Joint Ministry of Health-Health Partners

Summit, Accra

31st May to 4th June 2004

AIDE MEMOIRE

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Introduction

The Ministry of Health and Partners summit was held in Accra from 31 May to 4 June 2004. The summit brought together all key stakeholders in the health sector, including representatives from the Ministry of Health and its Agencies, Development Partners, Ministry of Finance and Economic Planning, Christian Health Association of Ghana (CHAG), National Development Planning Commission, Parliamentarians, and Civil Society. The main objective of the meeting was to review the performance of the health sector in 2003 based MOH and Agency reviews and independent reviews, and agree priority actions for 2004 Programme of Work and those to be taken up in the 2005 Programme of Work. This aide memoire captures the main priorities as outlined.

General Observations

The summit acknowledged the high quality of the extensive and comprehensive reviews and accepted them as the working documents. There was wide expression of satisfaction with the continuing efforts by health professionals, irrespective of severe resource constraints and low wages, to achieve key targets in public health and institutional development. However, the increases in infant and under five mortality and malnutrition in spite of high coverage of immunization and other child welfare services and increasing spending on health were issues of concern. Supervised deliveries, malaria control, HIV/AIDS and tuberculosis have performed below expectation and the Guineaworm situation has worsened. Clinical care and facility management appears not to have received adequate attention.

The summit identified that resource allocation needs to be improved to deal with the marked differentials in allocations and performance between districts and regions. Collaboration with the District Assemblies and other relevant sectors needs to be strengthened to improve planning and implementation of interventions that require cross sector solutions. The summit agreed the following five strategic priorities.

- Mainstream the pro-poor agenda in the health sector
- Improve the quality of clinical services and accelerate the key public health interventions, especially malaria control
- Pursue intersectoral collaboration in order to address the broader determinants of health
- Increase overall financial resources to the sector and ensure pro-poor and equitable allocation
- Enhance performance measurement, monitoring and use of information to improve productivity in the sector.

Mainstreaming the pro-poor agenda across the health sector

The summit agreed that poverty, as an important cross cutting variable that affects sector performance and health outcomes, should be mainstreamed across the sector. The poor suffer disproportionately from the burden of ill health. Significantly, the poor regions are also the worst performing regions. The 2003 in-depth review of the sector pro-poor agenda showed that while sector policies provide an adequate framework to achieve pro-poor objectives and equity, there was inadequate progress in reaching consensus on operationalising some of these policies, and in delivering interventions to ensure access to services for poor people.

The most significant challenge to successful implementation of these policies is the ability to exclusively identify and target the poor. Urgent progress is required to improve targeting of resources, including exemptions, and interventions to the poor. District poverty maps are now available as a powerful means of improving the targeting of resources to the sub-district levels across the country. The national health insurance programme could potentially increase access to services for the poor by providing subsidies for premiums through the district mutual health schemes.

Recommendations

- Prioritize diseases such as malaria, guinea worm, TB, maternal health, buruli ulcer, which disproportionately affect the poor in district plans and implementation
- Increase proportion of resources allocated to deprived regions and districts
- Develop sector-wide indicators for measuring poverty and equity related objectives
- Include poverty related targets in performance contracts
- Accelerate collaboration with district assemblies and other relevant agencies for better identification of the poor and better planning and implementation of poverty-related expenditures
- Review BMC plans to ensure they reflect the pro-poor agenda.
- Sustain and adjust the exemption scheme within the evolution of health insurance
- Implement provisions in ACT 650 regarding targeted financing of premiums for the poor through the NHIF
- Conduct research to establish the relationship between maternal exemptions and maternal health outcomes

Key Service Delivery Priorities and Actions

The coverage of public health services such as EPI, ANC, PNC were quite high albeit that 2003 appears to be recording marginal drops or stagnation. Clinical care services especially coverage of in-patient care and OPD per capita have also been increasing steadily since 2001. The improvements in the community based component of public health interventions have not been matched by equal improvement in facility based services. Maternal mortality is still too high, case fatality rate of malaria in under fives has stagnated, and TB case detection and cure rate though increasing are still too low. There are also significant problems with documentation and quality of care, including

nursing, laboratory and emergency services. The organisation and management of health facilities is still weak.

Some disease control programmes have also not made significant progress. Key among these is Guinea Worm, Malnutrition and coverage of ITNs in the population. Indeed, malaria continues to be a leading cause of morbidity and mortality. There are high levels of chloroquine resistance in the country and has resulted in a change in drug policy to artesunate-amodiaquine, a more expensive artemisinin based combination therapy. Coupled with the low coverage of ITNs a major issue will be the need to subsidise both the cost of ITNs and the drug to make them more affordable to government and to the people.

The ACSD implemented in the Upper East region provide a good model for scaling up ITNs and other relevant child health interventions. This will however require further assessment to determine cost effectiveness and sustainability.

