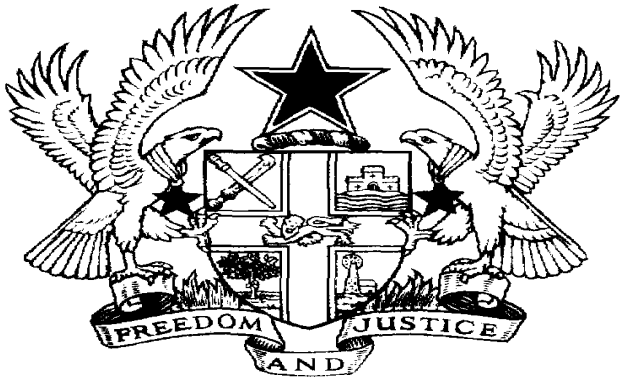
Ministry of Health

Ghana



Pulling together, achieving more

INDEPENDENT REVIEW

HEALTH SECTOR PROGRAMME OF WORK 2008

(DRAFT)

April 2009

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Acknowledgements

The review team this year consisted of Sophie Witter (team leader), Jaap Koot, Tim Cammack, Gilbert Buckle and Andreas Bjerrum.

This report would not have been possible without the support of the Ministry of Health, especially the PPME team and Janet Kwansah in particular, and without the financial support of the development partners, which funded our posts. We are also very grateful for the time given by key informants and the many documents they supplied.

Acronyms

ACCPAC	Accounting Package (brand name)
AFP	Acute Flaccid Paralysis
ANC	Antenatal Care
ARI	Acute Respiratory Infections
ARHR	Alliance for Reproductive Health Rights
ART	Anti-Retroviral Therapy
ATF	Accounting, Treasury & Financial
BCC	Behaviour Change Communication
BMC	Budget Management Centres
BPEMS	Budget and Public Expenditure Management System
CAGD	Controller and Account General Department
CBO	Community Based Organisation
CFR	Case Fatality Rate
CHAG	Christian Health Association of Ghana
CHEW	Community Health Extension Worker
CHIM	Centre for Health Information Management
CHPS	Community Health based Planning & Services
CHN	Community Health Nurse
CMA	Common Management Arrangement
CMS	Central Medical Stores
CMR	Child Mortality Rate
CONGOH	Coalition for NGOs in Health
CPD	Continuing Professional Development
CSO	Civil Society Organisation
CYP	Couple Years Protected
DA	District Assembly
DANIDA	Danish International Development Assistance
DfID	Department for International Development
DHA	District Health Administration
DHIMS	District Health Information Management System
DHMT	District Health Management Team
DP	Development Partners
DRG	Diagnosis Related Group
EmONC	Emergency Obstetric and Neonatal Care
EMT	Emergency Medical Technician
EPI	Expanded Programme on Immunisation
ERPFM	External Review of Public Financial Management
FD	Finance Division
FP	Family Planning
FS	Financial Statement
GDP	Gross Domestic Product
GHc	Ghana Cedi
GHS	Ghana Health Service
GoG	Government of Ghana
GPRS	Growth and Poverty Reduction Strategy
HA	Health Assistant
HAT	Health Assistant Technical
HFS	Health Financing Strategy
HIPC	Heavily Indebt Poor Countries
HIRD	High Impact Rapid Delivery

HIO	Health Information Officer
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HR	Human Resource
HRDD	Human Resources Development Department
HQ	Head Quarters
IALC	Interagency Leadership Committee
ICC	Interagency Coordinating Committee
ICT	Information Communication Technology
IDA	International Development Agency
IHP	International Health Partnership
IGF	Internally Granted Funds
ILO	International Labour Organisation
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
IMMR	Institutional Maternal Mortality Ratio
IMR	Infant Mortality Rate
IPT	Intermittent Preventive Treatment
ITNs	Insecticide Treated Nets
KATH	Komfo Anokye Teaching Hospital
KBTH	Korle Bu Teaching Hospital
NMCP	National Malaria Control Programme
MDA	Ministries, Departments and Agencies
MDBS	Multi Donor Budget Support
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ration
MoESS	Ministry of Education, Science & Sport
MoFEP	Minister of Finance and Planning
MoH	Ministry of Health
MTEF	Medium-Term Expenditure Framework
NAS	National Ambulance Service
NCD	Non-Communicable Diseases
NDPC	National Development Planning Commission
NGOs	Non-Governmental Organisations
NHIA	National Health Insurance Authority
NHIC	National Health Insurance Council
NHIF	National Health Insurance Fund
NHIS	National Health Insurance Scheme
NMR	Neonatal Mortality Rate
OPD	Out-patient Department
PETS	Public Expenditure Tracking Surveys
PFM	Public Finance Management
PFMSIP	Public Finance Management Issues Paper
PHMNB	Private Hospitals and Maternity Homes Board
PPM	Planned Preventive Maintenance
PPP	Public Private Partnership
POW	Programme of Work
PPME	Policy Planning Monitoring and Evaluation
PPBU	Policy Planning Budget Unit
PUFMARP	Public Finance Management Reform Program
QA	Quality Assurance
RBM	Roll-Back Malaria
RCH	Reproductive and Child Health
RHMT	Regional Health Management Team

RHNP	Regenerative Health & Nutrition Programme
RMD	Regional Medical Director
SARS	Severe Acute Respiratory Syndrome
SBS	Sector Budget Support
SMTP	Short and Medium Term Action Plan
SSNIT	Social Security and National Insurance Trust
STD	Sexually Transmitted Diseases
SWAp	Sector Wide Approach
STG	Standard Treatment Guidelines
TB	Tuberculosis
TBA	Traditional Birth Attendant
TOR	Terms of Reference
TTH	Tamale Teaching Hospital
U5MR	Under 5 Mortality Rate
UN	United Nations
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAT	Value Added Tax
WHO	World Health Organisation

Executive summary

This review examines performance of the health sector in 2008, the second year of the Five Year Programme of Work III (2007-11).

The sector-wide indicators show gains in a number of important areas of health service delivery. Outpatient visits to health facilities in the public sector went up by more than 10%, mainly due to the health insurance. There was also an 11% increase in number of deliveries assisted by skilled personnel. The vaccination coverage remained high, as did the coverage of antenatal care. Programmes for prevention of mother-to-child transmission of HIV and provision of antiretroviral therapy to HIV patients reached many more people. The tuberculosis programme achieved a higher success rate. There was a dramatic fall in guinea worm cases. On the other hand, the number of admissions to health facilities decreased; the coverage of family planning went down; the nutrition status of pregnant women did not improve. The number of maternal deaths in health institutions remained high, as did the number of neonatal deaths. There was some improvement in the number and distribution of human resources.

The improvements reflect the intensive efforts made by the sector in recent years and the huge investments made by government and Development Partners. The health sector is allocated close to the Abuja target of 15% of public spending(14.9%), and has seen continued growth in nominal terms in 2008, although a rise in inflation means a slight reduction in real terms. Within the health resource envelope, there has been a continued rise in the funds coming through the National Health Insurance channel, while the Government of Ghana core subsidy is now plateau-ing. Development Partners who funded the Health Fund in the past have shifted to Sector Budget Support, which is now subject to earmarking within the Ministry of Health. As other Development Partners apply earmarking in their funding as well, programme funding has now become the dominant modality of funding in the health sector.

The theme of this review – 'Pulling together, achieving more' – reflects the finding of the review team: while there has been progress in many areas in 2008 and some very promising new initiatives, the fragmentation in the sector as a whole is increasing. This leads to higher transaction and opportunity costs and means that the value for money is less than could be expected. Ghana is one of the leading countries in Africa in per capita expenditure on health, but not leading in health outcome indicators. With the skills and the resources, which Ghana has at its disposal, it could be achieving so much more, if the sector and the players worked closer together ang harmonised their efforts.

The review focuses on four main areas – service delivery; human resources; public finance management; and the National Health Insurance Scheme (NHIS). In most of these areas, policy documents, strategies and programmes of work are in place. However, the connection between intentions and practice is not always made. On the ground, some of the basic issues are not being addressed. In service delivery, to give one example, maternal health was declared a national emergency in 2008. A task team were established, stakeholders' consultations held, and innovations proposed. However, at the grassroots level, there has been little or no change. Health facilities cannot yet provide basic care for mother and newborn. Essential medicines and supplies are often not available, despite increased funding through the health insurance. Why not?

This calls for a reflection on how support activities such as planning, budgeting and disbursement are assisting or complicating the lives of those who have to deliver core services. At present, although there have been improvements in the way that the Programme of Work 2008 is structured, with clear agency objectives and deliverables, there is a mismatch between plans and budgets on the one hand and disbursements and financial reporting on the other. Government resources are not delivered in a timely way to regions and districts. Plans are produced as short-term projects, often reflecting donor priorities instead of local priorities, and leave out essential activities, which could have made a health impact. Plans have to be re-made according to the latest (often unpredicted) influx of money. Finally, reporting formats do not match budgets and plans, which makes it hard for all parties to assess their own performance.

Another core area is the production, distribution and management of staff. Here there have been some very promising initiatives in 2008, which offer a starting point to promote integration in the sector. The establishment of an inter-agency posting committee, which agrees allocation of new staff to different agencies, is an important start to a more rational distribution of human resources. In addition, the setting of regional quotas and the enforcement of postings to rural areas (by removal from payroll) are potentially effective mechanisms to retain staff in 'hardship' areas. More open processes of advertising posts and interviewing candidates, as well as the gradual rollout of performance appraisal mechanisms, may help to reward good personal performance in a way that has not been possible in the past.

The NHIS is playing an increasingly important part in financing curative care in Ghana, providing 41% of the total resource envelope for 2009. Serious problems emerged in 2008, which resulted in long backlogs of pay to facilities. Some of the more basic issues, such as adequate staffing to process claims, are being addressed, but the underlying drivers – such as cost escalation and inadequate subsidies being paid to DMHIS – require a more fundamental review. This review cannot take place internally in NHIA. It must involve all stakeholders and must present a clear overview of the facts, the options and their implications. Transparency is paramount, if confidence is to be improved. Returning to the theme of pulling together, the NHIS must 'join the team', rather than operating as an independent corporate entity.

All of these shifts imply the need for stronger leadership from the Ministry of Health. The current identified shift supports the new government's manifesto, which emphasises a unified approach to health care and universal coverage. At the highest level, the recently reinvigorated Inter-agency Leadership Committee may be the forum in which this more mutually accountable governance of the sector can be enforced.

Many of the insights and recommendations contained in this report echo comments made in earlier years. Officials interviewed expressed concern on progress made in solving governance issues. The question has to be asked: why were these issues not addressed in a satisfactory way? The answer must lie in individual and institutional interests, and in organizational culture. These are the underlying factors that must be tackled in any institutional reform. It is imperative to remove incentives to create parallel systems; and remove incentives to create financial and programmatic 'silos'. Development Partners have to contribute to this. Long tines of command are inefficient in a complex system. For improving return on investment, it is necessary to support a culture where lower level managers are empowered to act, and given resources and support, in exchange for simple but well monitored accountability. It is right that those who perform well are rewarded while those who do not are not.

Each section of the report contains specific recommendations by the team, which are also summarised in the final section. Here are the five over-arching ones.

1. **Together we are stronger**: pursue and enforce inter-agency collaboration, Stimulate effective and operational collaboration, conducted at all levels of the system from district to national. Make real efforts to forge public private partnerships, with CHAG, with non-governmental organisations and with the private-for-profit sector.
2. **Root out parallel systems** that increase inefficiency. For example, bring facility-based ambulance services together in one system with the National Ambulance Service, and let them make a tangible contribution to improved access to health facilities for women in labour. Stop the mushrooming of volunteer programmes for each and every health programme, and make serious work of community participation in decision-making on grass root health activities. The same applies for the multiple financial reporting software packages in use: sit together, and harmonise.
3. **Orient towards the grassroots**. The district and sub-district should be at the heart of the planning system. Re-instate the system of integrated districts plans, involving all sectors and governmental and non-governmental players, including the District Assembly. Let them produce plans tailored to local priorities based on resources, which are on offer, and use them to build up regional and national plans. These plans direct the resources of development partners, who buy into local plans, rather than dictating them.
4. **Give managers the freedom to manage**. This is starting to happen in some respects in human resources management, which is a very important step, but it can go further. The culture of mistrust must be reversed, so that supervisors provide the funds and effective technical and personal support. They should allow those below them in the system to plan and use resources flexibly, and should reward good performance.
5. **The flip side of this is accountability**. People must be held accountable for not doing their job, for which they were given power and resources. Non-performance must not be seen as the norm.

These recommendations do not deny the many strengths of the health system in Ghana and aim to build on the good work done so far. Ghana belongs in the top of the league table of health in Africa and needs to go this extra mile to reach the absolute top. Many key informants share the opinion that pulling together can make the difference. The review team is happy to articulate this ambition.

1 Background on Ghana

The macroeconomic situation in Ghana has changed considerably over the last 12 months. The 2008 fiscal deficit rose to 14.9% of GDP range, up from 9.2% of GDP in 2007. This was in spite of an increase in nominal tax revenues of 29.8% over 2007. A major factor in the fiscal deficit was an increase in the public sector wage bill, which rose to 11.5% of GDP, more than 40% per cent higher in nominal terms than in 2007. The wage overrun was mainly the result of higher than anticipated salary increases to public sector workers, as well as higher than programmed number of public sector workers.

In an effort to curb this trend, the new administration has signalled in the Budget Statement for 2009 that it will bring the fiscal deficit back to 9.4%.

Inflation is also increasing. It reached 19.9% in January, up from 12.7% at end-2007. Reflecting the inflationary increase, interest rates on 91-day Treasury Bills now stand at almost 25%, up from around 10% at the end of 2007. During 2009 the inflation rate is targeted to fall back to 15.3%.

Real GDP growth averaged 6.2% from 2005 to 2007 and 2008 saw strong continuing real economic growth at 6.2% (as reported in the 2009 Budget Statement), supported by high levels of public expenditures and the good performance of the country's main exports (cocoa and gold). Cognizant of the impact of the economic downturn, the forecast for 2009 is of real GDP growth of a slightly lower 5.9%.

The implication of the deteriorating macroeconomic position is that real cuts in public expenditure may become necessary. A recent World Bank report (World Bank, 2009) makes the following point which is of great relevance to the health sector: if expenditure cuts fall disproportionally on public investment, to protect public consumption such as wages and salaries, this is likely to lead to reduced growth in the medium term. Furthermore, since progress in poverty reduction is linked to real GDP growth, the choice between restraining public investment or restraining public consumption is really a decision about the future rate of poverty reduction.

2008 was also an election year for Ghana, with voters going to the polls in December and electing a new NPC government. This has introduced a hiatus, while new posts are filled and the policy direction of the new government established.

2 Introduction to the independent review

The review assesses overall health sector performance for the year. This year there were six specific focus areas within the TORs: service delivery; public finance management; human resources rationalisation; the NHIS and claims management; procurement systems; capital investment; and testing the holistic assessment tool. These TORs had to be modified, in that consultants were not recruited in the end to focus on the procurement and capital investment issues. These will now be assessed independently.

The review is part of a long process, starting in January, of BMC, agency and partner reviews, feeding into the independent review and thence to the health summit. This process is itself under review and we will comment later in the document on how it might be adapted to increase its effectiveness and reduce time inputs.

No regional or agency reports were available at the time of work of the team. Rather than validating reports, we have therefore used a combination of key informant interviews, site visits and search of documents and databases to assess performance.

The structure of this report closely follows the TORs. We start with a presentation of sector-wide indicators and a discussion of overall performance trends. This is followed by a focus on service delivery, human resources, health financing, the NHIS, and financial management. We end with reflections on the governance, including the review process, and annexes containing the holistic assessment tool and a summary of agency results against targets in the PoW for 2008.

3 Sector-wide indicators: targets and achievements in 2008

The table below summarizes the values of sector-wide indicators for the 5-Year Programme of Work and annual targets specified in the 2008 Annual Programme of Work. The values of the indicators have been provided by sources indicated below.

Table 1 Sectorwide indicators, 2008 and trend since 2006

(Greyed indicators are not measured annually)

	2006	2007	POW 2008 Target	2008 performance	Trend
Goal 1: Ensure that children survive and grow to become healthy and reproductive adults that reproduce without risk of injuries or death					
IMR	71		64		N/A
U5MR	111		105		N/A
MMR	N/A		N/A		N/A
U5 underweight	18%		16%		N/A
Total Fertility Rate	4,4		4,3		N/A
Goal 2: Reduce the excess risk and burden of morbidity, disability and mortality especially in the poor and marginalized groups					
HIV prevalence	2,9	2,6	<4	No information	N/A
Guinea Worm	4.136	3.358	<2000	501	-85.1%
Goal 3: Reduce inequalities in health services and health outcomes					
Equity: Poverty (U5MR)	1,18		1,18		
Equity: Geography (supervised deliveries)	2,05	2,143	2,00	1,97	-8.2%
Equity: Geography (nurse: population)	4,14	2,257	3,00	2,03	-10.1%
Equity: NHIS (gender)	N/A	N/A	N/A	1,22	N/A
Equity: NHIS (poverty)	N/A		N/A		N/A
Strategic Objective 1: Healthy lifestyle and healthy environment					
% Households with sanitation	60,70%		62,50%		N/A
% Households with access to impr water source	78,10%		80%		N/A
% Obesity in population	25,30%		25%		N/A
Strategic Objective 2: Health, Reproduction and Nutrition Services					
Exclusive breastfeeding	54,0%		60,00%		
% Attended deliveries	44,5%	35,1%	60%	39,3%	11.9%
Family Planning (Couple Year Protection)	N/A	765,566	N/A	462,556	-39.6%
ANC	88,4%	89,5%	95%	97,4%	8.8%
%U5s sleeping under ITN	41,7%	55,3%	30%	40,5%	-26.8%
Penta3	84,2%	88,0%	90%	86,6%	-1.6%
HIV clients ARV treatment	7.338	13.249	25.000	23.614	78.2%
OPD	0,52	0,69	0,6	0,77	11.1%
Institutional MMR	219	224	172	200	-10.7%
TB success rate	67,6%	76,1%	80%	84,7%	11.3%
Strategic Objective 3: Capacity Development					
% Population within 5km	N/A				
Doctor: population	15.423	13.683	8.559	13499	-1.3%
Nurse: population	2.125	1.537	1.756	1353	-12.0%
Strategic Objective 4: Governance and Financing					
% MTEF on health	16.2%	14,60%	15,50%	14,90%	2.1%
% Non-wage GOG recurrent to district	40%	49%	>40%	49%	0.0%
USD/capita	25,4	23,01	39,11	$23.23	1%
Budget execution rate	N/A	N/A		115%	
% Budget disbursed before June	N/A	N/A	50%	23%	
% Population with NHIS card	25%	36,2%	65%	45%	25%

	2006	2007	POW 2008 Target	2008 performance	Trend
% Claims settled within 4 weeks	N/A	N/A	40%		
% IGF from NHIS	45%	N/A	55%	66.5%	N/A

None of the indicators for Goal 1 are measured annually, and results of the 2008 Demographic and Health Survey were not published in time to be included in this review. It is therefore not possible to comment on the sector's progress towards 5-Year Programme of Work targets for this Goal.

For Goal 2, HIV prevalence data for 2008 could not be obtained, but the guinea worm incidence reduced significantly to 501 cases in 2008.

Goal 3 is related to reduction of inequity in health services and outcome, where the progress in 2008, compared to 2007, has generally been positive. The relative difference between best off and worst off regions, in relation to coverage of supervised deliveries and concentration of nurses, has reduced. Both geographic indicators are still close to 2, indicating that the best off regions has double the proportion of supervised deliveries, and twice as many nurses per population, compared to the worst of region. The highest concentration of nurses is found in Greater Accra Region with one nurse per 952 inhabitants, and the lowest concentration is found in Ashanti Region with one nurse per 1,932 inhabitants. Brong Ahafo tops as the region with most supervised deliveries with 51.5% compared to Northern Region being the lowest performing region with 26.0%. With regards to outpatient visits per capita, the same two regions represent the extremes: Brong Ahafo has 1.3 visits/capita compared to a national average of 0.79, whereas Northern Region only as 0.49 visits/capita. Considering the staffing situation in the two regions, they have roughly the same number of nurses per capita (1:1,767 in BAR and 1:1,770 in NR) but Brong Ahafo region has significantly more doctors per population (1:21,685 in BAR and 1:73,257 in NR). Another reason for higher service uptake in Brong Ahafo could be the region's comparatively longer experience with health insurance.

The gender equity indicator, which has not been analysed before 2008, shows that women register to a larger extend with health insurance than men. This is likely to be explained by a relatively higher need for medical services, including maternal services, among women as well as the government's initiative to register pregnant women free of charge onto NHIS, which was implemented in July 2008.

Indicators of Strategic Objective 1 are all based on survey data and cannot be analysed for 2008.

There was overall good progress in indicators related to service provision under Strategic Objective 2. Maternal services coverage increased; supervised deliveries however, still being significantly below the annual target of 60%, and as mentioned above with large regional variations. Family planning services, measured as contraceptive prevalence rate, increased but analysis of couple years' protection reveals that this figure has reduced. This means that FP acceptors are probably shifting to more short-term methods.

Institution MMR as calculated by the Maternal and Child Health Unit reduced from 224/100,000 in 2007 to 200/100,000 in 2008, but this calculation is a bit tricky. The denominator of this institutional MMR, the number of live births, erroneously included TBA deliveries, which could result in deflation of the institutional MMR. It has not been possible to clarify if this methodology is a continuation of previous years' practice. The review has not been able to access data for live births and maternal deaths strictly connected to facilities, in order to recalculate the institutional MMR.

The EPI indicator has slightly reduced but remains high at 86.6% coverage. An EPI survey done by the EPI programme covering year 2008 reveals a significantly lower figure of children fully immunized by the age of 1. The national median coverage was 47.1% with a range of 17.8% to 72.5% in worst and best districts. This figure is significantly lower than reported in the 2006 Multi Indicator Cluster Survey of 64% fully immunized by the age of 1 year. A survey on impact of malaria interventions shows that 40.5% of all children under the age of 5 slept under an ITN the previous night, compared to 55.5% in 2007. The Malaria Control Programme has questioned the comparability of the present survey with previous surveys, due to timing and seasonal influence on ITN use. Results from the 2008 EPI programme survey, which also included assessment on ITN utilization, reports the national median at 61.3%. This supports the NMCPs impression that 40.5% ITN utilization is an underestimation. The number of HIV-positive clients receiving ARV therapy has seen a sharp increase to 23,614, almost reaching the annual target of 25,000. Similarly, the TB success rate has improved.

