider payment systems for variable costs of direct patient care include:

- Refine provider payment systems for PHC
- Refine provider payment systems for outpatient specialty and inpatient or hospital care
- Improve drug payment in concert with addressing major policy issue of drug supply management
- Improve payment systems for other health-related programs such as population-based public health and medical education

Strategy 10 is improving capital purchasing. It is envisioned that planning and investment decisions for capital investments including facility infrastructure and major equipment purchases will continue to be managed directly by the MOH as health facilities are generally unable to fund these investments and planning of capital investment is an important aspect of cost containment. However, through



their provider payments health facilities could fund small capital investment up to a threshold, capital maintenance and all recurrent costs consistent with the health purchasing strategy as well as increases in health facility management autonomy and responsibility.

Major activities for capital purchasing include:

- Assess, design, and implement improvements to capital investment planning, capital regulation (e.g. certificate of need), capital purchasing or payment systems, and accounting for and managing capital costs
- Clarify thresholds and responsibilities for operating vs. capital costs and capital maintenance

Strategy 11 is strengthening public finance management (PFM) and information systems supporting health purchasing. From budget formation to

funds flow to accounting and financial reporting to internal controls, PFM mechanisms and processes serve as the operating foundation of health purchasing. Some aspects may need to be adapted to new provider payment systems to increase efficiency and transparency. As analysis of budget and actual expenditures and related projections become more sophisticated and accurate, this data should be incorporated into the budget formation process. Information systems would be unified to the extent possible and enhanced to increase efficiency, ensure effective operations including claims management, and ensure consistent and standard information feeds analysis and policy decisions.

Together harmonization and improvements will create efficiency gains enabling extending coverage and access, increase transparency by clearly communicating desired performance results to providers, and contribute to improving quality of health services.

Major activities strengthening PFM and information systems include:

- Strengthen PFM at all levels of the system and harmonize with output-based provider payment systems.
- Improve, standardize and unify to the extent possible health information and other supporting systems.
- Strengthen regulatory framework and operational procedures to receive standardized information from private providers

Strategy 12 is ensuring that health purchasing stimulates desired service delivery and quality improvements. Stimulating desired service delivery improvements is a key health purchasing role and can be envisioned as feeding or deepening the roots of the Ghana health purchasing tree. Health provider behavior change is nearly impossible to accomplish if the desired service delivery improvements are inconsistent with the financial incentives faced by providers. Health purchasing can contribute to broader health delivery system restructuring including shifting from a hospital-based to PHC-based system, and strengthening PHC and the periphery of the health system

especially in rural areas. In addition, health purchasing can enable priority service delivery improvements and enhancements in drug supply management and rational use of drugs. Human resource distribution, motivation and performance is also impacted by financial incentives in provider payment systems.

Ghana's health delivery system is a mix of public providers, subsidized private providers (e. g. CHAG) and fully private providers and it's important to level the playing field or ensure consistent financial incentives between all types of health providers. Stimulating management improvement at all levels of the health delivery system is critical to achieving health goals and objectives.

Refining health sector functional specification to further define and separate financing and management functions would enable increases in provider autonomy and improvements in provider management. Consistent with Strategy 7 services and benefit coordination, a high priority will be strengthening preventive services and PHC, improving continuum of care and ensuring seamless and patient-centered service delivery.



Major health purchasing to stimulate desired service delivery and quality improvements activities include:

- Establish preferred provider networks (PPNs) including CHPS to enable contracting for comprehensive PHC services in the capitation payment system expansion
- Identify specific desired service delivery improvements and refine health purchasing mechanisms and provider payment system incentives to enable achieving them (e.g. priority programs such as malaria or family planning, strengthening preventive services, improving continuum of care, rational use of drugs, quality assurance and quality improvement)
- Increase health facility autonomy and build management capacity at all levels of the health system in general and in the context of decentralization

6.5 Public and Private Financing Relationship

Strategy 13 contributes to improving relationships and coordination between public and private financing. The Health Financing Strategy includes all types of health financing and private financing is inherent in the three health financing functions. However, the relationship between public and private financing is key to moving toward UHC such that coordination of public and private financing across all health financing functions is an explicit strategy. For example, NHIS benefits will remain comprehensive but if they're slightly more prioritized or specified to cover less than the current 95% of the burden of disease or include minimal population copayments, it may create openings for private health insurance. Or improving health purchasing to better target health budget funding to priority services and poor populations could also increase clarity and create

market space for private financing products that increase risk pooling for uncovered health services. Private or voluntary health insurance alone cannot get Ghana to UHC but it can play an important complementary role in the process of moving to pre-paid from out-of-pocket expenditures. In addition, ensuring that private financing can fund health services in public providers and public financing can fund health services in private providers helps to level the playing field between public and private provision of health services.

Major public and private financing relationship activities include:

- Continuously strengthen the regulatory framework for private health insurance and ensure that there are no regulatory barriers to contracting with private providers
- Develop plans and mechanisms to improve coordination and leverage public and private financing in the context of moving toward UHC.

6.6 Monitoring and Evaluation and Communication

Strategy 14 is strengthening monitoring and evaluation (M&E) and monitoring Health Financing Strategy

implementation. It includes a variety of M&E interventions and their feedback of evidence-based information into next generation policy dialogue. Improving M&E for all aspects of the Ghana Health Financing Strategy is critical to guide continuous refinement of interventions, institutionalization and increased ownership at all levels of the health system. A priority will be improving expenditure tracking and analysis and continuing to enhance MOH budget projections and cost estimates.