The prevalence of HIV/AIDS is also still increasing. Preventive measures need to be intensified. Anti-Retroviral Treatment (ART) for HIV/AIDS is currently considered a vital component of continuum of care. It was agreed that an appropriate balance be sought between the prevention and treatment of HIV/AIDS to achieve synergy in the continuum of care. There should be a team to monitor implementation.

Recommendations

- Maternal and child health services should be given priority in facility development plan and the provision of care at all levels
- Improve Emergency Obstetric Care in all facilities
- Develop structured program to improve documentation and quality of nursing, laboratory and emergency services as well as organisation and management of health facilities
- Improve supportive supervision, peer reviews and other forms of quality assurance.
- Modernise all health care facilities and equipments to improve their standard and quality of services to the public
- Document lessons and cost effectiveness to provide evidence for the possible scaling up of the Accelerated Child Survival Development Programme piloted in the Upper East.
- Revitalise efforts to eradicate Guinea Worm
- Finalise the strategic framework for Community Health Planning and Service (CHPS), to clarify the concept, package of services, role of CHOs as providers including midwifery and the resources required in scaling up.
- Give priority to hard to reach areas in the roll out of CHPS.
- HIV/AIDS control should scale up the uptake and preventive measures such as Voluntary Counselling & Testing (VCT), ART and condom use. In this regard will be necessary to review the recommendations of the joint review document and take appropriate action.

- The national malaria control programme should prepare an action plan for the production, procurement, promotion, distribution and re-treatment of affordable (subsidised) Insecticide Treated Nets (ITN) to cater for current and future need.
- National Tuberculosis Programme should revise the drug treatment policy to allow for treatment at the community level

Financing the Health Sector

Total Government of Ghana spending on health increased from 9.1% in 2001 to 9.8% in 2003. The increase in allocation to the sector was due to increases in the wage and ADHA bills. The service and administration budget declined. All components of the health sector budget are still under funded. The proportion of allocation is still below the Abuja target of 15 percent. In view of this, there is an opportunity for the health sector to negotiate with the Ministry of Finance for increased allocation. In this regard, the use of needs based budgeting should help the health sector identify the additional resource required to achieve its objectives. It was noted that increases in spending in the sector should be accompanied in improving efficiency.

The health sector was also constrained by delays of three to six months in the disbursement of both donor and GOG funds. This resulted in less than the 42% of total budget expected to be released to districts and consequently a 27% cash balance at the end of 2003. Steps have already been taken in 2004 to release funds to districts on time and to improve the accounting in the Central medical Stores to capture central level expenditures on behalf of the districts. Further, Government has put in mechanisms to give adequate protection to the priority programs and districts in the event of budget cuts. Finally, direct disbursements to BMC bank accounts have been instituted to reduce the lead time between issue of cheques at HQ and clearing of cheques at BMCs.

Recommendations

- Negotiate with the MOFEP to protect health budget against budgetary cuts and increase the health share of GOG funds towards the Abuja target of 15%
- Negotiate with the MOFEP to protect the health budget against budgetary cuts
- Improve per capita allocation of resources to the most deprived areas in line with MDBS/PRSC requirements
- Continue to re-organise the accounts of Central Medical Stores to provide information on transactions with BMCs.
- Explore opportunities for reducing steps in disbursements
- Negotiate with MOFEP to have its GOG Administration budget released in the way the Service budget is released.
- Hold a meeting with the MOH, Partners and MOFEP to discuss the implications of the classification of ADHA on financial targets and disbursements
- Agree on a disbursement plan for BMCs and communicate to all agencies of the ministry during the first quarter of each year.

Institutional Reforms

Progress with the separation of MOH and GHS is quite far advanced with the Minister giving a firm commitment to continue efforts to clarify the different functional areas. The legal instruments on health insurance have been passed and the members of the governing council have been announced. The summit endorsed the adoption of insurance as the new health purchasing mechanism in the country and pledged their support to work towards its success. An effective regulatory environment was seen as a necessary requisite to ensure that the insured clients receive value for money through improved quality of care. NHIC will also add new dimensions to the relationship between the providers, regulatory bodies, the ministry and the insurance institutions. In the light of these, there is concern that unless there is a systematic program developed to clearly outline the cross-functional relationships, the difficulties that attended the MoH/GHS split might re-surface with added complications.

Recommendations

- A change management program should be developed to improve the relationship between MoH and its agencies. A progress report will be presented to the next summit.
- Strength the role of the statutory and regulatory bodies to regulate practice in both the public and private sector with a single standard for all.
- Review the legal instruments of regulatory bodies to bring them in line with recent changes in the health environment

Intersectoral Collaboration and Partnerships

It was agreed that the achievement of the health sector objectives did not depend on the health sector alone. In particular, important determinants like water and sanitation, food security, and girl child education fall outside the traditional boundaries of responsibility of the health sector. Other sectors like the Ministries of Local Government, Food and Agriculture, Education and other agencies such as Community Water and Sanitation Agency and the National Development Planning Commission all have responsible roles to play. There is also the need for continuing partnership with private providers, private entrepreneurs, traditional medical practitioners and community volunteers. Even though these were identified in the five-year programme of work, little attention has so far been paid to the realisation of these objectives. An in-depth understanding of the situation as well as developing the capacity to actively engage these various stakeholder Organisations would be required at all levels.