Workforce indicators for both nurses and doctors have improved in 2008 over 2007 figures. While the doctor-to-population ratio improved only slightly, the nurse-to-population ratio improved by more than 10%. As discussed above, there is large regional variance in distribution of health personnel, especially doctors. In Northern Region there are 73,257 inhabitants per one doctor, compared to 9,939 in Greater Accra. 70% of all doctors are concentrated in Greater Accra Region and Ashanti Region and only 4.2% of all doctors are serving the three northern regions.

Most financial indicators improved in 2008, compared to 2007. While the proportional MTEF allocation to health did not increase significantly, this indicator is just 0.1% point below the Abuja target of 15%, and GOG allocations to health increased significantly in nominal terms. The indicator of non-wage recurrent expenditure at district level and below is, as in previous years, based on an estimation done by MOH, and exceeds the target of 40%. Overall expenditure per capita in USD was $23.23 (reflecting all public sources, including aid, and IGF, but not out-of-pocket payments to private facilities, nor overhead expenditures by the NHIS)[1].

The budget execution rate for item 3 has been calculated at 115%. The high execution rate may partly be explained by unexpected high expenditure by NHIA on reinsurance of DMHIS,

[1] Total per capita expenditure would be $27.67 for 2008, if total NHIS expenditure were captured in the MoH financial statements.

exceeding the budget. 23% of funds for item 2 and 3 three were disbursed by end of June 2008. The figure is significantly lower than the target of 50%, partly due to delays in SBS disbursement to MOH. The Netherlands' contribution to SBS was transferred to MOFEP in the middle of May, the Danida one in first quarter of 2008 and the DfID contribution was transferred on the first of July. By the end of June, MoH had received only the Danida SBS contribution from MOFEP and by end of August, MoH received DfID as well as 50% of Netherlands SBS contribution (the remaining 50% were retained in MOFEP and disbursed to MOH in 4th quarter). 79% of budget allocations for item 2 and 3 were disbursed by end of August 2008.

The national health insurance coverage of cardholders continued to increase in 2008. Previous estimations of the percentage of the population holding a valid NHIS card had not been adjusted for population growth since 2004 and coverage figures had consequently been overestimated. In the current estimations, population data from the Centre for Health Information Management (CHIM) validated by the Ghana Statistical Service was used. The percentage of cardholders in 2008 is estimated to 45%, compared to 2007 (recalculated) estimations of 36%. The NHIA was not able to provide information on the proportion of claims settled within 4 weeks of submission because district mutual health insurance schemes do not report these figures to NHIA head quarters. Disaggregated figures for IGF were reported for the first time, showing that IGF from the NHIS has grown to provide two-thirds of overall IGF at facility level.

Performance against POW 2008, as reflected in agency presentations

The PoW for 2008 innovated by setting out specific objectives by agency. Although agency reports were not available at the time of the review, we have compared agency performance review presentations against agency objectives to assess to what extent targets for the year had been met. The comparison, which is presented in Annexe X, shows variable performance in terms of agencies referring to PoW objectives when assessing their performance. Many commendable new initiatives were undertaken in the year. However, if PoW objectives are to be useful as a planning and performance management tool, they should be used by agencies as a benchmark at the year-end.

4 Service delivery

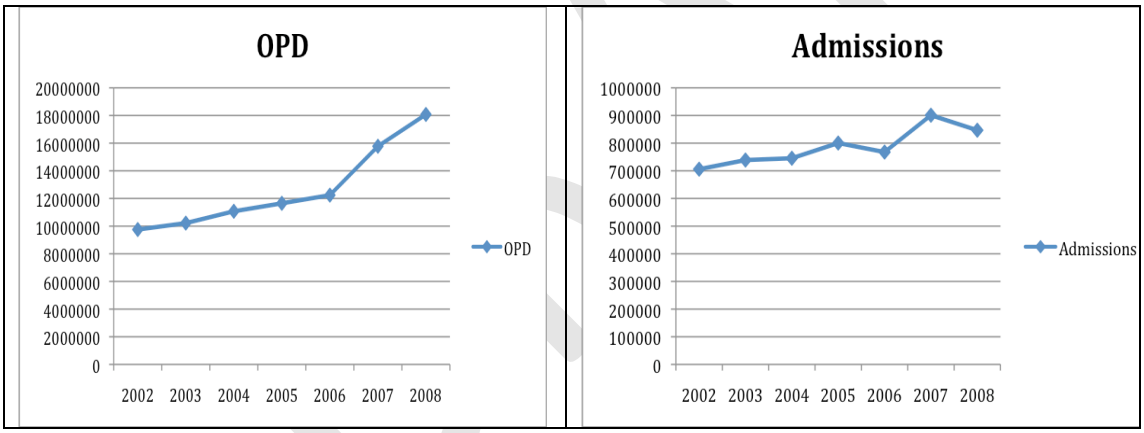
4.1 Clinical services

In this section, three topics of clinical care will be discussed: improvement of quality of care, the referral system including ambulance services, and emergency preparedness.

4.1.1 Quality of care

Clinical services have increased during the last years, mainly because more patients with health insurance have been treated. However, outpatient services have grown much more than inpatient services. The number of admissions has even slightly reduced in 2008, compared to 2007. The effects of increased OPD caseload and reducing inpatient caseload on quality of care in the Ghana health sector need further analysis. The table below shows considerable differences per region. In some regions OPD attendance reduced in 2008 compared to 2007. Admission figures also show differences per region (see tables next page). It is too early to conclude whether the health system is overburdened or not.

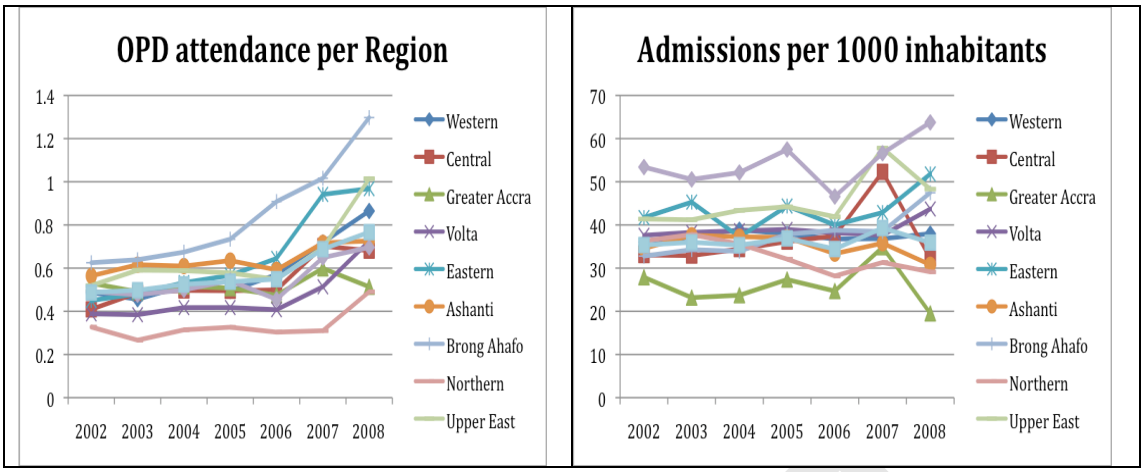
Figure 1 National OPD and admission trends, 2002-8



Source: Data base GHS 2008

Ghana recognised the importance of quality assurance (QA) of clinical services more than 20 years ago, and started working on pilot projects in hospitals. In the present Programme of Work 2007 – 2011, improvement of clinical services is one of the activity areas. According to the POW, not only should the services incorporate new therapeutic approaches to save lives (ambulances, intensive care), they should also respond to the increasing demand for treatment of non-communicable diseases (NCD).

Figure 2 Regional trends in OPD and admissions, 2002-8



Source: Data base GHS 2008

In the health sector in Ghana there are three elements of the quality improvement programme.

- **Improvement of work processes** in health facilities, through capacity building programmes, assisting health workers to provide health care in a better way
- **Clinical guidelines**, standards of operation and protocols, which provide health workers with information how the work should be done in a "state-of-the-art" manner
- **Accreditation**: regular external checks of elements of quality, often tied to permits of operation of facilities

Ghana Health Service has produced a Strategic Plan 2007 – 2011 for quality assurance. The strategic plan provides a framework for developing, promoting and working toward good quality clinical care in all GHS facilities and district hospitals owned by CHAG. Tertiary hospitals, other CHAG facilities than district hospitals and private services providers are not targeted by this strategy. The four strategic objectives are:

- Improve client-focused services (patient-providers relations)
- Improve patient safety (reduction of iatrogenic risks)
- Improve clinical practice (evidence based procedures)
- Improve management systems and accountability (supervision, information)

Work processes

Presently Ghana Health Service is working on a customer care programme, which trains health workers in improvement of patient-provider relations.

There are also training programmes in leadership. The programme has been slowed down because of resource constraints.

In many hospitals there are QA teams, though often not very active, which from time to time organise clinical mortality meetings and maternal deaths surveys. The follow-up on such discussions is minimal: according to informants, there is little or no change of work

processes as a result of the clinical meetings. GHS plans to change the methodology of maternal death surveys, to perform more in-depth analysis of problems.

Clinical guidelines and protocols

In recent years disease control programmes have produced several clinical guidelines and protocols. There are treatment guidelines for tuberculosis, treatment guidelines for malaria with new Artemisinin Combination Therapies (ACT), and clinical guidelines for Anti Retroviral Therapy (ART). Guidelines exist in many other areas, like Integrated Management of Childhood Illnesses (IMCI), family planning, etc. Also for nursing and paramedical services guidelines have been formulated. There is no common standard or methodology for development of these guidelines, and there is no place in the MoH where all clinical guidelines are collected. Practitioners cannot easily access available guidelines.

Accreditation programme

The Private Hospitals and Maternity Homes Board performs an accreditation that concentrates on infrastructure, availability of equipment and staff, but not looking at work processes.

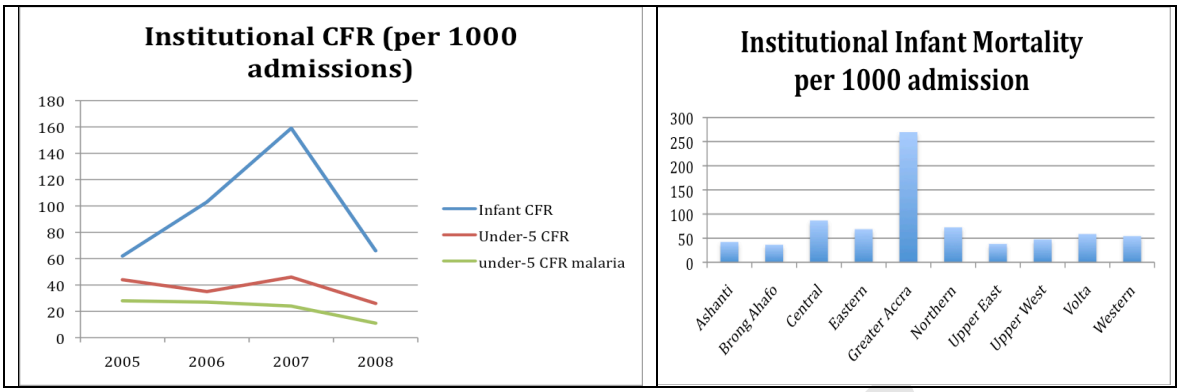
In 2004 GHS had started an accreditation programme for district hospitals. However, the programme was never implemented, partly because it was too elaborate and not actionable. The NHIA took on the accreditation programme in 2007, as part of its legal obligations. The accreditation tool used is an improved format of the 2004 tool. The tool was piloted in 45 facilities in 2008. Nearly all facilities failed accreditation, with as points for improvement safety and quality management, organisation and management and pharmaceutical services. NHIA gives feedback to facilities and indicates areas for improvement.

Discussion

In general it is very difficult in a short external review to make an appropriate assessment of quality of service delivery. From reports, interviews and observations in field visits, the impression is that quality improvement in clinical service delivery is a very slow process. In routine data collection few indicators provide insight into quality of care. Sometimes Case Fatality Rate (CFR) is used a proxy for quality of care. Under-5 CFRs (general and malaria-related) seem to improve slowly. Infant mortality, probably heavily influenced by neonatal mortality, is fluctuating strongly. In 2008 eight fresh stillbirths per 1,000 deliveries were reported (including deliveries by TBAs), compared to 10/1,000 in 2007.

Ansah et al. demonstrated in a recently published article that free access to health services in a rural area did improve utilisation, but did not improve health outcomes. This suggests that quality of care may be an important area for improvement.

Figure 3 Institutional CFR and institutional infant mortality rates, 2002-8, Ghana



Source: Data base GHS 2008

For more refined information on quality of care, it might be possible to collect more information on quality aspects, e.g. post-operative wound infections, near accidents, to be analysed and used at facility level.

Quality of delivery of clinical services is dependent on a number of elements:

- Availability of service delivery points (static or mobile)
- Accessibility of these points to clients (opening times and financial)
- Acceptability to clients (culturally and socially)
- Availability of the enabling environment (supplies, medicines, equipment)
- Availability of competent health workers (numbers and competencies)

A broad range of interventions is necessary to enhance quality.

Unfortunately, the indicator on population living within 8 KM from a health facility is not monitored, although part of the sector indicators. For sure, long distances from health facilities contribute to generally poorer health outcomes in the Northern part of the country. The strategy to expand the CHPS compounds and incorporate delivery services in the package will improve availability of services.

Financial obstacles still exist (as discussed under the NHIS below). Indirect costs play an important role in access to health services. Free or low-cost community health services are crucial pro-poor interventions, and the MoH has rightfully chosen this as priority.

Acceptability of services is an issue: negative staff attitudes are frequently mentioned in documents, including in the Programme of Work 2008. Research was planned into this issue in 2008, but not conducted. The Ghana Public Expenditure Tracking Survey in 2008 has a small section on patient satisfaction after treatment in health centres, which concluded that 99% of patients thought they were treated in a friendly way, and 81% thought they were given sufficient information on their ailment. Although the Review Team is not in the position to give a conclusive opinion on staff attitudes, it would like to warn against a blame game, in which managers push the blame for poor performance of facilities on grass root level workers. Frustrations among health workers may run high if the environment is not conducive to work in.

Recent inventory reports and field observations made it very clear to the review team that availability of equipment and supplies is serious problem in most health facilities. Many problems could be solved easily, if IGF were used to purchase stationery and basic equipment. Potentially, IGF provides a good basis for decentralised management of health facilities.

The improvement of competencies of health workers is the major thrust of the QA programme in the Ghana health sector. At the same time, it is high on the agenda of many other health programmes. Coordination between specific health and disease control programmes and the QA programme and building a coherent programme of Continuing Professional Development (CPD) could be a way forward.

From interviews and observations, the Review Team got the strong impression that newly trained staff may did not get sufficient training in skills, even in basic skills of hygiene and sterility. Training school should receive assistance to maintain quality of skills training, while increasing the numbers of students. The training institutions should be part of health sector QA systems.

Thirty years of clinical guideline development in Europe and the United States has taught us one important lesson: adherence to clinical guidelines is generally poor, when they are imposed top-down on health workers. Practitioners have to be involved in the development, teaching institutions in pre-service training and continuing professional development, and professional associations have to be involved in dissemination and making guidelines part of professional ethics.[2] It would be helpful to call in advice from the National Institute of Health and Clinical Excellence (NICE)[3] or similar organisation to strengthen the methodology of clinical guideline development.

Under the present circumstances an accreditation system can only work if it goes hand in hand with a quality improvement programme. Isolated accreditation programmes failed in other countries, because closing of facilities is no option in a country with low access to health services. The areas that need most improvement are exactly those that GHS has chosen as topics for the 5-year plan on QA. Collaboration between the NHIA and GHS seems logical; other affected agencies and the private sector should be brought on board as well.

Quality of clinical can be improved if all five elements of availability, accessibility, acceptability, supplies and staff are addressed at the same time. Quality assurance should therefore be operating more as a cross-cutting theme in all health sector activities, than as a separate programme. Given the resource constraints, quality improvement has to go in small steps, but should rather proceed with packages than in isolated training programmes. For example, training in use of partographs should be combined with provision of basic labour room equipment and supply of stationery. Introduction of ACT guidelines and

[2] See http://www.agreecollaboration.org/intro/ for AGREE methodology for development and introduction of clinical guidelines.
[3] See http://www.nice.org.uk

medicines should go hand in hand with introduction of rapid malaria tests or equipping labs with microscopes to improve on diagnosis.
Finally, quality improvement should be a sector-wide activity, not just confined to GHS institutions. It should involve the training institutions, the tertiary hospitals and the private sector from the onset.

Box 4.1

Black box: the private health sector

Facts and figures
In 2008 in Ghana 479 private facilities were accredited by the Private Hospitals and Maternity Homes Board (PHMHB), including 55 hospitals, 290 clinics and 134 maternity homes. The number with incomplete or no accreditation was much higher, according to the Board. The RCH report 2008 gives a much higher number of 824 private providers, which includes NGOs. Both reports exclude CHAG and parastatal facilities. The NHIA has accredited 395 private hospitals and clinics and 237 maternity homes, more than PHMHB accredited. It seems that accreditation by the PHMHB does not have any relevance for functioning as a health institution.
In 2003 private providers provided around 35% of services. This is supposed to grow to over 50% in 2011. The Programme of Work 2007 – 2011 mentions Public Private Partnership as an important component of creating wealth through health.

Policies and regulations
In 2003 a private health sector policy was launched, which sets the goal, objectives and strategies. The MoH wants to support the private sector to grow, and wants to support capacity strengthening and human resource development. It wants to increase partnerships at implementation level, and exchange of information. The policy has been only partly implemented so far, due to insufficient availability of funds. The Private Hospitals and Maternity Homes Board in the 2008 report explains that its performance is severely compromised by legal, financial and organisational constraints. There has been little progress in public/private collaboration since 2003 (with the exception of CHAG – MoH/GHS relations).

Reporting and information
CHAG institutions are all reporting their activities to the GHS through the district health information system. To what extent other non-state providers report their work is unclear. It is assumed that reporting is very low. The RCH directorate in GHS claims that nearly all private maternity homes report their deliveries.

As result of limited information on the private-for-profit and NGO sector, the annual health sector review turns a blind eye towards what may be 25% - 40% of the service delivery, according to some informants.

To illustrate concerns over lack of information:

- The increased utilisation of reported outpatient services (now 0.77 per capita) may represent a shift from use of private clinics to GHS clinics by health insurance cardholders. Without further analysis it is premature to claim increased access to health services.
- CYP figures on family planning are reducing, but most of pills and condoms are distributed through private facilities. This puts concerns over reducing family planning services in the public facilities in another perspective.

Way forward

Better regulation, better registration, better supervision, better information sharing is absolutely necessary to increase the involvement of the private service providers. Now the National Health Insurance allows private providers to seek accreditation, it is a high priority for the Ministry of Health to guide the public private partnership.

The 2006 annual review devoted a section to public private partnerships (p. 65 – 68). The recommendations in that section are valid and deserve new attention.

The Investment Climate Department of the World Bank Group, under the Health In Africa Initiative, is preparing a country assessment of the private health sector in Ghana, which is planned in 2009. This offers the Ministry of Health an opportunity to re-focus on this important part of the health sector.

4.1.2 Referral System

The functioning of the referral system has become a topic of discussion in the Ghana health sector for two reasons: doubts about effectiveness of the gatekeeper function of primary care facilities in the health insurance system, and questions concerning the performance of the ambulance services in Ghana.

Planned referral

In 2006 the GHS developed a Referral Policy and Guideline, which outlines how and when health workers should refer, and which documentation and forms they should apply. In practice, often referral documentation is used because of requirements by the health insurance. After introduction of the forms, no assessment was made on the quality of the patient information. It is not clear whether back-referral (from the receiving to the referring facility) is done as proposed in the guideline.

Referrals are appropriate when certain services are not part of the regular package that is provided by the health institution. Patients are referred vertically to a higher level (e.g. referral for Caesarean Section from a health centre to a hospital) or horizontally to a facility at the same level, because of diversification of services (e.g. orthopaedics, cardiac surgery). However, there are cases where services, that are part of the package of the facility, cannot be provided because of shortages of supplies, lack of personnel, etc. The referrals as result of this are inappropriate and cause problems in the system as well as unnecessary additional costs. There is no aggregated national information on referrals and reasons for referral, but

allegedly the majority is inappropriate. Officials interviewed think that primary health care facilities in urban areas are under-utilised, and that tertiary hospitals treat too many patients, who could be served at a lower level.
A special type of referral is when hospitals have multiple functions in the health system: tertiary hospitals may double as district or regional hospital. The tertiary hospitals run primary health care level health facilities and refer internally, directly from primary health care to tertiary level. According to informants this results in too many unnecessary referrals.

Discussion

Self-referral is difficult to stop: patients choose to go directly to the facility that they trust, and may decide to skip primary health care services, if they think they can get better care higher up in the system. In urban areas patients have more choice, certainly when private hospitals are accredited by the health insurance. The gatekeeper system can only be enforced if hospitals turn away bypassing patients, which is not the practice. Reduction of self-referral can be achieved by improvement of the quality of primary facilities. In urban areas the district health centres and district hospitals need to be strengthened to decongest regional and tertiary hospitals in Accra and Kumasi. Investments in primary health care pay themselves back through cost-containment.

Better equipment and supplies of lower level institutions can reduce inappropriate referral. Maybe some type of incentive system can motivate staff to reduce referrals. At this moment in time, adequate registration and reporting could help to quantify the referral problems. It is also important to register back-referral of patient to the facility that initiated the referral.
So far, the private sector has a limited role to play at the receiving end in referral system (with the exception of CHAG hospitals). There are few fully-fledged private hospitals accepting health insurance cardholders. Gradually, when the health insurance becomes an integral part of the system, investors may be willing to finance first referral level private hospitals and contribute to service delivery. The private health sector policy suggest loan schemes, helping in creation of additional facilities where needed. This may be the most realistic option for decongesting tertiary hospitals.

4.1.3 Acute referral

Ambulance services
The National Ambulance Service (NAS) started in 2004. The core mandate of NAS is to provide efficient and timely pre-hospital emergency medical care to the sick and the injured and transport them safely to health facilities. When the ambulance bill is passed, NAS will be an agency under the MOH.