A performance framework and monitoring indicator package will be developed for routine monitoring of the Health Financing Strategy. Its regular review will be incorporated into Health Summits reviewing all health sector indicators. Regular and comprehensive reviews of health expenditure will be strengthened and incorporate various tools including National Health Accounts (NHA) and public expenditure reviews. In addition to routine monitoring, periodic operations research studies and evaluations will strengthen policy analysis and contribute to continuous refinement of health financing mechanisms. M&E will be institutionalized at all levels of the system and information fed back into next generation policy dialogue



improving transparency, promoting results and increasing sustainability as the feedback loop begins to function on its own indicative of a more responsive health system.

Major M&E activities include:

- Monitoring HFS implementation including development of a performance framework and monitoring indicator package, indicator data collection and analysis, and regular indicator results reporting and dissemination through Health Summits and other forums
- Institutionalize NHA and strengthen expenditure tracking, public expenditure reviews and costing
- Design and completion of periodic policy analysis, operational research studies or evaluations to generate evidence for policy dialogue and review
- Strengthen mechanisms for active feedback of M&E information and

evidence into next generation policy dialogue

Strategy 15 is develop and implement a communications strategy. The purpose of the communications strategy is to inform and educate stakeholders, promote health sector results and advocate for resource mobilization, financial risk protection, efficiency gains and quality improvement. Rationale and impact of policy decisions and consequences of decisions will be communicated to all stakeholders. Positive health sector results will be promoted to policy-makers, health providers and the population. Capacity will be increased enabling the health sector to effectively advocate for resource mobilization, health system barrier removal, efficiency gains, service delivery improvements and increased population involvement in their own health.



Major communication activities include:

- Design and develop a communication strategy to communicate policies, promote health sector results and advocate for health sector priorities to all stakeholders.
- Implement communications strategy



CHAPTER SEVEN

7. Health Financing Strategy Implementation


The Health Financing Strategy states the “what” as defined by the fifteen specific strategies to improve health financing. Implementation mechanisms and processes determine “how” Ghana will implement the strategy to fulfill its vision and achieve its goal and objectives. Implementation mechanisms and processes are not elaborated in great detail in the strategy as they will evolve based on progress, changes in the environment, identification of barriers, and accumulation of experience, lessons learned and evidence to guide subsequent decisions.

To realize the specific health financing strategies elaborated in Section 6, implementation is categorized into four elements: implementation plans,

prioritization and sequencing; clear institutional structure, roles and relationships; building human and institutional capacity; and strengthened health sector coordination.

Implementation Plans, Prioritization and Sequencing

Following approval of the Health Financing Strategy, the MOH will develop an implementation plan. The general process will mirror that used for the Health Sector Medium-Term Development Plan 2010-2013. The Health Financing Strategy is ambitious and prioritization will be ongoing throughout the implementation process. Each specific strategy will make an important contribution and keys to success will be a comprehensive approach and development of synergies between all tasks to reduce weak links in the health financing chain.



Prioritization will be done by the extent of activities or level of investment within strategies which will be directly linked to implementation strategy and evolving environment.

An important aspect of the Ghana Health Financing Strategy underlying but not explicitly portrayed in the dynamic framework is implementation sequencing. For the purposes of this strategy, implementation sequencing is defined as the process of breaking down large daunting or intimidating tasks into simple and realistic steps and ordering them in a way that enables implementation to progress seamlessly and inevitably. The health financing functions of revenue collection and pooling of funds are generally discrete one-time policy decisions thus requiring less sequencing while health purchasing is continuous refinement requiring more sequencing. The implementation plan will elaborate sequencing and phases of implementation. Sequencing and phases could be segmented by a variety of factors including type of health financing intervention, geography,

country administrative level, type of health facility, or type of health service.

Institutional Structure, Roles and Relationships

Appropriate institutional arrangements or the right institution doing the right thing is critical to Ghana Health Financing Strategy implementation. It requires improvements in stewardship or leadership/governance and functional specification with corresponding institutional structure, roles and relationships. Particularly important roles and relationships include Government, MOH and MOF on financing level and mechanisms; MOH, NHIA, GHS and FDA at all levels on health financing and relationship of financing and service delivery, human resources, drugs and capital investment; role of local government; role of civil society organizations; level and nature of public provider autonomy; and relationships between public and private providers. Mechanisms such as a Health Financing Technical Working Group may be used to strengthen and increase participation in policy dialogue.



Building Human and Institutional Capacity

Improvements in both human and institutional capacity are vital to strategy implementation. Theoretical and practical human capacity will be increased through both education/training and on-the-job aids and support. Investments in institutional capacity increases through improved systems and operating procedures at all types and levels of institutions will also be a priority.

Strengthened Health Sector Coordination

Coordination is the fourth element of Health Financing Strategy implementation. Emphasizing

coordination in implementation of all specific strategies and activities will include multi-sectoral, across all MOH departments and agencies, across all country administrative levels and between public and private sectors. Country and development partner coordination is also a priority and coordination related to Health Financing Strategy implementation will be encompassed in Health Summits and other coordination mechanisms.

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