Recommendation

- The programme of work 2005 should identify as core, the important role played by other sectors and develop the appropriate policies and mechanisms for engaging with them to achieve the sector objectives.

- Ministry of Health and the Ghana Health Service should develop appropriate capacity to manage intersectoral collaboration and partnerships.
- The Ministry of Health should set up a 'desk' for intersectoral collaboration and partnership
- Guidelines for working with other sectors especially with the District Assemblies and Community Participation should also be finalized.

Human Resources

The entire area of human resource development came under critical review. It was appreciated that a considerable amount of draft policies have been developed. However, these documents have not been finalised for implementation and capacity for implementation continues be lacking. A critical analysis of the factors influencing the production and retention of health workers in deprived and hardship areas was also discussed extensively. There remains a tension between the need to pay incentives to retain staff, attract staff to poorly served areas, and growing concern over wage inflation. This is in light of the high proportion of wages to recurrent expenditure. Both objectives, of controlling wage and providing incentives, can only be achieved if there is rationalisation between incentives and service delivery objectives which in themselves are labour intensive. A critical analysis of the human resource situation in the urban areas and capital cities, vis-à-vis the concentration of personnel in the two teaching hospitals were also extensively discussed.

Recommendations

- Establish an inter-agency team to review the key initiatives including the Human Resource for Health strategy and the incentive package and develop pragmatic solutions to guide its implementation.
- Negotiate with MOFEP for the decentralisation of the human resource budget to the health sector
- A strategic approach should be adopted in the implementation of the law on the College of Physicians and Surgeons to ensure that personnel in the deprived districts gain access to the programs as an incentive for serving in these areas.
- Facilities outside the teaching hospitals should be considered as training sites for shorter programs.
- The training of auxiliary medical and nursing staff for the lower levels should be pursued in earnest especially for the CHPS program. This should take into consideration the clear functions of these cadres and the role expected of them. The distribution of personnel should also be re-considered to ensure equitable distribution.
- The human resource information system should also be strengthened to ensure regular up-date so as to eliminate the incidence of ghost workers.

Performance Measurement

The issues of information management to support decision making were discussed extensively at this summit. The most prominent feature in the information system was the

lack of reliable data due to inconsistencies in the units of analysis, data capture system including the store and retrieve system. The tools of data collection were in most instances duplicating the information collected and the skills of the personnel involved needed further improvement. It was also contended that the institutional system for dealing with information for decision support was considerably weak. A conscious effort should be made to move towards a systems approach rather than a programs approach to data collation and analysis. Feedbacks should be provided to all levels. In this regard adequate capacity – both human and infrastructural - should be developed to support this. However, a lot of work is already going on to ensure that these issues were addressed.

Recommendations

- The institutional architecture for data collection, analysis and management should be reviewed to introduce a high level of consistency and reliability in the information produced and its management.
- Set up a central system of data storage and retrieval for ease of access by all players in the sector.
- All agencies should develop their own central system of data collection and analysis in the short to medium term to support evidence based decision making. In the long term, data from these systems should feed into the national central repository.
- Conduct a survey on maternal mortality
- Review sector- wide indicators to include poverty, equity, and productivity and cost effectiveness indicators for possible adoption as part of the next five year program of work.
- Harmonise MDBS/PRSC processes, indicators and timetable with the health sector system.

MDBS/PRSC implications of SWAPS

The Multi-Donor Budget Support and PRSC are becoming one of the main mechanisms for mainstreaming resources through the central budgetary process. There are opportunities in the PRSC/MDBS mechanism as well as some inherent risks which should be carefully evaluated and mitigated to protect the interest of the health sector.

Recommendations

- A working group should be constituted to include MoH, agencies, MOFEP and partners to hold discussions to get a clearer understanding of the PRSC/MDBS and its implications for the sector-wide approach.
- The review and reporting mechanisms including timing of the PRSC/MDBS/GPRS activities should be synchronized with the Sector-wide monitoring and evaluation framework
- The health sector should strengthen its sector activities with the pro-poor working groups.

2005 Programme of Work and MTEF plans

The meeting discussed the time table for preparing the 2005 program of work and budget. It was agreed to use both the needs based and resource based planning. Partner stated their desire to participate in the planning process.

Earmarked funding

The meeting discussed the guidelines for earmarked funding as spelt out in the CMA and agreed to its continued relevance. Partners were encouraged to promote sector ownership of the programs. It was also considered important for partners to provide adequate information on earmarked funds in terms of availability and activities funded and called for more integration with sector plans and budget as outlined by the CMA.

Conclusion

The aide memoire summarizes the strategic decisions and priority actions emanating from the review reports and the summit. It is however recognized that the aide memoire does not cover the entire scope of what needs to be implemented.

Recommendation

The Ministry of Health should study the recommendations in all review reports and agree priority actions to be taken.

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