NAS works in close collaboration with the fire department and with the National Disaster Management Organisation (NADMO), under the Ministry of Interior, which is responsible for the management of disasters. Currently, NAS has 36 ambulances in 24 stations with two control rooms in the country. The coverage of ambulance services is limited to regional capitals and few districts. 230 Emergency Medical Technicians (EMT), with basic medical

training, operate the ambulances. In 2007 the costs per case were GHc 90 (covering fuel and maintenance only).

The ambulance services are free of charge. Refund of costs by the National Health Insurance is under discussion.

Table 2 NAS ambulance services, 2007-8

	2007	2008
Total number of cases	7,995	8102
Inter-hospital transfers	53%	75%
Emergencies from home or public area	29%	23%
Others	18%	2%

Source: NAS annual report 2007, 2008

In 2007 23% of patients were transported because of obstetric problems. Because of budget constraints in 2008, ambulances have sometimes been parked. Training and upgrading of EMTs was put on hold for the same reason.

There are plans for expansion of the number of ambulances, and advanced training of emergency technicians.

Many hospitals have facility-based ambulances. These ambulances are not controlled by NAS and not connected to the ambulance radio communication system. Data on actual availability and utilisation of these ambulances are not available. According to informants, the ambulances are under-utilised, mainly because patients or their families have to pay for fuel costs. Rather than using their own funds to transport patients in available ambulances, hospitals prefer to call in NAS ambulances, which do not charge the facility, or the patient. Inter-facility transport is by far the most important activity of the NAS.

Receiving facilities

The hospitals that can receive emergencies provide 24 hours a day care in the casualty department. However, most of the receiving hospitals do not have staff trained in emergencies. During nighttime, the staff on duty is mostly junior. Some hospitals do not have full-time laboratory services, do not have a stocked blood bank and there are no theatre staff on duty. Communication between ambulance and hospital is not always good, despite the connection of major hospitals to the radio network. Trauma patients may therefore arrive unexpectedly. Overcrowding of patients in emergency departments occurs frequently in the cities, leading to the refusal of patients brought in by ambulance.

Discussion

The parallel systems of the National Ambulance Service and facility-based ambulance services, which do not communicate with each other, seem to be inefficient. There is a need for rationalisation, especially because NAS is mainly taking care of inter-hospital transport. It

could be considered to bring all ambulance services under NAS and to make arrangements for payment of ambulance services by the national health insurance.

NAS ambulances seem to be under-utilised for road traffic accidents. The number of victims assisted is only a fraction of the total number injured in Ghana's dangerous roads (even less than the number of deaths due to traffic accidents). More publicity may be needed to make the services known to the general public.
Improving the capacities of hospitals receiving patients from the ambulance service is a clear priority. There should be a guarantee that patients brought in by ambulances always receive treatment. Inter-agency agreements could be made to this intent.

The NAS fleet is already ageing. Maintaining a public ambulance service is costly and few countries in Africa can afford it. Now Ghana has chosen it, budgets and resources have to be allocated for the ambulance services.

4.1.4 Disaster and Epidemic Preparedness

Ghana is exposed to general disasters with medical aspects (for example, major road accidents, or floods), as well as to disease outbreaks (for example, cholera or poliomyelitis). In 2008 there was an outbreak of wild poliovirus with 8 persons affected in Northern Region. The virus originated from northern Nigeria, and passed probably via Benin. Cholera cases were reported in Volta Region and in Greater Accra Region. There was an outbreak of meningitis in the northern part of the country. A few years back, there was Avian Influenza in poultry in two regions, but not in humans. Disasters and epidemics are therefore not just theoretical possibilities, but real threats.

Ghana has a functional disease surveillance system, whereby health facilities report cases to districts, and via regions to the head quarters of GHS. At regional and national level disease surveillance officers are in place. In some regions there is a system of community-based surveillance, often linked to the programme of eradication of guinea worm. The disease surveillance system has worked well for the cases of meningitis and polio, which were recognised in time. More problematic was the reporting of cholera, because not all tertiary hospitals and not all private providers reported cases to GHS.

Ghana has a National Disaster Management Organisation, with an Epidemic Management Subcommittee. In the MoH there is a Ministerial Medical Emergency Services Committee, which includes members from other sectors. So far the committee is not covering epidemic outbreaks.

In practice, the response to outbreaks is in the hands of programme officers in GHS: there is no unified standard response system. The EPI programme has its own system for monitoring cases of Acute Flaccid Paralysis (AFP) and response to the outbreaks of polio. In 2008 two sub-national immunisation days were conducted in response to the identification of wild poliovirus, in line with the WHO recommendations. The epidemic was handled adequately.

GHS has an Avian Influenza preparedness plan in place, and is preparing a plan for epidemic preparedness for cholera, which contains all elements of surveillance, intersectoral coordination, rapid response teams at various levels, communication, treatment, monitoring, etc.

Discussion

Ghana is doing quite well in management of disasters and epidemics. However, the system can be made more robust to fend off serious challenges. The coordination between epidemic response systems and the nation system of disaster management through the National Disaster Management Organisation seems to be ad-hoc, rather than systematic. Collaboration between agencies could be improved. Maybe the Ministry should play a more prominent role and formulate a policy for epidemic preparedness and medical aspects of disasters, assigning roles and responsibilities to the relevant agencies in the health sector. The Ministerial Emergency Services Committee could play a coordinating role.
Rather than having separate plans for diseases specific outbreaks, there could be one medical disaster preparedness plan, with sections for specific diseases. This could enhance the consistency of all plans. The draft cholera preparedness plan provides a good start.

Recommendations

- Turn the QA programme into a crosscutting theme, in all programmes and all agencies and link the QA programme to the NHIA as multi-agency initiative
- Bring in state-of-the-art approaches in development of clinical guidelines
- Unite the National Ambulance Service and Facility-based ambulances in one organisation and give it an important place in reduction of maternal mortality
- Develop a policy and protocols for medical disasters and epidemics preparedness and bring the lead under MoH

4.2 MGD 4 (Child Health) and MDG 6 (Disease Control)

The table below shows relevant indicators with regard to child health.

Table 3 Child health indicators, 2006-8, Ghana

	2006	2007	POW 2008 Target	2008 performance Routine	Trend
IMR	71		64		N/A
U5MR	111		105		N/A
MMR	N/A		N/A		N/A
U5 underweight	18%		16%		
Exclusive breastfeeding	54,0%		60%		
%U5s sleeping under ITN	41,7%	55,3%	30%	40,5%	-26.8%
Penta3	84,2%	88,0%	90%	86,6%	-1.6%

Source: Database GHS 2008

Child mortality figures seem to be decreasing. Vaccination coverage of Penta3 remains static and slightly below target, but high enough to achieve herd immunity. The number of fully vaccinated children by 52 weeks is 47%, and shows that only half of the children vaccinated get the vaccinations according to the international standards. The utilisation of Insecticide Treated Nets (ITNs) reduced, which some people attribute to the timing of the survey.

In 2007 in the three regions in the north of Ghana (Northern, Upper East and Upper West) a Multi Indicator Custer Survey (MICS) was done, which showed overall progress in nutrition status, breastfeeding, use of ITNs, malaria treatment and consistently high Penta3 vaccination coverage. The survey also showed downward trends in mortality, especially in under-5 mortality.

During the last years the High Impact Rapid Delivery (HIRD) strategy guided the districts in implementation of child and reproductive health activities. The HIRD package of services consists of well-known proven interventions in reproductive and child health. The child health interventions have vaccinations, Vitamin A and ITN distribution, de-worming, growth-monitoring, promotion of exclusive breastfeeding, etc. The essence of the HIRD strategy is to offer the interventions in combination and to concentrate on community-based delivery of interventions. In the POW 2008, GHS confirmed the HIRD strategy as basis for scaling up interventions.

In October 2008 the GHS, in collaboration with UNICEF and WHO, produced an in-depth situation analysis of health of children under 5. The External Health Sector Review 2006 discussed HIRD extensively (pp 12 – 20, and pp XIX - XVII), as did last year's 2007 review (pp 25 – 26). Important issues raised in the GHS analysis and reviews are:

- The package of interventions is appropriate and has proven its value for improvement of child health. Continuation of the services is absolutely necessary. However, neonatal mortality contributes to 27% of under-5 mortality and has to be tackled urgently. It "falls between the cracks" of maternal care and childcare. At community and facility level attention for neonatal care is still insufficient
- Community interventions are essential to make headway in improvement of child health. However, the community strategy needs rethinking. There may be too many different volunteers for different programmes
- The interventions are initiated by disease control, child health and nutrition programmes, which have their own sources of funding, own procedures and own methods of work. HIRD has not managed sufficiently to pull these programmes together, partly because funding comes vertically from Development Partners, the Global Fund, etc.
- General capacities for planning, managing and reporting are weak. The HIRD strategy with its own planning format, budget, and reporting has become a vertical programme on its own
- The monitoring systems are weak, and information is hardly analysed. There is little uptake of lessons learned from assessments and evaluations

The MoH is drafting a new Under-5 Child Health Policy, which wants to introduce a child-centred, rather than programme-centred approach, with a continuum of care for the child: from foetal stage, to neonatal stage, to infant stage and to childhood. At the same time there should be a continuum of care from home, to community, to facility. The policy outlines the essential interventions for achieving results. This integrated approach is anticipated to lead to reduction of child mortality to 40 per 1,000 by the year 2015.

The GHS is drafting a new Under-5 Child Health Strategy 2007 – 2011 at the same time. The major objective of this strategy is to improve neonatal health by improving the coverage with antenatal care interventions and delivery interventions, as well as neonatal interventions. Secondly, child health is to be improved by comprehensive coverage with evidence-based interventions for children 1-59 months. The strategy proposes more community interventions, with increased attention for health promotion and behavioural change. The strategic plan outlines how capacities should improve to coordinate, plan and manage activities for child health, through strengthening health systems. The plan suggests increase of competent human resources, delivering child health interventions, including private sector providers. It indicates strategies for resource mobilisation and monitoring.

In the previous paragraph the outbreak of wild poliovirus in Northern Region was mentioned and the subsequent vaccination campaigns, as required by the WHO.
The absolute number of vaccinations increased, but the coverage reduced slightly. Just to keep up with the population growth, the number of vaccinations must increase 2-3% every year. The creation of 38 new districts in recent years created a challenge for reorganising the system. More than 50% of district vehicles and motorcycles are more than 5 years old, creating new challenges for the vaccination programme.

Apart from the campaigns related to the polio outbreak, there were two nationwide events: the National Child Health Promotion Week and the Integrated Mother and Child Health Campaign. Fears have been expressed that campaigns are very costly, and take place at the expense of regular services, and in the end are less cost effective. Campaigns could contribute to untimely vaccinations. At this moment in Ghana a study is being performed into costs and benefits of a vaccination campaign approach versus a routine vaccination system.

Discussion

First of all, the review team wants to acknowledge that child and infant mortality are coming down after years of stagnation around the same level. Finally, years of investments and hard work in health care are showing results.

However, at the same time, the review team wants to underline the conclusions of previous reviews and the analysis of October 2008. The 47% coverage of fully vaccinated children by 52 weeks is too low. Penta3 in Ghana therefore cannot be considered as a proxy for fully vaccinated. There is no reason for complacency with regard to success of the EPI programme.

After the field visits the review team must conclude that neonatal care in facilities visited was sub-standard. There is a lot to be gained by relatively simple interventions in neonatal resuscitation. The CHPS compounds visited operated as small health centres, being a useful extension of the formal health service in rural areas. However, their status as community-based health programmes is unclear.[4]

Box 4.2

Categories of community-based volunteers include:

- Community-based distributors (family planning);
- ITN sales agents;
- Community-based agents or c-IMCI volunteers – to treat diarrhoea and fever and refer ARI;
- Community change agents for BCC;
- Community-based growth promotion volunteers;
- Community-based surveillance agents.

Source: GHS inventory under 5 child health October 2008

The community-based strategies in Ghana are much more developed than in other countries, where there is a fierce debate on the sustainability of volunteerism. However, it may be wise to give the approach some thought. The number of different volunteers, linked to separate programmes, may not always work well. For example, one may give out ITNs for free, while the other is selling similar nets at a subsidised price. One volunteer may approach the young mother with the message of exclusive breastfeeding, while the other tries to promote family planning with slightly different information. Some informants spoke of potential confusion in community work. According to information, quite often one and the same person volunteers in different programmes. One UN agency suggested in an interview to do a mapping of what happens where with community volunteers in Ghana, and come to a more uniform approach and some rationalisation. The review team supports this suggestion.

Many health workers interviewed are still finding their way in managing internally generated funds. Some would rather wait for programmes to donate and to instruct, than using their initiative to procure essential items. More self-confidence in management capacities at facility level could help.

In interviews, GHS officers and officials from other agencies and NGOs question the present mode of operation. The prevailing culture has helped turning HIRD quickly into a new vertical programme, with the usual elements of separate plans, budgets, management and reports. This year, it will be integrated into comprehensive planning. While HIRD was an instrument for the district level and below, it did not contribute to integration of work at higher levels in the system. There it was mainly seen as a new financing instrument. The parallel programmes of malaria, HIV/AIDS, tuberculosis, nutrition, reproductive health, HIRD

[4] The CHPS strategy is subject of a separate in-depth review this year.

led to high transaction costs at the peripheral level, the district and the regional level. Such inefficiencies are not easily recognised at national level, where programme officers are focused on their own programme and on accountability towards Development Partners, who each want to see results. Where the national level health officials requests Development Partners to improve alignment and harmonisation, they could apply similar principles in their own work in relation to districts.

There could be a wealth of untapped resources if the 237 local non-governmental organisations (which are member of the National Coalition for NGOs in Health) were seriously engaged in service delivery in child health.

The situation of under-5 child health services is eloquently portrayed in the Under-5 Child Health Analysis, and the solutions are clearly described in the Under-5 Policy and Strategy. What is needed now is to give body to the proposed paradigm shift from programme-centred to child centred work. This will be further elaborated in the final section of this chapter.

Recommendations:

- Reinstate the comprehensive district health management system, based on partnerships between GHS, CHAG, NGOs and private providers, that integrates vertical programmes and give districts pivot role in implementation of the under-5 child health policy
- Give District Assembly and population a role in decision making on priority setting and utilisation of funds
- Map and analyse present practices of volunteerism and best practices in CHPS for harmonising community health approach.

4.3 MDG 5 Maternal Health

In July 2008 the President of Ghana declared maternal mortality a national emergency. He announced free membership of health insurance for pregnant women (and women who delivered shortly before the announcement) for the full package of antenatal, deliveries and post-natal care, as well as all medical costs for the year.

The Ministry of Health convened a consultative meeting of national and international stakeholders to discuss Ghana's maternal mortality burden on July 8th and 9th 2008, which recommended documenting best practices and replicating them as appropriate. The meeting proposed to invest in CHPS and Community Health Extension Worker (CHEW) systems and train skilled birth attendants (especially nurses and midwives). The meeting suggested forging partnerships between health services and communities, and with private and non-governmental actors. The meeting asked authorities to secure funding for strengthening broader health systems. The Minister of Health inaugurated a multi-disciplinary Ministerial Task Team for the coordination of activities. The team was to mobilise resources, to identify areas for technical support and to monitor progress. The Safe

Motherhood Task Force under GHS was instructed to link up with the Task Team as a technical team, overseeing responsibilities at the regional and district level.

The Ministerial Task Team met several times and formulated four priority areas of family planning, emergency obstetric care, adolescent health and post-abortion care. Several participating MDAs made their pledges for activities. The Ministry of Women and Children's Affairs organised a workshop in November and started mobilisation of women's groups. The Ministry of Education promised to revise the education materials on adolescent sexual health. The Private Road Transport Union pledged to sensitise members to support to women in labour. Because of the election and change of government, the Task team has not yet meet in 2009 and could not brief the new Minister on progress. The request of the November 2008 Health Summit to the Task Team to formulate a timed and costed implementation framework will probably not be honoured before the next summit.
The Safe Motherhood Task Force has not met since the stakeholders' consultation in July. The Family Health Division continued working on reproductive health programmes. It produced an outline of a work plan for community sensitisation and mobilisation, for strategies around CHPS/CHEW involvement in reproductive health and capacity building of staff, and for sharing of best practices. The division produced a proposal for training midwives in life-saving skills, but could not start training without approval from the agency to which the request for funding was addressed.

The theme for the POW 2009 is "Change for Better Results: Improving Maternal and Neonatal Health", indicating that this topic is key priority for the health sector. The Ministry formulated as priorities for 2009, following up on the consultation's recommendations: free maternal services, repositioning family planning, and training and deployment of staff for RCH.

The GHS continues working along the lines of the Reproductive Health Strategic Plan 2007 – 2011 and the Roadmap for Accelerating Attainment of MDGs. The strategy elaborates in detail how to tackle issues of antenatal care, delivery, post-natal care, neonatal care, family planning, adolescent health, post-abortion care, etc.

Table 4 Reproductive health information, 2008

	2006	2007	POW 2008 Target	2008 performance	Trend
Total Fertility Rate	4,4		4,3		N/A
% Skilled deliveries	44,5%	35,1%	60%	39,3%	11.9%
Family Planning (Couple Year Protection)	N/A	765,566	N/A	462,556	-39.6%
ANC	88,4%	89,5%	95%	97,4%	8.8%
Institutional MMR	219	224	172	NA	

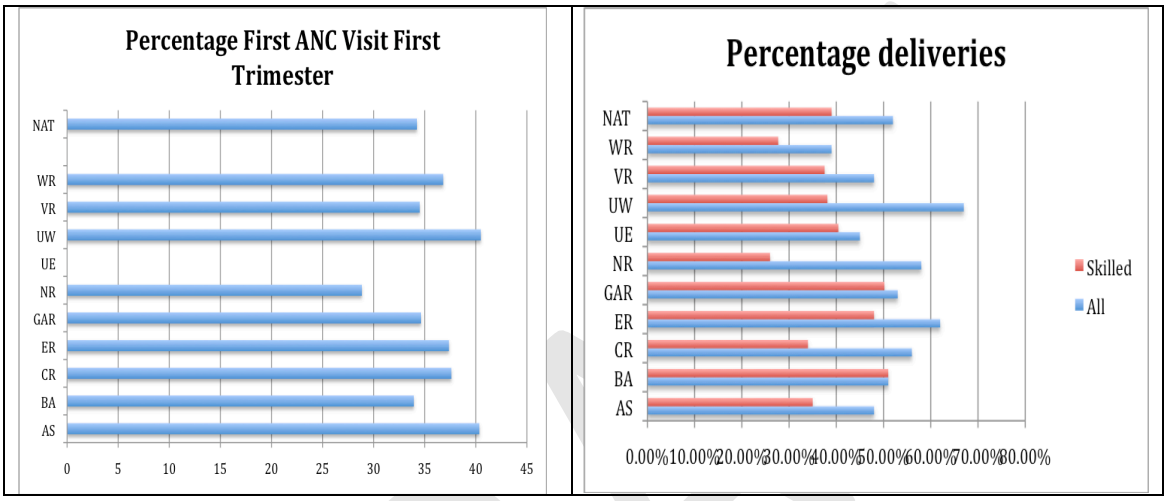
Source GHS-RCH report 2008

The figures for family planning (FP) seem to indicate serious problems with utilisation of modern FP methods. In 2008, there have been problems with supplies of commodities, and

discussions concerning inclusion of family planning methods in the Health Insurance Package. According to informants, payment for family planning (even token amounts) – while other medicines are free – sends out a wrong message. The total fertility rate is decreasing slowly, while Couple Years Protection is reducing.

The implementation of the Roadmap for Repositioning of Family Panning has been slow, but preparatory work has been done with the Ministry of Education, Ministry of Women and Children's Affairs to start information campaigns.

Figure 4 Regional pattern for ANC and skilled deliveries, 2008

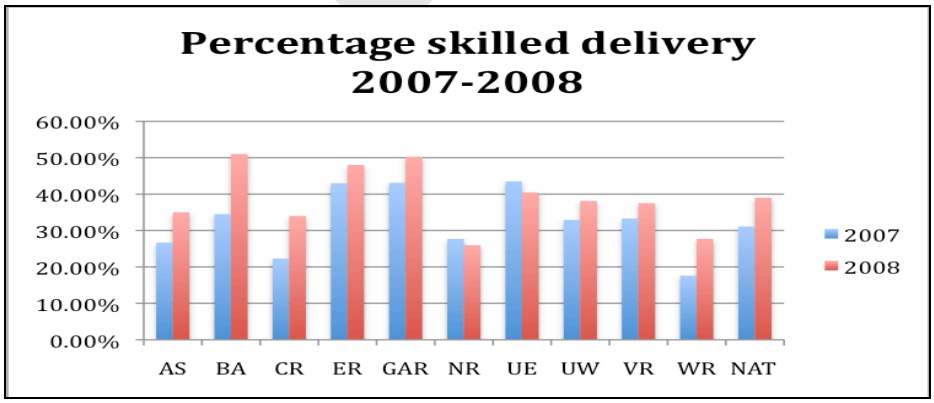


Source GHS-RCH database 2008

Antenatal care coverage continues to be high with increasing numbers of pregnant women coming in the first trimester and increasing numbers completing at least four visits (64% in 2008).

The number of skilled deliveries has increased to 39%, but is still far from the target of 60%, which was set for this year.

Figure 5 Percentage skilled deliveries, by region, 2007-8



Source GHS-RCH report 2007 and database 2008

The comparison of figures over 2007 and 2008 sheds a light on the effect of free delivery services. Overall, an increase is there, but with variation over the regions. Two regions in the north even show a decline in skilled deliveries.

Discussion

Coverage figures for family planning are worrying indeed, and give evidence for the many voices in Ghana saying the programme is off track. The repositioning of family planning, as initiated in 2006, has not so far succeeded. Pills and condoms are mainly distributed through the private sector and may not show in the statistics. The private sector has tremendous potential contributing to improvement of family planning that should motivate the MoH and GHS to turn rhetoric on PPP into practice.

Box 4.3
Family Planning commodities and Anti Retroviral Treatment medicines are not free of charge, contrary to other medicines through NHIS. The price charged is a token amount, in comparison to the market costs. The NHIA does not want to include them in the insurance's medicines list, because the enormous costs attached to procurement, which are still covered by Global Fund and DPs, but may come to NHIS in the future. For districts the little income from these commodities and medicines is important to pay for transport, which is separate because their logistics systems are parallel from medicine distribution to facilities.

Health workers complain that clients accuse them of fraudulent charges, as those clients do not understand why one medicine is free of charge and the other not.

The coverage of ANC is high and has increased, maybe as result of free health insurance for pregnant women. There is however room for improvement of quality. For example, the percentage of anaemic women in 2008, compared to 2007, remains stagnant at around 27% and Intermittent Preventive Treatment (IPT) for malaria slightly decreased compared to 2007. During the field visit the review team found clinics without ANC cards.

The coverage of deliveries is increasing, but is still lower than in 2006. Maybe the real effect of free maternal services will only be seen in 2009. In previous years the figure of institutional maternal mortality ratio (IMMR) played a big role in discussion around the quality of maternal health in facilities. Trend analyses were performed and conclusions were attached to it. This year, the review team wants to stay away from this discussion. In the inter-agency review meeting, GHS presented a figure for 2008 of 200 per 100,000 live births, compared to 224 in 2007. According to this presentation, the number of institutional deaths went down from 1,023 in 2007 to 955. However, this figure is based on incomplete data. Furthermore, the denominator of live births includes deliveries by TBAs, which deflates the IMMR number by maybe 25%. Probably this practice of including live births by TBAs has been in place for many years. Previous reviews have warned against the practice of using IMMR as proxy for national MMR. With increasing use of facilities for deliveries, better transport, etc. IMMR may take an ever-growing share of total MMR. The only reliable figure

should come from the national MMR study, conducted in 2007, and probably published in May 2009, which will be too late to incorporate in the 2008 review process.

Interestingly, when including TBA deliveries, coverage figures of total deliveries are highest in rural regions. How do women in urban areas deliver when they do not go to a facility? Are they exposed to bigger risks? Or do we just see a reporting confounder?

The field visit was a real shock for the review team, especially for consultants who had never visited GHS facilities before. The labour wards visited were all in an appalling state, with rusty delivery beds, incomplete delivery sets, and no material at all for neonatal resuscitation. Unfortunately, inventory reports from other regions and statements from interviewed officials confirmed that the poor state of labour rooms is the rule, rather than exception. It does not need innovations, but reading 35-years old books by Maurice King and by David Morley, to learn how with simple means an adequate labour ward can be created in a health centre or small hospital. The review team is convinced that the IGF in most facilities is sufficient to cover the small investments required. Apparently, the HIRD has not contributed to improvement of delivery services.

Box 4.4
The "Zorko initiative" became famous in the country: a series of interventions were carried out in Zorko sub-district to improve communication with pregnant women in the village, to improve transport to the facility, to improve 24-hour availability of staff and to make the delivery more acceptable. Providing a millet drink to stimulate breastfeeding and a hot bath belonged to the package of services.
During the filed visit health workers presented in some places to the review team the "Milo/bath initiative" as critical intervention, without any of the other Zorko interventions, even in the health centre where there was no magnesium sulphate and only one package of suture left in the labour room. This cherry picking of interventions was probably not meant by the recommendation of the stakeholders' consultation to spread innovations over the country.

Maybe we have to make the cynical conclusion that Ghanaian women are smart: they know that they can benefit from antenatal services and therefore they come; at the same time they know that in a labour room in a facility they are hardly better off and deliver at home.

The human resources for health are discussed in another chapter. Suffice it to say here that the issue of roles of CHPS in delivery care remains unresolved. Interviews with trainees in midwifery and community nursing did not give the Review Team the impression that these young women have the practical skills to make a difference in maternal health. It seems that they have to acquire their skills after qualification. They should work first under close supervision in a bigger centre, before the can be posted to a remote area.

As discussed under the paragraph on quality of care, improving maternal health requires a total package to be worked on, with better access through strengthening of CHPS zones, community-based interventions, improvement of staff, availability of equipment, etc.

Thinking outside compartments in the health sector could bring solutions. Two examples can show this: transport and blood bank services.

- In some areas, GHS is collaborating with the Private Road Transport Union to improve transport for women ready for delivery, a very good initiative that the review team welcomes. But what should be done with the more than 100 ambulances in the country that are severely under-utilised? Is there no possibility of making better use of the mobile phone services covering nearly the whole country? Could vouchers for transport be given to women who attend at least four times during pregnancy (subsidised by the health insurance)? The Coalition of NGOs in Health discussed a credit scheme for village women to provide transport. Could such initiatives be embraced?
- Post-partum haemorrhage is the second-largest cause of maternal deaths. Blood transfusion is often necessary to safe lives. Yet, only 10% of hospitals have a blood bank meeting minimum standards. Ghana has put in place a National Blood Policy to reduce risks of contamination with HIV, hepatitis, syphilis, etc. and to increase availability of blood products. The National Blood Service has become an independent agency. Implementation strategic plan is delayed by lack of funds. Under the given conditions it may take decades before a reliable National Blood Service is in place.

The National Ambulance Service and the National Blood Service could both make important contributions to reduction of maternal mortality, when involved in finding solutions for the national emergency of maternal deaths.

The TOR for this review asked for an assessment of progress on MGD 5 against recommendations of the national stakeholders' consultation. The answer was given by Dr. Henrietta Odai-Agyarko. It was the fourth delay, in addition to the three other delays in maternal health: high level talk without action. Whatever was done between July 2008 and now was already in the pipeline, or resulted from other initiatives.

What needs to be done is all described in great detail in the Reproductive Strategic Plan 2007 – 2011, and does not need to be repeated here. Years of high level consultations, strategic plans, road maps and policies have not resulted in a turnaround of the maternal mortality. The same conclusion as for child health is valid here: the paradigm shift from programme-centred to client-centred work has to be translated into concrete action.

Recommendations:

- Reinstate the comprehensive district health management system, based on partnerships between GHS, CHAG, NGOs and private providers, and give districts pivot role in implementation of the Reproductive Health Strategy
- Give District Assembly and population a role in decision making on priority setting and utilisation of funds
- Bring all agencies, NGOs and private providers on board in improvement of reproductive health; stop talking, act.

4.4 Regenerative Health and Nutrition

The National Health Policy 2007 'Creating Wealth through Health' aims at addressing the broader determinants of health. The policy puts promotion of healthier lifestyles in the context of physical and social environment in which people live. The Regenerative Health and Nutrition Programme (RHNP) was initiated to develop tools for addressing determinants of health and started in November 2006. The programme is located in the Ministry of Health. In 2007 a Strategic Plan was developed, that concentrates on healthier diet, exercise, rest and environmental sanitation. The programme wants to work through capacity building, partnerships and communication. The strategic plan does not contain practical proposals for monitoring and does not have a budget proposal. The programme proposes to develop into a National Commission of Regenerative Health.

Since the beginning, the programme has been operating in a pilot mode, in 14 districts where it works with change agents. The programme is working with the Ministry of Education, Science and Sport on integration of lifestyle issues into the standard school curriculum and setting up of keep-fit clubs. It is discussing with the Ministry of Agriculture education for farmers on use of pesticides. The programme discusses with the training schools in the health sector how to improve the curriculum on determinants of health and lifestyle issues. There are no concrete results yet and up scaling of activities is hampered by budget constraints.

Discussion

Given the development of non-communicable diseases in Ghana, with sharp increases in diabetes and hypertension, and a growing segment of the population overweight, it is the appropriate time for putting healthier lifestyles and improvement of determinants of health in the spotlight.

Unfortunately, there are no reports available over actual work done in the programme since its inception, which makes it difficult to assess performance.

The RHNP is operating in isolation in the Ministry and does not work together with the Department of Public Health, where the non-communicable diseases (NCD) programme is located. The programme is developing a new strategic plan for tackling NCDs, in collaboration with WHO. GHS has its strategies for health education and promotion of healthier lifestyles and better nutrition.

The parallel programmes in MOH and GHS do not seem to be effective use of resources. Lack of information sharing, and operating in isolation in the MOH is not productive for development of such an important programme as RHNP. The way forward seems to be integration in the GHS public health activities, maintaining the sector wide cooperation with all agencies and the intersectoral collaboration with other ministries.

Recommendation:

- Integrate the RHNP into GHS NCD and health education programmes, ensuring that the multi-agency, multi-sector concept remains preserved.

4.5 District Health Information Management System

The District Health Information Management System (DHIMS) was introduced in 2007. DHIMS is a health data repository with simplified reporting forms, using standardised entries and automated calculations. The DHIMS collects programme data for all programmes except the TB Programme and Neglected Tropical Diseases Programme. The DHIMS was originally developed to capture financial data, but this is being discouraged due to implementation of the ACPAC financial software. The system has been set up to generate a large number of performance summary statements for any level or facility, and provides a powerful tool to inform decision-making on all levels. An analysis module is currently being developed which can track trends of indicators over time, generate a number of graphical presentations etc.

The flow of information is currently only towards the centre, i.e. the district collects information from the sub-districts, the region from the districts etc. Information does not flow in a decentralised direction. Districts, Regions etc cannot compare their performance with institutions at same levels. Local information is exported to a file, which can be emailed or transferred by USB pen-drive. Transfer by pen-drives has shown to be a big source of viruses, which is reported to be a large problem at all levels.

Health Information Officer (HIO) positions have been established at regional and in 90 out of the 170 district level health administrations. By the end of 2008, the DHIMS was expanded to cover all government and CHAG facilities, and in most regions private facilities, including midwifes, report through DHIMS. Due to implementation late in 2008, the DHIMS data for 2008 is incomplete and the full capacity of the system cannot be utilised for the 2008 sector review.

Box 4.5

The NHIA has installed all over the country advanced computer systems and satellite communication systems, which allow communication between the health facilities, the DMHIS and NHIA (regional and national offices). One computer and satellite disk costs around USD 5,000.00.

The systems are locked and cannot be used for any other purpose than communication of health insurance data. Despite the ultra-modern communication installation in-house, the district HIO has to travel by bus to the regional capital, to take data by pen-drive (memory stick) to the Regional HIO.

In 2007, parallel to the DHMIS, a Health Service System Database (HSSD) was introduced at regional and district level to capture MCH data. Many indicators were common to both systems, and in 2008 the use of HSSD was discouraged by GHS HQ. Another system with potential overlaps and synergies is the NHIS claims management system. The system is first

phase of the NHIS ICT strategy, which comprises the setting up of computers and network infrastructure in facilities and DMHIS all over the country. The NHIS information system is independent from the DHIMS, and communication between the systems is currently not possible.

Recommendations

- Ensure full implementation of DHIMS in 2008, including entering information from 1st January 2008
- Optimise system to enable decentralised dataflow
- Install virus software on all PCs operating DHIMS and ensure regular virus updates
- Continue education of District Information Officers to reach full coverage by end 2009
- Provide quarterly reports on implementation status and completeness of reporting

5 Human resource rationalisation

During the review process it was realised that an implicit common framework of understanding existed within the MoH and its agencies concerning human resource rationalisation. Four thematic areas formed the framework for discussions. These are human resource production, human resource distribution, human resource productivity and human resource wage bill.

The Aide Memoire of April 2008 agreed to the organisation of a conference on Human Resource in Health in which critical issues would be discussed.

5.1 The Roundtable conference

The Roundtable Conference on Human Resource in Health was held in June 2008. The inputs made from various stakeholders addressed many key areas of the human resource challenges facing the health sector. A proposal has been prepared by the HRDD MOH, as a follow-up to the conference, and was presented to the Inter Agency Leadership Committee in September 2008. The proposal reflects a number of recommendations emanating from the Round Table Conference on Human Resource for health, which, if pursued, will significantly address the key identified challenges facing the sector. The proposal further maps out the way forward and if implemented will facilitate the implementation of interventions identified and raised in the roundtable conference. Some of the interventions in the proposal are already being addressed, as evidenced by the new approach to allocating recruitment ceilings by staff numbers to agencies and not individual staff by name.

5.2 Human resource production

A focus on middle level cadres has been maintained, especially in the following cadres: general nurses, midwifery, environmental hygiene staff, community health nurses, health assistants (technical) and medical assistants.

Table 5 Enrolment into Health Institutions, 2007-2008

Category	2007	2008	% Change in enrolment
Nursing	2277	2245	-0.7
Midwifery	551	911	24.6
Environmental Hygiene	557	469	-8.6
Community Health Nurse 1 (2yr certificate)	1841	1944	2.7
Community Health Nurse 2 (3 year diploma)	66	63	-2.3
Health Assistants Technical	1193	2541	36.1
Medical Assistants [diploma and post diploma]	101	181	28.4

Source from Ministry of Health Human Resources for Health Development Enrolment into Health Training Institutions, 2000-2007

The production of nurses has reached a plateau at around 2200 students from 2006 to 2008. This is attributed to the fact that the existing schools have reached their maximum intake capacity. This is influenced not only by the availability of physical infrastructure of the schools but also sites for practical training and other training resources.

Questions are being asked as to the quality of the workforce being produced. There are mixed experiences by the service agencies in relation to the skills and competencies of new health workers. This is more so with the nurses, health assistant technical and heath aides. The Nurses and Midwifes Council is also concerned about the quality of nurses being produced and has attributed the low level of skills and competency to the inadequacy of training sites to match up with the number of schools and the expansion of intake. All the private nursing schools cropping up are also using the same hospitals and the staff are either tired of all these students and do not have time for them or do not have the skills to be effective preceptors for the students.

There is an explosion of health aides and health assistants technical. Both public and private institutions are being set up to train this cadre of staff. The MOH set up 5 new ones and many others have been set up by district assemblies (politically motivated and initiated). There is concern that this cadre, established as a short-term measure, will face similar challenges of being absorbed into the health system and fashioning a career path. If there is an exit strategy to stop their production, what will happen to them thereafter? There are differing opinions as to their usefulness and long-term relevance, as well as their competence.

There is a strong call for the re-introduction of midwifery training for community health nurses. It has been realised that “professional” midwifes are less enthusiastic, and they are less oriented to practice in rural areas, compared to the cadre of community health midwifes.

A simple projection of health workforce production, especially in the area of nurses, indicates that at the current rate of about 2,200 intake a year, in 5 years Ghana will have produced 11,000 nurses and some 12,000 health assistant technical. There is no evidence of an exit strategy and there is the real danger of overproduction.

The following questions should be asked:

- is the country moving to an overproduction of health workers [nurses]?
- is the sector sacrificing quality for quantity?
- is the present production strategy relevant for future needs?
- is the right skills mix being produced [health assistant technical , health aides]?
- what is the exit strategy for production of middle level cadres?

5.3 Human resource distribution

There are still significant inequities in the distribution of health workers among service agencies, within service agencies and across the country. A major effort to address this has

been effected through the Inter-ministerial Posting Committee. This committee has been in existence for at least 3 years but in 2008 engaged in and implemented significant decisions on staff distribution to agencies that have the potential to address the distribution issue. The membership of the committee includes representatives from all the agencies of the MoH, the police and military.

The interagency staff allocation is being done to reflect equity and need. The MoH has removed itself from operational distribution in that it no longer posts to institutions but to the head of agencies and agencies are exercising their mandates to effect internal postings as they see fit. The MOH in exercising its oversight responsibilities to ensure that equity is assured discusses and comes to agreements with the agencies as to numbers they can recruit, as well as where postings should be focused. Agencies now conduct interviews to recruit who they want and those not successful have to move on to other agencies which have not filled up their quota allocation. All agencies confirmed this as the way forward and are all supportive of it. This current practice has the potential to push prospective health workers to priority areas of need.

Box 5.1
Case study on improving distribution: how to enforce postings to 'deprived' areas?

In 2008, ten doctors were posted to Northern Region. None came. 11 pharmacists were posted. One came. Out of 13 doctors posted to Upper East in the past three years, one came. This was not surprising: if they failed to turn up, they remained on the pay roll. This year, for the first time, with the regional quota system, the RMD has felt able to ring the payroll department and stop their pay. These staff should then not be re-employed in other parts of the health system, otherwise this sanction will not work. In addition, managers should feel empowered to demote staff who are not working at their jobs (for example, by moving them to less desirable posts). Until recently, such measures have not been part of the accepted norms, which meant that there were no incentives for good work (working well and working in less desirable areas), and no sanctions for poor. Personal networks, rather than performance, were the focus. This culture needs to change if performance is to improve. Ghana cannot afford many more health workers: it has to get more from the ones it has.

The challenge of staff re-distribution within and between agencies is still being pursued. Efforts have been made by the GHS to redistribute existing staff but this has proved to be a major challenge. Resistance to redistribution by staff was experienced and evidenced by staff petition letters. Petitions were reviewed and those which still had to be transferred were 'threatened with salary blockages' if they did not move. It worked! The general resistance to change has come into play and will require skills and competencies in change management in agency leadership. It will also require un-flinching commitment and political will, not only amongst agency leadership but within government itself, because of the potential of a redistribution exercise to cause staff agitation and unrest.

A key challenge that is being recognised is the lack of agreed staffing norms, which makes it difficult for agencies to objectively classify a facility as overstaffed or understaffed. There is

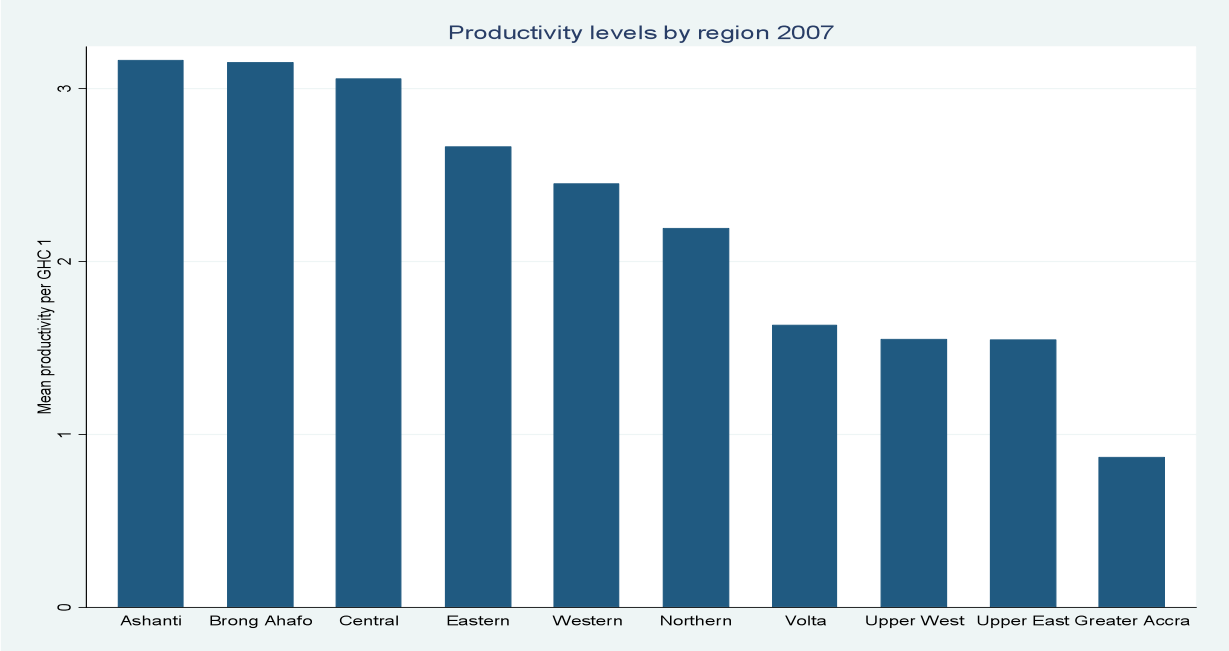
also the systemic challenge of how to effect an interagency transfer or termination of appointment, since all the agencies' salary is managed centrally. In as much as there is an increased awareness and desire in agency leadership to re-distribute staff the critical bottleneck is that there is no clear process or guideline to support agencies to relieve themselves of staff they do not need. The GHS is taking bold steps to use salary block to effect this.

5.4 Human resource productivity

The issue of workforce productivity remains a high priority for the MoH as well as its agencies, both service and regulatory. This not withstanding, there is no clear direction as to what constitutes health workforce productivity. Definite models of measuring health workforce performance are yet to be developed. Agencies and the MOH agree that the critical issues are that there are no standards for institutional staffing norms, no workload measures for health workers and no objective criteria to measure worker-specific as well as institutional performance and productivity. Use of sector wide indicators is considered inappropriate.

Available estimates on workforce productivity shows that health workers in the Greater Accra region are the least productive and those in the Ashanti and Brong Ahafo most productive. The more productive a region the more service output per health workforce it has. The model used in determining this has not been accepted as a national approach.

Figure 6 Workforce Productivity by Region, 2007Workforce Productivity by Region



Health Workforce Productivity, a Presentation at the Roundtable Conference on Human Resource for Health, 11-13th June 2008 by Eddie Addai and Sam Bosumtwi

There is a general feeling that the workforce can be more productive. Key informant comments summarise the sentiments of many others as follows: 'We are producing more to do less". Another significant comment was: "We now have 7 times more community health nurses than we did 5 years ago but we have not experienced even a 50% improvement in service output data that they are expected to influence". Across agencies significant concern exists as to how to ensure and improve workforce productivity.

Definite interventions are being continued or initiated by agencies to address workforce productivity. The HRDD of the MOH has developed a workload analysis for health workers, which is still a work in progress. The GHS have introduced a staff performance appraisal system with requisite forms[5] and another tool[6]. The staff performance appraisal form looks at staff-determined objectives and generic assessment factors applicable to all staff. KATH has introduced contract arrangements for doctors and intends to continue with it for its entire staff. Within CHAG discussions have commenced and facility performance tools are being discussed and developed.

Staff performance management is still an issue. Agencies are trying out different models to do so. The critical challenge is the capacity of supervising staff to effectively carry out staff performance management functions in an objective manner that leads to improved performance and productivity. Basic inputs such as clear job descriptions and functions are not readily available to respective staff. These inputs are to come from the agency headquarters. GHS, CHAG and the teaching hospitals are all either in the process or have developed job descriptions and specification which they are testing. These documents are fairly similar in content, especially for the professional groupings.

The discussions on staff productivity recognises the influence of rewards and sanctions, clear measurable objectives and targets for staff and more importantly the capacity of supervisors to effectively manage staff performance and productivity.

5.5 Human resource wage bill

The wage bill: the wage bill of the MoH continues to escalate. For 2008, a deficit budget was generated. Efforts to control this included setting recruitment ceilings for agencies, putting a freeze on promotions, and limiting recruitment to 'essential staff'. In 2008, 93% of GoG funding for health was used to pay salaries and wages.

The wage bill is being affected by three parameters

1. The sector is becoming top-heavy, with large numbers of staff occupying the top end of their professional grading, while the number of senior professional grades is increasing. Without staffing norms this situation will continue and the wage bill will escalate.

[5] Annual Staff Performance Appraisal Form [GH S]
[6] Staff Appraisal Logbook [GHS]

2. There is an ongoing perception that all health workers produced must be employed by the MoH or its agencies. Again, with no staffing norms, this will continue. It is worth noting that a significant proportion of staff are employed and paid for directly out of IGF especially in the teaching hospitals and CHAG which is not captured in the sector wage bill. Korle bu indicates that it pays nearly 600 "non-essential staff" from its IGF and CHAG institution average about 15% of professional staff and most if not all their non-essential staff are paid through IGF.

3. There has been an explosion of new recruitment in the area of middle level workers. For example, nearly 3,000 health assistant technical, an additional 6,000 nurses each year [output from training schools] and though nominal some 13,000 nursing students [various categories] are on student allowances.

On the premise that the public facilities are understaffed, as the MoH moves to fill in the vacancies the wage bill to government will increase. The most critical factor affecting the wage bill is the lack of staffing norms informed by productivity measures. Even now there is a general feeling that the output of the sector could be better if distribution and productivity were improved, meaning a better return on the wage bill. The likely future squeeze on resources makes better use of existing staff necessary.

Decentralised salary management: Discussions were held between the MoH, MoFEP and service agencies [the teaching hospitals and GHS] to pilot decentralised administration of salaries as an option to manage the wage bill. This did not happen on account of the MoFEP indicating that it did not think the agencies had the capacity to do so. During the year efforts at managing the wage bill included a 'clean up of the staff nominal roll', which led to the identification and removal of approximately 6,000 "ghost names". This situation makes the MoFEP hesitant to support decentralised administration of salaries.

There are mixed views on this position. The teaching hospitals are confident that they can manage their payrolls since a significant proportion of their staff categorised as 'non-essential' are paid through their internally generated funds. Within the GHS different opinions exit: some believe they can manage it and others think not. The benefits of decentralised salary management are believed to out-weigh the risks. Challenges identified are primarily attributed to systemic issues in the IPPD systems, the sheer overload at the Controller and Accountant General's Department in centrally making salary inputs etc. The specific skills and competencies in relevant staff of service agencies can easily be acquired.

5.6 Conclusions and recommendations

The role of HRDD-MoH is increasingly being accepted by agencies for leadership and a facilitative role. It is operating in a more consultative and inclusive manner.

On HR production, this has been improved but there is a risk of overproduction, especially for nurses and health assistants technical. The appropriateness of some new cadres has also

been questioned [HAT, health aides], and there is a need to plan for reduced production in future of some mid-level cadres.

On distribution, there have been definite improvements in distribution efforts and activities, with better coordination amongst agencies, though intra-agency distribution remains a challenge.

On productivity, there is increased agency leadership awareness and commitment to efficient utilization of available staff. Performance models are being developed and tried. However, there is not as yet a general agreement on how to define and measure health workforce productivity.

The wage bill still poses a major challenge and is escalating. It is hard to reach a consensus on how to solve it, given that, in some areas, staffing gaps still exist which require recruitment.

Recommendations

- Roundtable conference
  - The proposal developed by the HRDD of the MoH should be disseminated to all stakeholders for inputs and buy-in.
  - The proposal should be supported in its implementation
- Human resource production
  - The production strategy should be reviewed to reflect the future health scenario.
- Human resource distribution
  - The Interministerial Posting Committee should be enhanced and supported to continue with its decentralisation of health workforce management and increasing agency ownership and responsibility.
  - As a matter of urgency, basic criteria for determining staffing norms that reflect the level of services, expected coverage and desired quality of patient outcomes should be developed and adopted by agencies to support the efficient utilisation, distribution and productivity of staff.
- Human resource productivity
  - A national conference on human resource productivity should be held with all stakeholders to share current experiences, define and agree on parameters of workforce productivity, and develop models of implementation and measurement
- Human resource wage bill
  - The Ministry of Finance, in collaboration with the MoH and its agencies, should develop criteria and models for agencies to work towards to ensure the successful implementation of decentralised salary management
  - There must be a move to recognise the private sector as a credible and willing employer of the health workforce being produced. Efforts should be made to support the private sector to grow so it can absorb the workforce being created.

6 Health financing and public finance management

6.1 Introduction: public financial management in Ghana

An External Review of national PFM is currently being finalised and drafts of the report (World Bank, 2009) have informed this document. The report focuses attention on the need for strategic budgeting, which is doubly necessary where resources are scarce. It sets out the challenges posed by a poorly functioning budgetary allocation process, and the persistence of line item based, non-strategic budgeting (see box). These issues are reflected at the level of the health sector and suggest that long-term solutions to some of the budgetary difficulties faced at sector level will require national level support.

Box 6.1
Strategic budgeting processes in Ghana
At present, the MTEF appears to be neither strategic nor medium term. In practice, budget formulation takes the form of annual incremental line item budgeting. The MDAs' MTEF volumes are focussed on presenting detailed items with little or no link to the overall strategic policy context. The emphasis in budget discussions tends to be focussed on implementing the budget according to line items, rather than on how resources are used. Whilst these expenditure items are presented under individual (specific and detailed) objectives and activities, the fact that they exclude a significant part of public resources necessary for assessing policy trade-offs to provide efficient service delivery serves in effect to render them meaningless for overall strategic direction.

The effect of these weaknesses is that prioritisation takes place by default (by item, rather than by policy objective or activity). This undercuts the strategic basis of the MTEF and encourages a non-strategic, incremental approach to budgeting. In effect, there are 3 separate budget processes with separate processes of prioritisation, namely: (1) medium term fiscal framework: the aggregate (top-down) macro-fiscal framework; (2) MDAs' budget submissions, effectively incremental and by line-item; and (3) in-year budget changes.
Source: draft ERPFM 2009:30

6.2 PFM in the health sector

6.2.1 Background

In accordance with standard procedures in the GoG, budgetary responsibility is divided between the Budget Unit of PPME and the Finance Division (FD). The PPBU is responsible for the preparation and monitoring of the budget, as well as liaison with MoFEP over releases of funds. The FD is responsible for all subsequent disbursement, the maintenance of the accounting system, recording of transactions and financial reporting. To this end the FD consolidates all financial reports to produce a quarterly Financial Statement (FS) which compares actual spending against budget[7] and sets out the financial position of the MoH

[7] The Finance Division comprises five sections: Reporting -- responsible for all financial reporting and the Financial; General Accounts -- responsible for all HQ expenditures and reporting; Financial Management

and its agencies. This division of functions leads at times to duplication of effort and confusion over roles, particularly in the area of reporting. The issue is discussed further below.

The annual budget planning cycle begins in the second quarter of the year with an identification of policy priorities for next year's plan based on a review of the previous year's performance. The MoH submits a sector estimate to MoFEP in the third quarter for incorporation into the three-year rolling MTEF and national budget. The national budget is usually approved before the beginning of the budget year, but in 2009 was delayed by the 2008 election[8].

The health sector budget is presented in great detail by agency and line-item in the officially produced Annual Estimates. It is also reproduced in a similar but related format in the Health Programme of Work (PoW) and the difference between the two causes difficulties in reporting and lack of clarity about outcomes, which are discussed more fully below. In neither case does the budget follow a programme format. Activities identified are not easily related to specific units and departments in the MOH and its agencies, nor are resources clearly identified with the key outputs in the Programme of Work.

Box 6.2
Programme budgeting and organizational structure
When establishing a program classification, it is important to ensure that: (1) clear responsibility for managing the program, and accountability for its results, is allocated to a specific unit and program manager within the ministry or department concerned; and (2) the requirements for data collection and analysis are kept within reasonable bounds. A programmatic approach has the advantage of encouraging managers in each organization to clearly define their objectives and to consider what results have been achieved. It is thus often linked to the development of a performance-related approach to budgeting.
Source: IMF Fiscal Affairs Department, Public Financial Management Technical Guidance Note on Budget Classification

There are multiple systems in use to support budgeting and accounting in MoH and its agencies. Many systems are manual (sometimes supported by Excel) and this is especially so at district and sub-district level. However, computerisation has been haphazard and numerous computerised budgeting and accounting systems exist. Foremost amongst them is BPEMS – an Oracle-based system at developed and supported over many years by MoFEP, but which even now has limited coverage in just a few ministries. At MoH HQ and at Ghana Health Services, budgets are developed on Activate (a customised Access-based software) although this function can now be carried out using the budget planning module of BPEMS

Systems -- responsible for all transfers to agencies and management of the related bank accounts; Salaries -- responsible for HQ payroll; and Treasury, which manages HQ-related bank accounts.

[8] The national budgets for 2006 to 2008 were all approved in the preceding December. However, as a result of the elections in December 2008, approval of the 2009 budget was split, with approval for the first quarter of 2009 approved in November 2008, and preparation and approval of the budget for the rest of the year to be approved during the first quarter of 2009. The 2009 health budget was finalised and appropriated on March 26th 2009.

by those who have received the necessary training[9]. For accounting purposes, Ghana Health Services has installed ACCPAC – a well-established off-the-shelf accounting package -at its HQ and in RHOs. MoH HQ intends to install ACCPAC, but in the meantime is using Excel for many accounting functions. Korle Bu Teaching Hospital has installed SunAccount - another well regarded and locally-supported off-the-shelf accounting package. Finally, those agencies working with the Global Fund have installed Great Plains accounting software which is poorly supported and is still not fully functional. It is understood to have been running in parallel with the former system for more than one year.

A modified version of accrual accounting has been adopted throughout MoH and its agencies. That is to say expenditures are recorded when they are incurred (as opposed to when they are paid) and certain revenues are recorded when they are contractually due (e.g. National Health Insurance revenues) rather than when received. Full accrual accounting would also require the introduction of all fixed assets into the books of account, but this requires a full and current inventory, and thus has not yet been done[10].

Box 6.3
Extract from Draft ERPFM of 2009:46
The MDBS PFM advisers, in their April 2008 study of BPEMS functionality, found that BPEMS, which was supposed to become the main computerized PFM system for the Government, had at best a symbolic presence in the agencies it was supposed to be rolled out to, and elsewhere had hardly any impact at all. Of the five MDAs visited by the group of PFM advisers, only three out of the 6 modules were being implemented. Across government, other systems operated in parallel with BPEMS. Paper systems remained predominant, cheques were printed manually, and there were long delays in the approval of invoices. While BPEMS Secretariat is in the process of developing reports specified by the users, the group of advisers estimated that overall no more than 6 percent of the value of Government spending through the budget was being processed through BPEMS.

During the course of 2008 two significant reports have been produced which impact upon the public financial management of the MoH. The reports are the Public Expenditure Tracking Survey (PETS)[11] which covered both health and education; and the Public Finance Management Strengthening Issues Paper (PFMSIP)[12]. The findings of the PETS are summarised at a later point in this document.

The PFMSIP picked up on a number of the contemporary challenges facing PFM in the health sector, some of which are elaborated upon in this review. In particular, the PFMSIP highlighted blurred reporting lines amongst agencies; the need to develop a structured performance management framework in the health sector; the need to strengthen risk management; and training requirements following new legislation and the introduction of

[9] And this is in fact required by the 2009 Budget Circular
[10] The state of completeness of the Financial Statement is not clear to the review. Especially, it appears that the Central Medical Stores is not at present incorporated.
[11] The PETS activity generated several papers including: Trujillo, 2008
[12] Ministry of Health, Public Finance Management Strengthening Issues Paper, 13 December 2008

NHIS. Several proposals for strengthening budget planning and budget execution were offered and need to be elaborated. In the area of Accounting and Reporting the PFMSIP identified as key issues the different formats of the budget and the quarterly Financial Statements, and the plethora of computerised systems operating within the MoH and its agencies. The paper also identified weaknesses in Internal Audit, and pointed out the difficulties arising from the unclear relationship between the NHIA and the MoH.

6.3 Financial position and trends 1 – revenues and sources of funds

The computation of the budgetary allocation to the health sector as a percentage of the national budgetary discretionary allocation is made difficult by fragmentation of budgets at both national and sector levels. It is further hampered by the significant levels of off-budget funding in the health sector. With that said, allocations to the health sector as a percentage of the national budget are as follows:

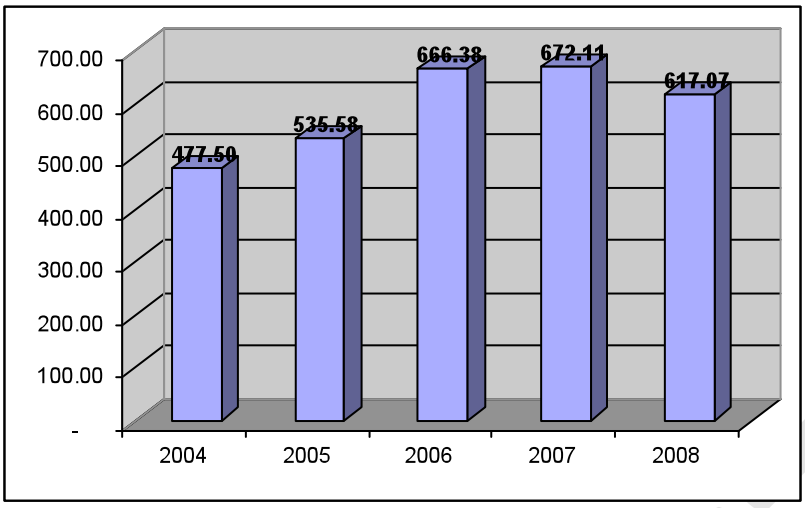
Table 6 MTEF allocations to health, 2006-8

	2006	2007	2008
MTEF allocation – Health	478,654,800	563,756,400	752,233,368
MTEF allocation – Total	2,948,398,300	3,869,832,200	5,059,868,063
% MTEF allocation to Health	16.2%	14.6%	**14.9%**

Source: Annual Budget Statements

There is some doubt over the accuracy of the 2006 figure. While the total allocation to health, in nominal terms, increased by 33.4% from 2007 to 2008, the proportional MTEF allocation to health only slightly increased by 2.1% in the same period, which results in a neutral outcome of this indicator. By contrast real health revenues (after adjusting for inflation) as reflected in the Financial Statement levelled off in 2006 and 2007 and have fallen in 2008. However, revenue in the Financial Statement includes only that part of National Insurance which accrues to MoH or health facilities, and not the gross amount paid to NHIA, which is not known.

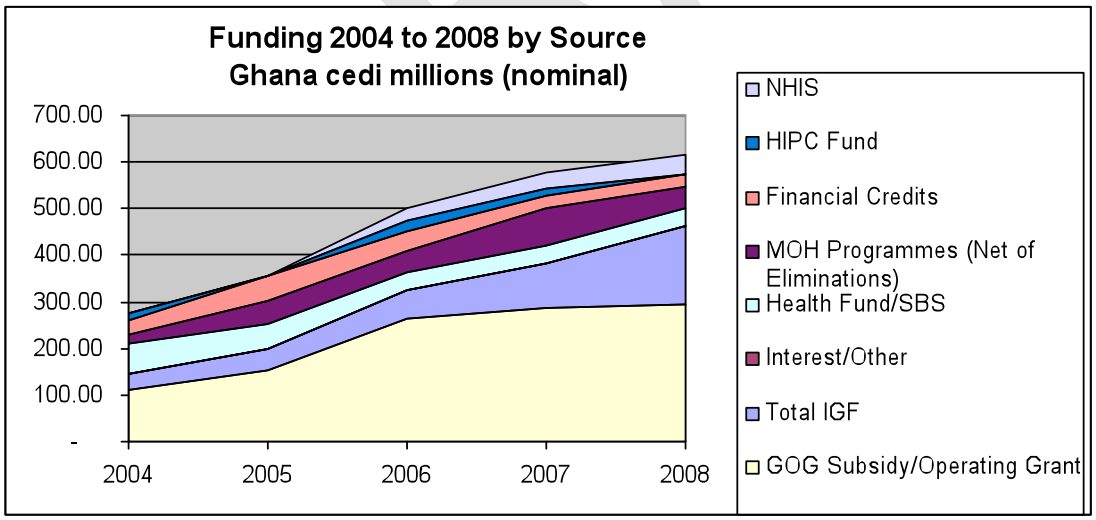
Figure 7 Real health sector revenues, 2004 to 2008 (GHc million)



Source: Financial Statements 2004-2008, applying GDP deflators as 2005:15; 2006 12.8; 2007: 14.4; and 2008 (estimate) 16.2.

Health sector financing is changing in two ways: the relative shares of different sources are changing, and the method/ease of access to those sources is also changing. In terms of sources, financing is characterised by a levelling off of the share of GoG funding even in nominal terms, and a significant increase in share of Internally Generated Funds (IGF), powered by the growth of National Health Insurance. From 2006 to 2008, the GoG subsidy has increased by only 11% in nominal terms, whereas IGF has increased by 176%.

Figure 8 Health finance, 2004 to 2008, by source (GHc, nominal)

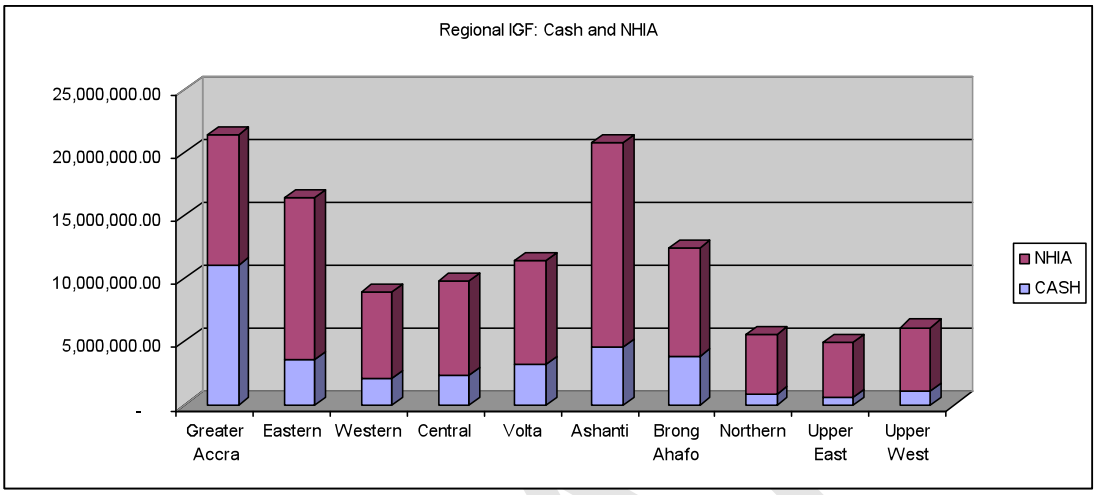


A number of these sources deserve special comment. First, the IGF funds comprise two separate income streams: insurance claims paid through NHIS and the district scheme concerned, and private payments known as "Cash and Carry". Within these, the Cash and

Carry component is diminishing in importance as the spread of NHIS membership increases. This is discussed further in the section on the NHIS.

The share of NHIS income and 'cash and carry' varies widely amongst regions. NHIS funding is proportionately most important in the North and least important in Greater Accra.

Figure 9 Shares of NHIS and 'cash and carry', by region, 2008



NHIS funds are expected to continue to grow. The 2008 budget statement projected the following NHIS revenues over the medium term, albeit with an assumption of 7.4% growth which may now be difficult to achieve.

Table 7 Projected NHIS revenues, 2008-2010, GH c millions

	2008	2009		2010	
	Gh C Million	**Gh C Million**	*% increase*	**Gh C Million**	*% increase*
CEPS Collection	125.60	150.40	*19.7*	178.60	*18.8*
VATS Collection	74.41	87.94	*18.2*	104.42	*18.7*
SSNIT Collection	35.42	38.26	*8.0*	41.32	*8.0*
Total	**235.43**	**276.60**	***17.5***	**324.34**	***17.3***

The development of a Health Financing Strategy (HFS) is important as a means to manage the rapidly changing funding environment in the health sector. It has for some time been on the agenda of the MoH, as well as the establishment of a Health Financing Task Force whose functions would include monitoring of health flows under the Strategy and the composition of health funds over time. Neither of these things has happened and the fact that they have not points to either capacity constraints within the MoH, or possibly a concern amongst some stakeholders that such an HFS might have only a limited effect. If it is a capacity issue, MoH may have time to monitor an agreed and established HFS, although not to develop it. In this case a facilitating consultancy might be the catalyst required to get the strategy developed.

6.4 Financial position and trends 2 – expenditures and budget execution

6.4.1 Budget execution

The table below presents a budget summary using provisional data from the Draft 2008 Financial Statements and allocating against the approved budget from the Annual Estimates. For the purposes of this exposition, MOH Programmes of GHC72,587,797 have been included in their entirety under Donor Item 3, although a number are from off-budget earmarked funds. Similarly, the amount of GHC27.3 million for financial credits has been recorded as Donor Item 4 for the purposes of this exposition. The amount at the foot of the budget column is the total of the Approved Estimate, but the amount paid directly to NHIS has been separated out because it cannot be monitored by MoH.

Table 8 Budget execution – spending against budget by selected categories[13]

		Estimates	Expenditure	Variance	
		GHC	GHC	GHC	%
Government of Ghana					
01	Personal Emoluments	239,310,886	266,737,401	(27,426,515)	*(11.46)*
02	Administration Expenses	10,904,145	8,014,250	2,889,895	*26.50*
03	Service Expenses	10,038,900	8,446,737	1,592,163	*15.86*
04	Investment Expenses	8,263,104	2,611,191	5,651,913	*68.40*
		268,517,035	285,809,579	(17,292,544)	*(6.44)*
IGF					
01	Personal Emoluments	-	9,300,484	(9,300,484)	*!*
02	Administration Expenses	475,329	36,882,598	(36,407,269)	*(7,659.38)*
03	Service Expenses	113,049,100	80,344,219	32,704,881	*28.93*
04	Investment Expenses	1,546,169	5,742,752	(4,196,583)	*(271.42)*
		115,070,598	132,270,053	(17,199,455)	*(14.95)*
Donor					
01	Personal Emoluments				
02	Administration Expenses	500,000	668,654	(168,654)	*(33.73)*
03	Service Expenses	39,700,000	108,816,649	(69,116,649)	*(174.10)*
04	Investment Expenses	86,531,219	31,933,976	54,597,243	*63.10*
		126,731,219	141,419,279	(14,688,060)	*(11.59)*

[13] To be refined in final version to show spending from earmarked funds separately.

	Estimates	Expenditure	Variance	
	GHC	GHC	GHC	%
HIPC	6,485,000	667,208	5,817,792	*89.71*
NHIS Grants	-	42,391,756	(42,391,756)	*!*
Sub-total MoH Controlled Funds	516,803,852	602,557,875	(85,754,023)	*(16.59)*
NHIS Memorandum	235,429,513			
	752,233,365			

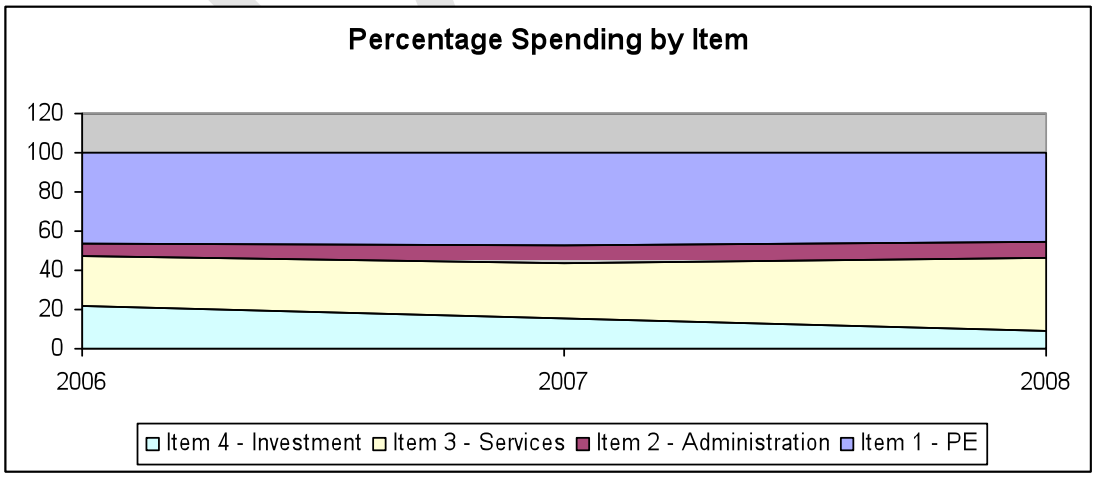
A comparison of spending by Item shows that in spite of the increasing costs of Personnel Emoluments they are holding steady at around 46-47% of the total spend. Over the three-year period below, Item 2 shows no particular trend. Spending on Services is gaining rapidly at the expense of investment, which is falling rapidly, even in nominal Cedi terms.

Table 9 Budget execution – spending against budget by selected categories[14]

	2006		2007		2008 Draft	
	GH¢ m	%	GH¢ m	%	GH¢ m	%
Item 1 - PE	235.22	47	264.81	47	275.87	46
Item 2 - Administration	27.42	5	53.64	10	45.56	7
Item 3 - Services	130.00	26	159.17	28	227.78	38
Item 4 - Investment	109.46	22	86.07	15	53.35	9
Total	**502.10**	**100**	**563.69**	**100**	**602.56**	**100**

Or seen graphically……

Figure 10 Shares of NHIS and 'cash and carry', by region, 2008



[14] To be refined in final version to show spending from earmarked funds separately.

6.5 Key issues in PFM in the health sector

The previous sections above have sought to paint a picture of recent financial trends in the health sector and especially to comment on financial outcomes in 2008 -- the year currently under review. This section of the report focuses on systemic issues of budgetary and financial management in the health sector, both institutional and procedural. In many cases they take up the issues raised in the Health Sector PFM Issues paper referred to above.

6.5.1 Staffing and capacity

In many respects the Ministry of Health and its agencies (especially Ghana Health Services and urban Teaching Hospitals) have good capacity in financial management. Many senior finance staff hold respected professional qualifications in accounting, and many others are studying hard in their evenings and weekends to complete such qualifications. Ghana Audit Services reported to the review team that the financial management in the health sector is significantly more advanced than in other parts of the GoG, partly as a result of protracted engagement with Development Partners and a resultant high level of support and scrutiny. Why then is financial management capacity often reported as an issue of weakness? There are several reasons.

First, within MoH financial and budgetary management is shared between PPME's Budget Unit and the Finance Division. Arguably, the accounting staff in the FD have greater opportunities for professional development than their counterparts in the Budget Unit. Second, there is the question of numbers: it is generally considered that there are sufficient staff to maintain the present system, but when major reforms or programmes of computerisation are planned (as is currently the case) additional support is required; third, skills may be sufficient to maintain existing systems, but continuous training is required to support the move towards further computerisation as well as to familiarise staff with new legislation (such as the Finance Administration Act of 2003 and the new ATF procedures) and to support new procedures such as those associated with the NHIS; at the sub-national level there is reported to be high turnover of staff which could serve to undermine any training programmes or institutional learning; there are particular reports that many sub-districts without finance staff find difficulty in developing financial information and especially in finding the time to prepare insurance claims; the PETS study in health revealed widespread poor record-keeping in medical supplies; finally, there appears to be a difficulty in recruiting financial management staff at the sub-national level as indicated in the following table from Ghana Health Services:

Much of the commentary on financial management capacity is anecdotal. The view of many is that it will not be fully addressed by training, although training of new staff members is important. Capacity is undoubtedly strengthened by the regional financial monitoring teams.

The review heard that on occasion the lack of interest of a supervisor adversely affects the performance in otherwise capable staff. A major thrust must be to ensure that all District and Sub-District heads are aware of the importance of record-keeping, and are encouraged to regularly follow up on progress with their staff.

Box 6.4
Regional Financial Monitors

Regional Financial Monitors are engaged by GHS and attached to all health regions with responsibility to support financial systems at the sub-national level; to monitor and validate the financial information produced; and to enter it into ACCPAC for routine financial reporting. They are a major source of capacity development at the sub-national level but they report that their own effectiveness is limited because:

- they do not have portable laptops
- they often re-enter data into ACCPAC that may have been entered into another system because of the multiplicity of operating systems
- they suffer from high staff turnover
- they are unable to visit districts and sub-districts on a quarterly basis (as planned) because of other responsibilities at RHO and because of transport availability; they often use public transport

These points are self-reported by Financial Monitors and not validated by the review team. Nonetheless they require follow-up and comment.

It is desirable in a review of this nature to propose a way forward for capacity strengthening in financial management. However, there seems to be a great deal of anecdotal information about capacity shortages (and strengths) but not so much concrete information to indicate whether existing capacity deficiencies are to be remedied by greater numbers of staff, more efficient working practices, training, equipment, or simply better supervision. At a later point in this document, this review recommends that a plan of action is drawn up for the development of financial management in the health sector. It is proposed that an early event in this plan should be a one-day session on capacity strengthening with a focused agenda and high representation from the sub-national level, to include not only finance people but also health workers who are required to perform financial activities and a selection of managerial staff.

6.6 Budgeting, the POW and the Financial Statement

The official budget of the Ministry of Health and its agencies is line-item based and organised by agency and administrative unit. Accordingly, there is a fundamental disjuncture with the Programme of Work (POW), which by its nature is required to be programme and activity-based. Moreover, the POW is used in practice as a tool to secure an ex-ante ring-fencing of priority expenditures in the health sector, and therefore identifies budgets for particular activities which are not separately shown in the official budget document. Over the years a significant number of ring-fenced items have been introduced, and have been listed in the POW. As a result, the official budget document and the POW can invariably be

reconciled, but the similarities are not immediately apparent and the differences serve to confuse.

The variation between the two documents causes real difficulties in addition to being a source of confusion for those who seek to understand the financing of the health sector. A particular difficulty arises because the central financial reporting document of the health sector, the quarterly Financial Statement, broadly follows the official budget without the modifications introduced in the POW. Accordingly, there is no tool to effectively monitor the detail of the POW budget.

However, as shown in the table on next page, in total the POW broadly follows the budget. The major difference is the addition of ring fencing for project lines and the off-budget "Earmarked Funds" of almost 93 million.

The Financial Statement seeks to monitor the budget, and to an extent succeeds. It is prepared by the Reporting Unit of the Finance Division using reports from all agencies of the health sector with the exception of Central Medical Stores. It is the only statement of consolidated actual expenditures as opposed to recording of budgetary data, receipts and budget releases all of which are recorded in the Budget Unit of PPME. For monitoring purposes, the Financial Statement includes schedules to monitor spending against budget by level and Item for GoG (Schedule 12), Health Fund and SBS (Schedule 13), and IGF (Schedule 14).

Table 10 Comparison of the Budget from Budget Book and the POW 2008

		Official Budget		POW	
		Ghana ¢ millions		Ghana ¢ millions	
GoG	PE	239.31		239.31	*
	Administration	10.90		10.90	*
	Service	10.04		10.04	*
	Investment	8.26		8.26	
		268.51		268.51	
IGF	PE				
	Administration	0.47		0.47	
	Service	113.05		113.05	
	Investment	1.55		1.55	
		115.07		115.07	
HIPC	Service	6.50	U	3.25	
	Investment			3.25	
				6.50	
NHIS	PE			8.82	
	Administration	235.42	U	16.69	
	Service			174.96	
	Investment			34.95	
				235.42	
Donor/SBS	Administration	0.50		0.50	*
	Service	39.70		40.16	*
	Investment	86.53		86.07	*
		126.73		126.73	
Earmarked Funds	Service			51.22	*
	Investment			41.70	*
				92.92	
Total		752.23		845.15	

Source:2008 Budget Book; 2008 POW
*Legend: U = Unallocated by Item; * = with further analysis and ring-fencing*

The monitoring of GOG and Donor Funds is complete at the level of the official budget. However, in monitoring the IGF budget, the Financial Statement revises the budget to actual spending, which is unhelpful since it produces no variance. It should retain the original budget figure so that the overall budget is easily compared with the official budget and the POW. The Financial Statement does not present any budget comparison for HIPC, the NHIS or, of course, the off-budget Earmarked Funds. HIPC funding, though small, should be monitored against budget, although it is rapidly diminishing. The NHIS budget is the amount proposed to be provided to the NHIA for the year and it must be dealt with in one of two

ways: either it can remain in the Ministry of Health budget, when MoH should be provided with quarterly information to enable spending to be captured in the consolidation, or it should be removed from the MoH budget since the information is not there to monitor it.

Box 6.5
The Financial Statement – strengths and areas for improvement:
Strengths
- Partial Accrual Accounting – the Financial Statement includes a Balance Sheet
- Based on Double-Entry Bookkeeping
- Released within the quarter
- Covers most of health sector
- Includes narrative report to explain key figures and trends

Areas for improvement
- Ensure all agencies submit timely reports and produce in 60 days or less
- Incorporate CMS/RMS
- Include Budget Book figures more completely and ensure that all budget items are monitored effectively (show a summary of budget against spending that agrees to original budget total)
- Address POW issues in accompanying narrative
- Produce customised reports e.g. aged analysis of insurance owed; report on spending against ring-fenced items where possible

6.7 Systemic issues in financial reporting

The timeliness of financial reporting is fair, but can be improved. MoH provided information on timeliness of financial reports submitted by agencies for the quarters of September 30 and December 31 of 2008. Out of 35 financial reports due, 21 September quarter reports were received within 30 days of the quarter end and a further 3 were received within 60 days of the quarter end. 11 reports took more than 60 days before submission. There was a similar picture in December with 20 report is being submitted within 30 days, a further three with in 60 days and 12 reports taking longer than 60 days. In both quarters MoH HQ, all hospitals and most regions submitted within 30 days. The Financial Statement itself is generally prepared within 90 days of the quarter end, and a final version of the year end Financial Statement was provided to the review team on 31st March, 2009.

Reports submitted are subjected to validation procedures, and all agencies are required to provide bank reconciliations along with their financial reports. There is a network of regional financial monitors supporting the districts in preparation of financial statements, and GHS HQ provides further support.

A major difficulty in financial reporting results from the state of computerisation of budgeting and accounting in the health sector. There are two strands to this. First, in the absence of any co-ordinated strategy for the introduction of Information Technology, there is a plethora of diverse systems in operation. These systems have been recounted above.

There are several consequences of such an uncoordinated approach including: inadequate support for all systems resulting in system failure, and prolonged periods of parallel running requiring duplication of effort and aggravating capacity constraints; difficulty of providing coordinated training; and difficulties in securing an adequate interface of the different systems in operation. All of these systems have sprung up as a result of the accounting vacuum created by delays in the introduction of a full service from BPEMS, and it is not realistic to expect that BPEMS will provide a suitable platform for at least 2 to 3 years. Accordingly, it is imperative that MoH should urgently carry out a review of computer systems operating throughout its agencies and select a single off-the-shelf software for use as a standard throughout. Subject to an adequate evaluation, ACCPAC may be the preferred software since it is already in use across much of Ghana Health Services.

A second concern is the widespread use of Excel to maintain Cash Books in the MoH and its agencies. Such cash books are highly insecure, as they leave no audit trail of any changes to entries which occur subsequent to the original entry. In this respect manual cash books are superior and less susceptible to error and fraud. The early introduction of standard accounting software will eliminate this risk.

Lack of coordination between the PPME Budget Unit and the Finance Division also contributes to inefficiencies in reporting. This is evident from the discussion above about the inconsistencies between the Budget Estimates, the POW, and the Financial Statements which have not been resolved, and to the knowledge of the review team have not yet been clearly set out.

In addition, the Budget Unit reports that it does not find the Financial Statement very helpful and generates its own separate data for the Business Meeting based upon receipts and known releases. This seems to be an unnecessary duplication which could be avoided through discussion and collaboration. It is not clear to the review team whether this information is reconciled with spending information or with the Financial Statement more generally. The Finance Division is a service division and must ensure not only that its product is accurate and technically sound, but also that it meets the needs of PPME in content and timeliness. In so far as it does not do this, it contributes to duplications in reporting[15]. It is proposed that improved coordination should be established through the existing PFM Working Group which includes representatives Unit heads from Finance Division, key PPME Budget Unit personnel and possibly representatives from GHS Budget and Finance. Alternatively the tasks could be carried out through a mandated MoH PFM sub-group. The PFM Working Group itself should have clear Terms of Reference and should be tasked to develop the HQ PMF/Budget agenda under a national health sector PFM plan. It should include as a beginning the synchronisation of key reporting documents and procedures.

[15] In a similar vein, during the months of January to March of this year PPME has been carrying out a survey of expenditures designed to provide financial and human resource information on sub-national facilities. However, this possibly desirable initiative was carried out without reference to the Finance Division and appears at first sight to include a lot of information already available within the financial reporting system.

There are reported to be similar coordination failures between MoH Finance and GHS Finance. Again, the PFM Working Group should be tasked with discussing key areas such as streamlining the consolidation process, including associated IT activities; refining roles and responsibilities; and supporting PFM strategy development.

6.8 Earmarked funding

Below we present earmarked and other donor funding, with earmarked funding representing just under half of the total. Of the earmarked funding, Global Fund takes the lion's share at 77% with a further 11% taken up by the IDA Malaria Nutrition programme.

Table 11 Donor contributions, including earmarked funds, 2008 (GHC million)

Donor	SBS/ Health Fund Contributions	%	Earmarked Funds	%	Total	%
Budget Support-Denmark	10.80	26.69	3.53	9.19	14.33	18.17
Budget Support-DFID	0.42	1.04	-	-	0.42	0.53
Global Fund		-	29.58	77.04	29.58	37.51
The United Nations Children's Fund	-	-	0.52	1.35	0.52	0.66
ADB		-	0.07	0.18	0.07	0.09
The World Health Organisation	-	-	0.02	0.05	0.02	0.03
UNFPA	0.50	1.24	0.47	1.22	0.97	1.23
IDA (Nutrition & Malaria)	0.66	1.63	4.21	10.97	4.87	6.17
Budget Support-Netherland	27.66	68.34		-	27.66	35.07
Nordic Fund	0.42	1.04		-	0.42	0.53
Interest	0.01	0.02		-	0.01	0.01
	40.47	100.00	38.40	100.00	78.87	100.00
Percent of total	51.3		48.7		100.0	

6.9 Recommendations

- Develop a monitorable and credible PFM Plan of Action for the health sector to be monitored by the Health PFM Group. This plan to include as a minimum: (1) Strengthening FD/PPBU coordination at HQ and inter-agency coordination in health sector finance (2) Procedure for harmonising Estimates, POW Budget and Financial Statement into a unified budgeting and reporting system (2) Streamlining consolidation of Financial Statements (4) an IT Strategy for Health Sector PFM pending BPEMS effectiveness (5) Capacity development assessment and plan and (6) strengthening of procurement if this is not part of a separate plan (note: this process has already begun with the PFM Strengthening Issues Paper and the proposed kick-off meeting on April 3rd).
- Under the plan above, MoH to urgently carry out a review of computer systems operating throughout its agencies and select a single off-the-shelf software for use as a standard throughout
- Under the plan above explore possibilities for developing full Programme Budgeting with programmes aligned
- Create better links between PPBU and Finance, including a monthly meeting of a budget working group to monitor key aspects of the PFM plan including synchronisation of the harmonising Estimates, POW Budget and Financial Statement
- Resource allocation processes can be strengthened by ensuring regular quarterly meetings of the MoH HQ Budget Committee which will also serve to strengthen PPBU links with Finance Division.

7 National health insurance

The National Health Insurance system (NHIS) has undergone some major developments in the course of 2008. These include:

- Substantial growth in membership
- Increase in number of accredited providers
- Addition of a new exempt category of pregnant women in July 2008
- Introduction of new tariffs for payment of services
- The introduction of a new ICT system
- The creation of regional coordination offices
- Proposals for amendment to LI 1809
- Piloting of new accreditation tools
- Introduction of new national membership card

At the same time, some serious problems have emerged in the system, the core symptom of which is the delay in settlement of claims at facility level. This issue is discussed first, then linked to the wider questions of the overall organisation of the NHIS, its financial sustainability, and the system's impact on equity, efficiency and quality of care in the health system.

7.1 Delays in reimbursement

7.1.1 The chain of delays

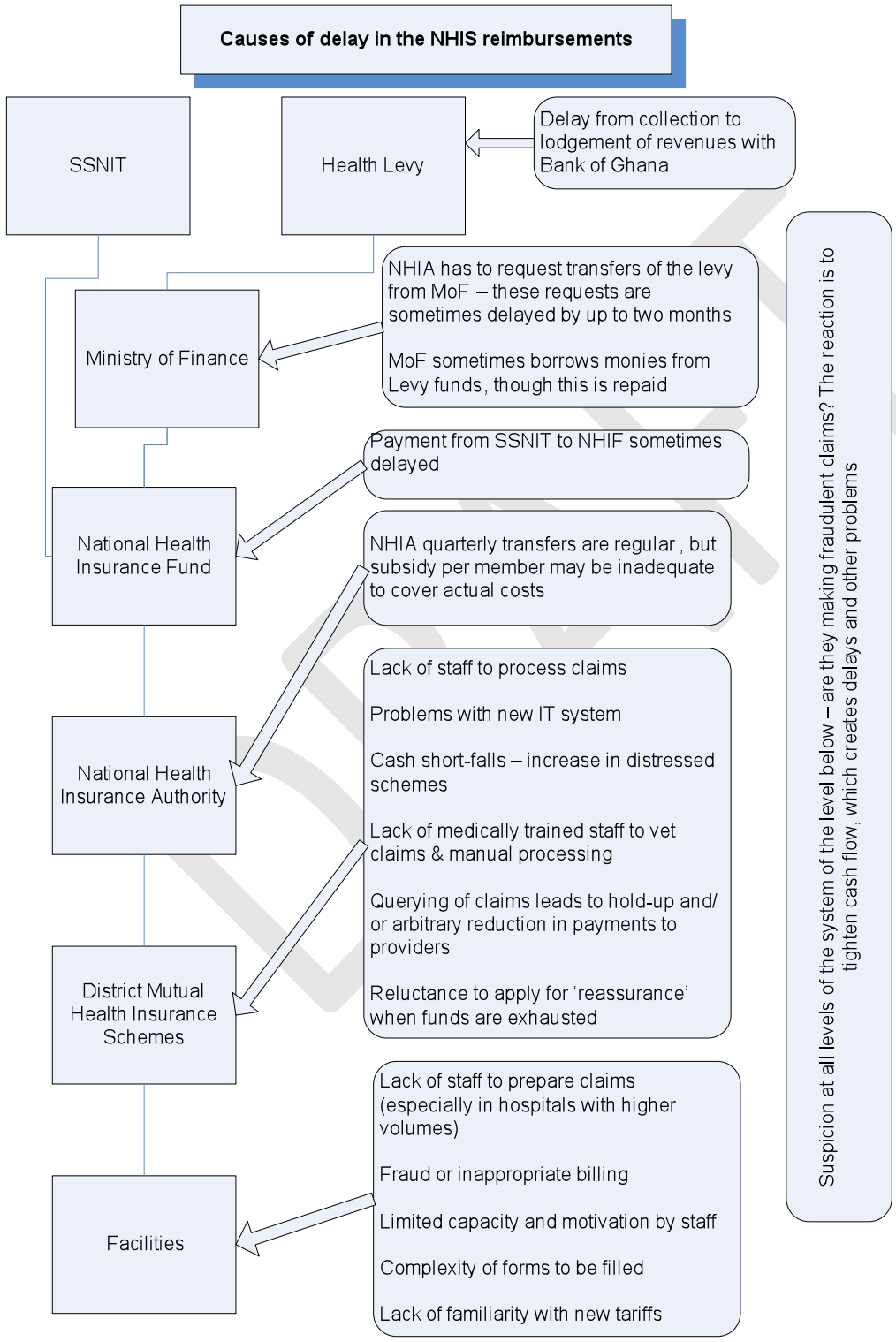
As of the end of 2008, GHc 49 million was owing by to health facilities, according to the financial statement (not all but almost all of this is due to unpaid NHIS claims). This is equivalent to 3-4 months' worth of total IGF. This accords with provider reports of delays of 2-6 months in settlement of bills during the year.

Based on interviews conducted during the review, the delay in reimbursement is the result of a chain of factors, of varying importance, reaching from the top to the bottom of the system. These are summarised in Figure 10.

It is not easy to quantify where the greatest blockage lies – these vary by area and some have recently been reduced. For example, speed of processing by providers is said to have increased now, so that the average gap from treatment to submission of claims is four weeks. Re-organisation to enter claims daily (rather than waiting until the end of the month) may have contributed. Some have gradually taken on new staff too to help with claims processing. At scheme level, many DMHIS, which started with poorly qualified staff, are now recruiting more experienced people. Some of the problems were transitional, relating to the need for training in the new payment system introduced by the NHIS last year. Others may be improved by the new ICT programme, although this is not yet rolled out to the providers. However, the build-up of non-payment through 2008 suggest that some more fundamental

issues of cash flow at the DMHIS level are likely to have been a more significant contributor to delays. The factors affecting this are analysed below.

Figure 11 Chain of delays in NHIS reimbursements



Fund releases at top levels

No information has yet been provided by the NHIA on fund flows into and out of the NHIF. However, a PETS study conducted in 2007 found inconsistencies in the amounts released by the SSNIT to the NHIF, and also delays in transfers. Similarly, it found big delays in MoFEP transfers to the NHIF, as well as inconsistencies in onward payments from the NHIA to district schemes. It seems then that all links in the chain need clear examination and improved systems

Box 7.1
A story of mistrust and micro-management (the two Ms)

It is interesting that at each level of the system, there is a feeling that the level below is not handling money properly. From the MoFEP to the NHIA to the DHMIS to the providers – all are telling the same story: 'if I give them money, they will misuse it'. Consequently, cash flows are delayed and reduced; problems arise; suspicion deepens. Is there a way to cut through this vicious circle and provide reliable funds, in exchange for clear accounting? This story is a microcosm of issues elsewhere in the sector.

7.1.2 Impact of the new tariffs

In June 2008 a new tariff structure was introduced by the NHIA, based on a DRG system (paying per episode of care, according to disease groups, but also differentiated by level of care and sector). Although financial data has not been available from the NHIA to analyse the overall impact of the new tariffs, scrutiny of selected health facilities' claims shows an immediate jump in NHIS claims, sometimes a doubling with the month. This suggest that the tariff itself (leaving aside other factors which have also contributed) has been a cause of cost escalation, leading to cash flow problems in the district schemes and so delayed payment of claims to facilities.

Drug costs are currently billed separately on top of the fixed DRG payment per episode, and it is reported by the NHIA that the number of drugs per prescription have increased, from 4.5 in 2004 to 6 now, with some more expensive drugs being particularly favoured by some doctors. All of this would be unsurprising, given the current payment system, but the review team did not find data to validate this .

Another common result of the introduction of DRG systems is 'tariff creep', which is being reported by NHIA informants. ('We don't get simple malaria cases any more – all malaria is complicated'.)

7.1.3 Impact of growth in members

In addition to the factors discussed in the previous section, which are causing increased financial strain on the NHIS as a whole, there is the contribution of increased membership. While in a 'normal' insurance system, increased membership would bring in increased

income from premia, in the NHIS, the income is largely de-coupled, 90-95%[16] coming from SSNIT and the VAT levy, which will grow with national income rather than membership numbers. GDP growth (6.2% in 2008) is below the rate of growth of membership (from 36% in 2007 to 45% of valid card holders in 2008). This means that the more successful the NHIS (in terms of coverage[17]), the greater the risk of financial difficulties.

Table 12 NHIS registrants and card holders, by region, 2008

Regions	2008 population	Registrants	% population	ID cardholders	% population
Ashanti	4,720,916	2,767,949	59%	2,377,396	50%
Brong Ahafo	2,211,897	1,484,771	67%	1,331,596	60%
Central	1,882,115	1,014,246	54%	237,135	13%
Eastern	2,354,537	1,377,474	59%	1,214,477	52%
Greater Accra	4,100,706	1,421,417	35%	1,319,637	32%
Northern	1,901,179	1,281,481	67%	1,064,542	56%
Volta	1,979,814	945,290	48%	786,217	40%
Upper East	1,004,244	603,776	60%	562,268	56%
Upper West	659,826	439,423	67%	463,099	70%
Western	2,476,127	1,182,733	48%	1,061,519	43%
Total	23,291,360	12,518,560	54%	10,417,886	45%

Source: CHIM population data; NHIA[18]

[16] Estimate based on presentation by NHIA CEO to IALC in 2008; whether this fully reflects DMHIS collections from the informal sector is not clear.

[17] Analysing membership trends is complicated by some data issues. Currently, the NHIA presents coverage figures based on numbers registered with the various schemes. This is a misleading approach, as registration does not indicate any entitlement to services by clients or financial responsibility by schemes. 'Valid card-holders' is the most relevant category, and should be broken down by different types of exemption, for monitoring purposes. Even the category of 'card-holders' contains a number of different categories of people, including those who once paid but have not renewed; those who have renewed but have not received a new card etc.

[18] The figures in this table vary from those cited by the NHIA, which used 2004 population figures as their denominator (which inflates population coverage with registrants to 61%, as opposed to 54%, above). Membership data is inconsistent between sources: figures cited by the GHS differ from the NHIA ones given to the review team, which are also different from the ones presented by the CEO in March 2009.

The growth in members was accelerated in 2008 by the addition of all pregnant women, who from July 2008 were entitled to free membership of the NHIS and all maternity care. Enrolment response has been substantial (433,000 by year end). The MoH transferred GHc 16 million to the NHIA in the summer of 2008 in order to assist with the additional costs which the new policy would impose on the NHIS. However, the subsidy which was passed on by the NHIA to member schemes was the standard GHc 14 per member (rising to GHc 18 in 2009), which is well below the average cost of maternal health care (ANC, intrapartum care, and PNC)[19]. One estimate of the cost of the full maternal health care package and other non-maternal health covered during the year of exemption was GHc 100 per woman. The authors estimated the total cost of the exemption at over GHc 30 million for 2009 (Banking on Health 2008)[20]. The risk is that under this new mechanism schemes have a disincentive to enrol pregnant women and face financial difficulties if they do. There may then be a repeat of the recent experience of Ghana with direct maternal fee exemptions (Witter et al. 2009).

7.1.4 Growth in utilisation of services

In addition to the increase in tariffs and increase in members, there has been an increase in utilisation of services by members, which is the expected result of any reduction in financial barriers to care. While this is a positive development (OPD per capita visits remain under the expected norm), it is also something to monitor carefully, in terms of the implications for cash flows and, ultimately, sustainability. Increased utilisation of curative care is not self-evidently positive and care patterns can be distorted by provider interests and also unequal access by different groups. In addition, the quality is critical. These issues are discussed further below.

While there is no trend data on OPD use by insured/non-insured patients, the overall trend in OPD, as described in the service delivery section, shows a marked and growing increase from 2005 onward, compared to stable (low) use before. The timing and pattern correlates with growth in NHIS membership, indicating that the NHIS has indeed increased service use[21]. According to an ILO paper of 2006, utilisation for the insured was then at around 0.9 OPD per capita – almost twice the non-insured (then at 0.49 visits per capita). It is interesting to note however that overall admissions have been stable over the past few years, which is unexpected.

[19] It seems that something similar may be happening with DANIDA support for providing free cards to PLHA. It is paying GHc 40 per person, but this may not be reflected in the subsidies transferred to schemes.

[20] The NHIA tariff for ANC, normal facility delivery and PNC at a CHPS/HC comes to just over GHc 14. Any additional complication, illness during pregnancy or seeking care at higher levels would therefore push the cost over the subsidy level.

[21] Note that increased use cannot be automatically equated to increased access – that requires an assessment of who is using the services. A big increase by a small group is less beneficial than lower use by a wider pool. The socio-economic and geographic distribution of membership is also important and is discussed below. In addition, it is important to know whether the increase is 'real' or reflects a shift from (previously unrecorded) visits to private facilities into public facilities from which utilisation data is gathered. A full gathering of data from all sectors would help to illuminate this.

The poor gate-keeping in the health system – discussed above but also reflected in the health insurance system – also raised prices, as it means people frequent higher level facilities more, which results in higher reimbursement per episode. This is another factor to address in cost control and to improve the efficiency of the system.

7.1.5 Increase in accredited providers

An increase in accredited providers widens access and so has an impact on the cash flow of the NHIS. In 2008, there were 1,551 accredited private providers, providing one-third of all services reimbursed by the NHIS, according to a recent report (Banking on Health 2008). Given that the tariff for private providers is higher (and consumers in urban areas have no price disincentive to visiting them), this may be another driver of increased spending, which should be monitored. According to a World Bank trip report from March 2009, 50% of services are provided by public facilities; 30% by CHAG and 30% private.

7.1.6 Fraud and informal payments

There is anecdotal evidence of various types of fraud (against schemes but also, some allege, by and with schemes). It is not easy to assess their scale, not least because some mis-billing reflects lack of understanding of the new tariff. The shift from fee for service, which health facilities are accustomed to, to a DRG-based payment system is not simple. The payment is per illness episode, but the definition of episodes, and the rules about return visits (designed to control costs) are quite complex for providers to follow. For example, emergency readmission is not chargeable as a new episode if it is to the same provider, and is within 14 days of discharge, and the original admission was less than 1.5 times the average LOS for that G-DRG (NHIA 2008). There may also be some gaming by providers[22]. In one region visited, an estimated 20-25% of claims presented were rejected, for a variety of reasons.

Examples of reported informal payments by clients include:
- Charging for services out-of-hours
- Asking patients to pay for drugs, which are said not to be in stock
- Asking patients to pay for 'better' drugs, said to be not provided under the NHIS

One person involved in discussions at community level thought that around 40% of clients might have paid something. This is a pure guesstimate, but if right, is worryingly high. One of the factors is the increased workload for staff – they have experienced a growth in work without any compensation (except for midwives, who do get some small allowance per delivery, at least in some areas). Consequently, they may feel justified in charging small amounts for what they see as 'extra' services.

[22] To give one example, the NHIS operation manual states that one episode for OPD consists of a maximum of three visits. These are paid in three equal parts. If most costs fall in the first episode, it is in the provider's interest to ensure that the subsequent visits are either made or at least billed for.

The NHIA publishes a number for members to call if they are illegally charged for services and there have been cases of providers being reported and being cautioned and forced to pay back monies. For this to be effective, there may need to be harder sanctions publicised in future, such as being disaccredited.

7.1.7 Impact on providers

The financial impact of the NHIS on providers in 2008 is complex to assess. On one hand, price and activity levels increased, all of which increase revenue and lower unit costs. On the other hand, reimbursement delays obviously damage cash flow and non-payment causes longer term debts (to suppliers, such as the medical stores and others).

The regions with higher membership are particularly dependent on NHIS reimbursements – in Northern region, nearly 90% of IGF in 2008 came from the NHIS. In one district hospital visited by the team, government funding provided 6% of total revenue for 2008; programme funding 4% and IGF 90%.

Some reports of overcrowding, particularly in OPD, were reported but it is not known if this is a general problem or specific to some facilities.

7.1.8 Impact on schemes

There was no information available on the financial situation of the DHMIS. However, the NHIA disbursements for distressed schemes are escalating quickly: GHc 8.32 million for 2008 (as against a budget of GHc 5 million for the year), rising to just under GHc 30 million for the first quarter of 2009 alone (according to a presentation made by the CEO in March 2009). This indicates both poor budget planning, on the part of the NHIA, as well as the growing gap between subsidy to schemes and the costs which they face. Although schemes can apply for 're-assurance', many may be reluctant to do so, partly because of the administrative hurdles involved, but also because of the presumed taint of 'mismanaging' the funds.

The DMHIS are heavily dependent on the subsidies they receive from the NHIA, which provides some 80-90% of their revenue. There are some who believe that the subsidy was deliberately set too low in order to undermine district schemes and so hasten centralisation. The original setting of the subsidy amount per member (which has since been adjusted upward by a small amount each year) was apparently based on the premia used by the existing mutual health organisations. However, these were offering very limited packages at the time, so could not have provided an accurate basis for such broad coverage as is offered by the NHIS.

One symptom of the cash short-fall is the fact that most schemes which used to up-front payments of 40% or so of claims to providers (while claims were checked) have stopped the practice in 2008. Some scheme managers report that while they had surplus to invest in

2007, there were none in 2008. In addition, they are put in a very difficult position locally, when they cannot pay facility claims, with pressure from local leaders etc.

The information provided on claims, nationally, suggests a more reassuring picture (Table 13), with an average annual expenditure per member of GHc 12.4 (within the subsidy for the year of GHc 14). Presumably, this relatively low figure is explained by the low level of claims settlement at year end (i.e. reflects the bills unpaid by the DMHIS, which caused the application for distressed scheme funding to rise abruptly early in 2009).

Table 13 Visits and claims by members, NHIS, 2008

Item	Number
OPD visits in year	9,045,457
Inpatient visits in year	838,141
Total visits	9,883,598
Claims paid (GHc)	129,161,433
Average payment per visit (GHc)	13
Number of cardholders	10,417,886
Average visits per cardholder	0.95
Average annual payment per cardholder	12.40

Source: author's calculations, based on figures from NHIA operations department

The Network of Mutual Health Organisations estimates an average of 1.4-1.5 visits per card holder per year. Doing a back-of-the-envelope calculation on this suggests that each claims officer (a fixed quota of 6 per scheme) must process around 1,500 claims a month, which is quite significant, given the need for vetting, as well as data entry. Most are reported to have backlogs. How much the new ICT system will help address this blockage is as yet unclear.

7.1.9 Impact of ICT

The introduction of a new ICT system, with interactive platform, is adding to delays on the ground. The following problems were reported to the review team by the district scheme managers:

- Districts are unable to analyse their own records
- The system for data entry is slow
- When the live link is down (which is not uncommon), data cannot be entered
- The antivirus programme is causing the system to freeze

From the provider side, there is also concern about the top-down way in which the programme is being implemented, with terminals being put in inappropriate places in facilities, without consultation or any discussion of how they are to be set up, used and maintained. According to key informants 80-85% of systems installed in facilities are not working. The processes for submitting claims remain as before (using Excel spreadsheet).

They are not aware of any plans to use this very expensive communication system for the benefit of the system as a whole.

While some of these features may be transitional - the inevitable teething problems of a new IT system – others may indicate longer term problems. It would be of great concern, for example, if the schemes continue to be unable to analyse their own data.

In addition to the new ICT system, delays were reported in getting the new NHIS membership cards, which are printed in Accra. Some schemes visited claimed they had backlogs back to last August. In the meanwhile, members have been issued with temporary cards.

7.2 Taking stock of the NHIS as a whole

7.2.1 Social health insurance versus district mutual health insurance model

The NHIA is proposing some fundamental changes to the way in which the NHIS works and presented amendments to LI 1809 to Cabinet in 2008. The objective is to remove the autonomy of the district schemes and merge them into a unified system. This offers advantages in terms of creating a single risk pool and also potential efficiencies in terms of processing claims in ten regional centres (rather than 145 district schemes). Set against that is the loss of local accountability and potential for local mobilisation which was a feature of the original 2003 Health Insurance Act (Act 650). A stronger decentralisation (with the NHIA as regulator, not fund manager, as at present, where it combines both roles) would mesh well with broader decentralisation, if the present government decides to pursue that goal.

This is a political issue, which calls for an inclusive debate, involving all stakeholder groups and considering all of the available information and options. The discussion should address the fundamental issues outlined in this section. It should also aim to increase transparency and communication between the main players. The current lack of information (also experienced by the review team) is causing a crisis of confidence relating to scheme management and other areas, such as procurement.

Given the fundamental importance of the NHIS to the health care system as a whole (with the NHIS now providing 41% of the total public resource envelope, according to the MTEF budget for 2009), the NHIA has be brought into any discussion of changes to governance in the sector and plans for integration. While it is essential that it is autonomous in managing its affairs, it is not independent and should develop more regular operational contacts with key units in the MoH and its agencies.

The NHIC and all district health insurance boards were dissolved in February and have not been reconstituted. The oversight of the NHIS at all levels is therefore in abeyance and needs to be re-established urgently. Ways of reducing board member numbers but making

them more effective and accountable should be discussed, learning from experience in areas with more mature schemes, such as Brong Ahafo.

7.2.2 Financial sustainability

Financial sustainability, in the current model, is threatened by a number of factors, including:

- Current payment systems (including incentives to over-prescribe and 'tariff creep')
- The absence of co-payments to limit demand
- A benefits package comprising an estimated 95% of all treatments in Ghana
- Poor gate-keeping in the health system (patients able to present at higher facilities without restriction – tertiary institutions use their polyclinics as an entry point into specialist care)
- Poor monitoring and control systems within the NHIS
- Low premia by the informal sector (around GHc 8 per person)
- High proportions of exempt groups

These have been highlighted by previous annual review reports and by ILO actuarial modelling (Leger 2006). It is hard to update and adjust these models in the absence of information on the NHIF, its revenues and expenditures for 2008 and its balance at year end. This information should be placed in the public domain urgently, as these are public funds for which the Council and NHIA are responsible, and lack of transparency erodes confidence in how well they are being invested and managed.

7.2.3 The one-time payment

The NPC government has committed itself to a 'one-time premium' for members of the NHIS. This is currently under study within the NHIA, to assess its longer term implications. On one level (financial), the implications are relatively modest, given that premia currently only contribute some 10% of the overall NHIS revenue, and generate collection costs. However, in terms of perception, the switch to a one-time payment is likely to alter the view of the NHIS as an insurance approach. It would then be seen as a tax-based system for funding curative care (using a third party payment mechanism), with some additional contributions from formal sector workers.

7.3 Impact of the NHIS to date

7.3.1 Monitoring and evaluation

In order to assess the overall impact of the NHIS, there should be a clear monitoring and evaluation framework which can be used by the NHIA itself, the district schemes, the providers and the MoH. At present this is absent, and the quality of data collected within the

NHIS system is inadequate to help steer its development. The new ICT system may assist in providing more detail on case-mix, treatments, trends in costs etc. However, a broader approach is desirable. A starting point for developing the indicators could be earlier reports, such as the framework paper produced in 2004 (Ghana Health Service & PHRplus 2004). The ILO has also developed financial indicators, which have been adapted in some districts by organisations dedicated to building district capacity, such as SNV.

7.3.2 Impact on household care seeking and expenditures

There has been little research to date on the impact of the NHIS in relation to household care seeking and expenditures, particularly as the NHIS has increased in scale. However, one study has compared baseline data in two districts, before the NHIS (in 2004) and after (in 2007) (Sulzbach 2008). Its findings suggest that there has been an increase in access to formal care amongst members, as well as a significant decrease in expenditure. However, there was no difference in use of maternal care (ANC, deliveries or caesareans) between the intervention and control group, which is an unexpected finding. In addition, the study showed that enrolment in the NHIS remained pro-rich.

According to a figure cited in a recent World Bank study, the out-of-pocket expenditures as a percentage of private expenditure on health reduced from 79.5% in 2000 to 78.8% in 2006 in Ghana (Beciu & Haddad 2009). This is a very modest improvement, but will hopefully escalate as NHIS coverage increases.

7.3.3 Equity

The NHIS is technically compulsory, and so should provide universal coverage. However, in practice, there are many barriers to joining – economic, geographic and cultural – and so membership remains partial and skewed against marginalised groups.

While the premium for informal sector members is low, there is also an enrolment fee (GHc 1-3 for all except pregnant women), which together are sufficient to deter many on low incomes. In addition, there are many living remotely who do not have easy access to health facilities and therefore may not perceive the benefits of membership. Analysis of data collected in two districts in 2007 found that while higher economic status affected enrolment (positively) (Asante & Aikins 2007), renewal of membership was not affected by economic status, but was affected by location – 88% of urban members said that they were willing to renew, compared with 57% of rural residents (Bjerrum & Asante 2009).

In addition, in the new insurance-financed system, money follows infrastructure – as the regional director for Greater Accra puts it in her annual report for 2007, a hospital with laboratory will tend to generate more income than a health centre without. There will therefore be a tendency (as with IGF previously) for higher facilities to capture reimbursements disproportionately, and similarly with areas (districts or regions) which

have higher levels of infrastructure. In this way, historical imbalances between areas are reinforced and perpetuated.

While the deterrent to recruiting 'indigents' has been removed (collectors are now paid the same commission, whether they recruit paying or exempt members), the definition of 'indigent' in the 2003 Act is very restrictive. Many district schemes have now asked community groups to identify the poorest for enrolment, but it is not clear how effective this strategy has been. Overall, 2% of the population was registered as indigent at the end of 2008 (compared to an estimated 28% living under the poverty line, according to 2006 GLSS figures). For cardholders, the proportion of the total population with NHIS cards for indigents was 1% for 2008 (Table 14). The MoH is now working with the Ministry of Social Welfare to use their system for identifying the poorest (under the Livelihood Empowerment against Poverty programme) to more effectively target them for free NHIS membership. The GHS has also done some useful analytical work in 2008 looking at the cost and leakage associated with different targeting approaches. In some regions, NGOs are also paying for cards for particularly vulnerable groups. All of these initiatives can be combined to ensure that more effective coverage is provided in future to the most vulnerable.

Table 14 NHIS card-holders, by category, 2008

Category of member	ID card holders	Proportion of total population
Informal sector	3,727,454	16%
Aged	816,956	4%
Under 18s	6,305,727	27%
SSNIT	811,567	3%
Pensioners	71,147	0.3%
Indigent	302,979	1%
Pregnant women	432,728	2%
Total	12,468,558	54%

Source: calculated, based on CEO presentation[23], 19th March 2009, Inter-agency performance review.

In 2009, the NHIA is proposing to add all under-18s to the exempt groups, whether or not their parents are enrolled. This (or a more limited approach of offering free coverage to the under-fives) is a further shift toward universal coverage, which may contribute to MDG goals, but would certainly need to be carefully evaluated from an actuarial standpoint.

One of the equity concerns relating to the NHIS is how it has affected the non-insured. When the new tariff was introduced in June 2008 it affected 'cash and carry' prices as much as those paid by the DMHIS. For the non-insured, who are commonly the less well off, this will have increased existing financial barriers to health care. Assessing to what extent the non-

[23] Note that these figures do not accord with those given by his agency (above). Card holders here are similar in number to registrants in table 1.

insured have been 'squeezed out' of the market is not straightforward, but at the fact that two-thirds of IGF is now generated by the NHIS, while membership is 45% of the population, suggests that the non-insured are using fewer services and/or less expensive services. Whether they are using fewer services than they did prior to the tariff hikes would require more in-depth study, but it seems intuitively likely.

As the NHIS extends towards full coverage, some of the equity concerns will be reduced. In addition, the current regional membership patterns (with high membership levels in the north, less so in areas such as Greater Accra) suggest that the rich in urban areas may be self-selecting out of the scheme for private care (though this hypothesis would need investigation).

7.3.4 Impact on quality of care

As the NHIS is pushing up consumption of health care, it is obviously critical that measures are put in place to ensure that the health care provided is appropriate and effective. As one key informant put it: 'We want health outcomes – not just to inject money!' This will involve investment on the provider side – investment in quality assurance systems, which are currently underfunded – as well as the development of an accreditation system, which has recently been piloted by the NHIA, with donor support (National Health Insurance Authority 2008). To be accredited, the provider will have to score more than 50% on the core modules, relating to organisation, quality assurance and staffing. If facilities fall below this level, they will be given six months to improve. If they score very highly, on the other hand, there may be some financial incentives, such as being paid a premium of 5% on reimbursements (for over 70% scores) or 10% (for over 85% scores).

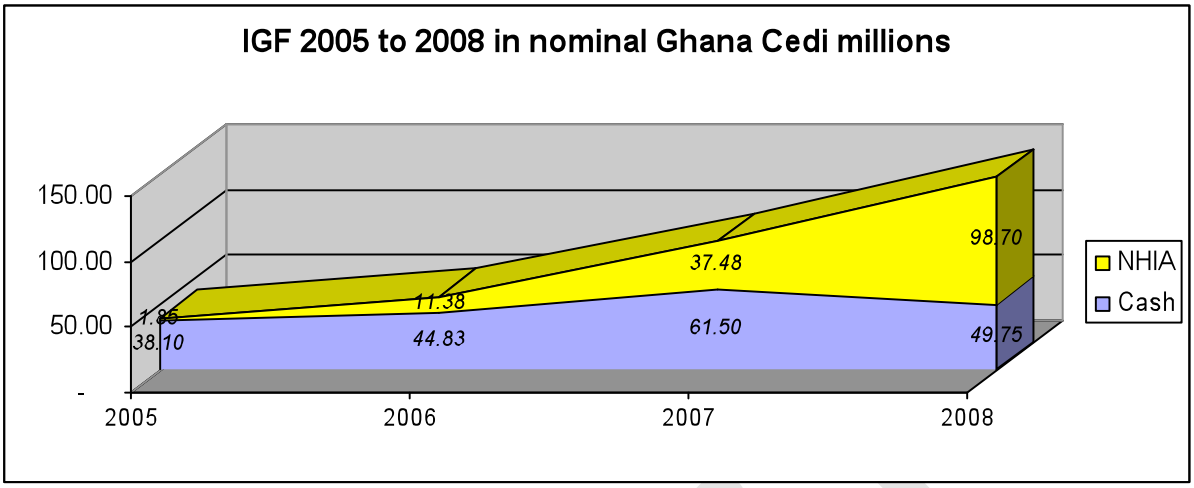
The accreditation system needs to be sensitive to the context of different facilities, but also have credible sanctions, which may be problematic, especially for public sector facilities. Additional resources may have to come from the provider side, but much can also be achieved by re-organising for more efficient processes. Training will be provided by the NHIA and partners, starting in April 2009.

7.3.5 Impact on overall health care expenditure, efficiency and the health system

The role of the NHIS has changed subtly but significantly over the past few years. Its original intention was to replace user fees and so reduce financial barriers to health care, inequity and health-related poverty. This is now changing, with a greater proportion of health care being funded through the NHIS channel. While user fees only constituted around 15% of the overall resource envelope in the first half of the decade, the NHIS is now estimated to contribute 41% of the overall revenue (according to the MTEF for 2009).

Initially it added to, rather than supplementing 'cash and carry' IGF: only in 2008 did the cash and carry component start to reduce (Figure 12).

Figure 12 IGF 2005-8, NHIS and 'cash and carry'



Instead of merely covering the recurrent non-salary costs of services, it is now gradually expanding to take on other functions. In the guidelines for the 2009 budget, item 3 and item 2 are either reduced or cut for facilities which generate income, and hospitals are directed to set aside 10% of IGF revenue for replacement of equipment and minor rehabilitation of infrastructure. IGF revenues are also used to pay staff. The overall need to control growth in PE may be being circumvented by the fact that institutions are increasingly able to hire 'casual' staff, paid by IGF. These personnel costs may be 'hidden' under item 3.

At the facility level, how are the growing revenues from the NHIS being used (from hospitals down to CHPS level)? Anecdotally, some are using them to upgrade facilities and pay for maintenance. Others are sitting on balances, perhaps because it is hard to get approval from district managers to release funds. Further investigation of how facility activities have been affected would be interesting.

The trend towards funding the full cost of curative care from the NHIS poses a risk, if the management of the NHIF is not fully transparent and sustainably managed. Early surpluses (based on low membership and accumulated funds from the period prior to commencement) should not create a false sense of security, particularly if cost containment mechanisms are not effectively implemented.

A separate concern is the balance between preventive and curative services. At present, those facilities generating revenue from the NHIS are becoming increasingly financially independent, while funds for public health activities, while not falling, are stagnant. This changes the power balance between hospitals, in particular, and health managers at district, regional and national levels. Ensuring that this does not contribute to increased health sector fragmentation requires careful thought and action. While there is some evidence that facility funds at the sub-district level are benefiting the wider district (relieving the need for district managers to pay for fuel for outreach etc.), there is no evidence of any redistribution from hospitals to health administrations.

Another area of concern is that the current payment system risks creating 'perverse incentives' to provide more curative and less preventive health care. In other countries, 'payment for performance' systems tend to incentivise public health activities. If the NHIA remains a significant funding channel for health care in Ghana, some thought might be given to modifying it to cover preventive care. This would not only benefit the health of Ghanaians but also save the NHIS money. This was noted in a recent study, which estimated the cost savings which could be generated by including family planning in the NHIS benefits package (Banking on Health 2008).

7.4 Conclusion

Relatively speaking, the NHIS is still young and subject to many pressures, financial and political. It is now four years old, and it is a good time to sit down and undertake an inclusive review, looking at what it can offer to Ghana and to the health system in particular. Which services are best financed through the NHIS? How much are they likely to cost? What trade-off should be made between widening coverage (in population terms) and providing a broad package of care? How can the NHIS be integrated into the sector, so that better operational links are developed at all levels? These are the big questions, and once those are settled, the more minor ones (but still very important) such as how quality is addressed and how costs are contained can follow.

Health financing is fungible, and what has been added to the sector resource envelope via the NHIS is being taken from other areas, such as HIPC, so an overall assessment of its function and benefits is necessary. The NHIS has generated high transaction costs[24]. These are only justified if it becomes a tool for purchasing cost-effective services and increasing the responsiveness of the system.

7.5 Recommendations

There are five main groups of recommendations.

An inclusive stakeholder review

- Stakeholder assembly to be held to review the NHIS, four years on from its inception, and to plan for its future sustainability and success
- It should include a clear presentation of the current information, the main options and their implications – the trade-offs that have to be made. The one-time payment would be one of the items to be considered here
- The structure of the system should be put on the table. What issues are best handled at what level? Where should accountability lie? Etc.

[24] Just looking at data for 2008, 45% of funds going to the NHIA, which appear in the budget, do not appear in the end-of-year financial statement (i.e. have not flowed back into the system via IGF payments to facilities or national level transfers to the MoH). These are effectively NHIA overhead costs.

- The agenda should also include a discussion of how working relations can be improved, especially between the NHIA and MoH, including more technical representation of the MoH on the NHIC
- Governance is also a high level issue, including the boards should be reconstituted or replaced and how the membership can be improved

Resolving claims management issues

- NHIA to streamline requests to MoF for Health Levy funds
- NHIA and other stakeholders to recalculate average costs per member, based on information on average costs and contacts. The ILO might be able to assist with this. This should feed into the subsidy level per member
- Meetings to be held with DHMIS and other stakeholders to resolve ICT problems, and plan for better use of ICT
- Giving more flexibility to DHMIS to set staffing norms (perhaps within an overall administrative budget which is linked to membership numbers)
- Once cash flow problems are resolved, restarting system whereby facilities are paid part of their claims upfront
- Facilities should review their 'business process' for handling claims to reduce the delay in presenting claims
- Is there a need for an independent adjudicator for disputed claims? Some areas have already set up vetting committees set up in some areas?
- There should be strong enforcement of the 'no payments' rule – any providers found contravening it should lose accreditation, at least for a period

Cost control measures

- One option to discuss is for drugs to be included in tariffs, to reduce over-prescribing. Need also to allow for drugs which are distributed free by vertical programmes, improved efficiency in purchasing pharmaceuticals
- A review of procurement is being conducted separately – this should also look at prices paid by NHIA for drugs. It may be able to reduce inefficiencies. The NHIA may also choose to restrict some of the more expensive drugs to specialists (at present, all drugs are available to all levels)
- Should the DRG tariff be set by type of care rather than level? Currently it is structured to pay higher amounts to higher levels, even though they may have lower unit costs because of high throughput. This encourages an upward movement of simple cases
- In the longer term, a switch to capitation-based payment systems provides more incentives to reduce costs and is generally a simpler reimbursement system to operate
- The NHIA should review its benefits to cover defined essential care packages at different levels, in coordination with the MoH. In other words, tertiary institutions should not be paid to carry out primary care, and primary care facilities should not be offering (and being reimbursed) for complex procedures which they are not equipped etc. to conduct.

- FP should either be added to the NHIS package or should be provided free at the point of use for households through central funding – this is a cost saving measure!
- In conjunction with the wider system, the NHIS should play its part in reinforcing gate-keeping through its tariff structure (it already does this to some extent, but this could be tightened even more)

Quality control

- The accreditation programme which is starting up is to be welcomed, but some issues need to be resolved, including the question of who invests in facilities which are failing to meet standards, and how sanctions and rewards can realistically be applied in the public sector (especially in areas with very limited competition between facilities)
- The best institutional home for the accreditation agency should also be reviewed. Should it be the NHIA, or an independent body, such as one of the professional regulatory bodies?
- The development of accreditation standards should be linked with the workload review discussed in the section on HR and with the definition of care packages to be provided by different facilities

Development of a clear plan for M&E

- The stakeholders should identify key indicators to be tracked, by the NHIS and providers, and operationalise them consistently, so that this great national experiment can be properly monitored and adjusted
- Within the NHIA, there is a need to develop operational research capacity
- The use of the category of 'registrants' is muddying the waters – it should be dropped and card-holders used instead. The databases of members also need cleaning so that consistent figures are produced
- In relation to the balance in the system of preventive and curative care, it is excellent to note that the MoH is planning to track this. That should tell a very interesting story and may inform the decision to include preventive care in the NHIS package. The impact of the NHIS on the non-insured is also an important sub-theme for monitoring

8 Reviewing the annual review process

The review process as a whole takes up the first four months of each year and involves a considerable expenditure of energy on the part of many players, not least the MoH PPME. The team were asked to reflect on how the process might be streamlined to reduce its intensity.

This question has to be considered in relation to the primary purpose and audience of the review (particularly the external review component). Historically, the independent review grew out of the SWAp process, and enabled pooled funding donors and government to jointly assess performance and make adjustments. The primary audience was the core of SWAp donors, who engaged in intense debate with Ministry and other partners and used the independent review as an accountability device.

In the post-SWAp world of Ghana and in the context of the Paris Declaration, this relationship no longer appears appropriate. The sector as a whole needs to take ownership over the review and is well able to do so. It may wish to involve external parties in participating, but participating is not the same as doing.

A second goal in any changes should be to reduce the amount of time and work involved in the review process. Given the low uptake of recommendations from previous reviews and indeed from the Aide Memoires, a more low-key approach would seem justified.

There are a number of options to be considered here. These are given as a menu for discussion. It is not appropriate for the review team to make recommendations here, but rather to outline some thoughts for further internal discussion.

8.1 Improving routine systems

One of the reasons why conducting the external review takes three weeks and seemingly intense external inputs is that routine data sources are not maintained and collated. It is hoped that with the strengthening of the DHIMS this will become easier (and more inclusive – as mentioned above, the inclusion of data from the private sector and NGOs is very important). If the quarterly reports are produced, and checked by supervisors for completeness and accuracy, then the whole task of producing and analysing summary data for the sector as a whole become easier. This is a year-round task, which should also be used as part of the regular management structures, to assess performance and provide support as necessary.

8.2 Condensing the BMC reviews and planning processes

At present, there is a long process of BMC performance review, rising from district to national level, in January to April, which is shortly thereafter followed by a separate set of

BMC planning meetings for the following year. Would it not be possible for the BMCs and agencies to submit reports on key results in January-March but hold to performance review meetings jointly with planning meetings later in the year (June-July), looking back and forward at the same time? This would considerably reduce the time involved and might speed up the provision of information to the national level so that annual reports could be completed on time.

8.3 The Partners' review

The review of DP's performance in 2008 took the form of a self-assessment questionnaire, using various criteria for harmonisation and alignment. Having observed the process and read the draft report, it seems that there were a number of major flaws, including non-comprehension of questions, a high non-response level, a highly biased sample of respondents, and a failure to respond in depth to many of the questions. One system which might work better would be to agree on benchmarks (which would have to be tailored to the type of donor and their organisational constraints), and then conduct peer assessment and support throughout the year, so that each donor can track and report on its own movement (hopefully in the right direction).

8.4 Reducing the frequency of the external review

The PPME could draw together a group of staff from relevant agencies to put together the core indicators each year, and submit these, with discussion of overall trends and current issues, to the Health Summit for discussion. This could be supplemented by more in-depth mid-term and end-of-Five Year PoW reviews, involving a mixed team of local and international consultants.

8.5 'Internalising' more of the annual (national) review

Alternatively, a core 'internal' team could put together indicators and analysis annually, to be discussed by and with international consultants, but who would visit for a shorter time, in April, to discuss the findings, jointly visit the field, and then participate in the Health summit and finalisation of the review report.

This would also improve the timing of the visit, which currently takes place in mid-March, when much of the data is not yet available. By early April, the financial statement and other documents would be prepared, which would save time – and so money.

9 The governance of the sector

Governance was not a priority area identified for the team in the TORs. However, in addressing some of the topics of the report, including the existence of a number of parallel and competing structures, the Review Team should focus on the role of governance. The theme of the review, *pulling together, performing better*, indicates that governance is the key issue for improvement of performance of the health sector. The message is that districts should become the pivot of health services planning and delivery. The higher levels have as core business to facilitate that work, and serve the grass root level. In this approach there is no place for empire building, silo thinking or competition between agencies, programmes or DPs.

9.1 Institutional reform in the health sector

For the past few years, there has been discussion of the need for changes to the legislative framework for the health sector in Ghana, to improve interagency cooperation and clarify roles and functions. This was a focus of the annual review of 2006, and has since been the subject of a separate study by Shawbell Consulting. Discussions around reorganisation are on-going and need to take account of the new NPC government's agenda to create a more integrated health service.

One very positive development of 2008 has been the revitalisation of the Inter-Agency Leadership Committee, which is creating more unity in the sector, with high-level strategic issues tabled for joint decision-making and mutual accountability for implementation. This more 'informal' approach to harmonisation may indeed produce many of the gains which legislative reform was intended to achieve, if mutual accountability within the group is enforced (reporting back on agreed actions etc.). Donors are also supporting leadership training at different levels in order to improve working relationships, horizontal and vertical.

9.2 Government/DP relations

At present there is a sense of drift in relations, according to key informants, with Development Partners and governments following their own tracks without a common framework. While the formal CMAIII may no longer be appropriate, there is now more than ever a need for an agreement on how to cooperate in such a manner as can maximise benefits for Ghana.

A 'Terms of reference: Health HIV and AIDS Sector Group' document provides the only framework at present. However, as noted in a recent report by the IHP+ (July 2008), while it may provide a basis for sector dialogue, it 'fails to provide an effective guide for promoting harmonisation and alignment of partner financing, programme implementation and management, accounting and reporting systems with that of government. … It does not commit partners to clear benchmarks for financing and for harmonising and aligning their

systems'. The report sets out a recommended process for arriving at new Compact (or MOU, or CMA III).

There is a clear willingness among some earmarked fund donors to improve on coordination and working with government systems. This should be exploited and should link with the district planning approach outlined below. The measures described above (in PFM) to improve financial planning, management and reporting should also increase donor confidence to put their funds through the GoG systems and should satisfy accountability requirements by linking resources to programmatic output areas.

9.3 Comprehensive district health planning, budgeting & management

Comprehensive district health management reinstates the district as the pivot for planning and implementation, as it was meant in the early days of health sector reforms in Ghana. The district focus also anticipates developments of devolution, whereby District Assemblies will play a bigger role in health care management.

9.3.1 Comprehensive planning and management

At the heart of the integration process, which should move the health system from programme-centred to client-centred work, is the comprehensive district health planning and management.

The planning is comprehensive because:
- It incorporates the whole range of services from community level up to district hospital level
- It involves all relevant stakeholders: GHS and other agencies operating at district level, District Assembly, CHAG, NGOs and interested private providers
- It follows a bottom-up procedure whereby community representatives, facility representatives and sub-districts contribute to priority setting and planning.

The management is comprehensive because:
- Stakeholders are transparent towards each other in their capacities, resources and constraints and commit themselves to mutual support
- In quarterly district health stakeholders' meetings involved parties monitor progress based on plans, DHIMS data, etc.
- Adjustments in plans are made jointly

9.3.2 Comprehensive District Planning

Steps in the planning process

1. National level framework for the planning process
   - Package of Essential Health Services, describing four levels of services: community, CHPS, health centre, hospital. The package is based on national policies and

strategies, as defined by programmes, re-aligned in service packages, crossing lines of vertical programmes (as intended in HIRD)

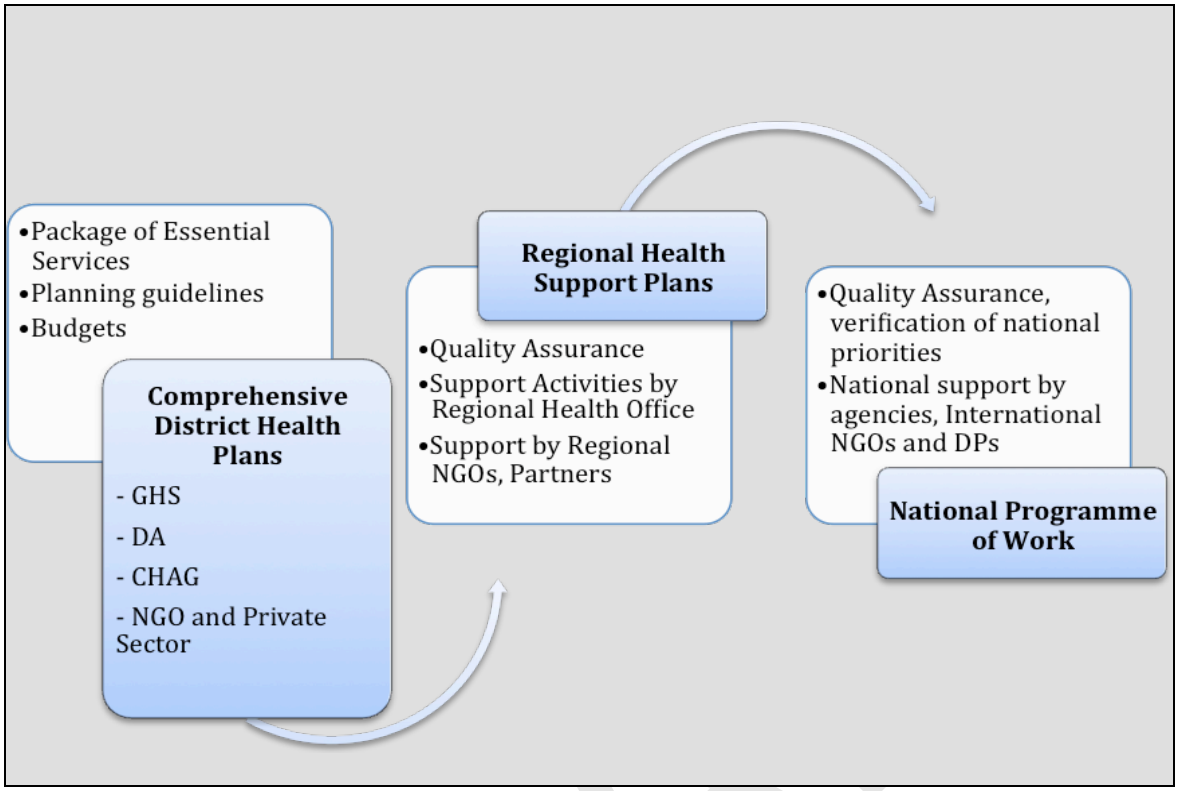
- Planning guidelines are issued annually by the MoH and include guidance on the planning process. The guidelines can be developed on the basis of the 10-step guideline for the HIRD planning. The planning guidelines should include a few absolute priorities on which districts cannot miss out. The planning guidelines also provide the format for the plan, and a few priority indicators that should be monitored.
- Budgets: to the extent possible the national level provides estimates budgets for relevant items. National or international NGOs can declare their intended support, even if provided in kind. Fund-holders at national level (e.g. Global Fund) declare their intended support. Districts add their own estimates for income for IGF.

2. Comprehensive District Health Plans
   - Districts produce their plans in a bottom-up, multi-stakeholder mode, using the national guidelines, whereby inputs and contributions from various stakeholders are described. These are joint plans, not exclusive GHS plans. However, the contributions and (if possible) budgets from stakeholders are identifiable.
   - The Regional Health Offices, regional NGOs or agencies can offer coaching services, but should support the comprehensive approach. The regional level can help in quality improvement, etc.

3. Regional Support Plans
   - The Regional Health Offices, together with NGOs or agencies which operate at a regional level produce a support plan, which summarises the main points of the district plans and describes how the regional level can support, facilitate and supervise the districts
   - The national level can support regions in producing support plans and can verify whether the regional plans (built on district plans) contain the national priorities.

4. National Programme of Work
   - The National Programme of Work is built on the Regional plans and adds all elements of support that different agencies provide.
   - International NGOs, MDAs, and other entities can “buy” into the national programme of work.

Figure 13 The district-based planning process



9.3.3 National agencies in the planning process

National agencies declare in the initial phase of planning, what kind of support they can give to district health services. Where they actually provide services at district level (e.g. regional hospital doubling as district hospital), the institutions participate in the district planning. Where the agencies or institutions under an agency have clearly defined functions, not related to district functions, they make their own plan. Regional institutions produce plans, which become part of the regional support plan, and national agencies summarise their regional plans and the contribution head quarters can make to the National Programme of Work.

9.3.4 Integration of earmarked funding

Agencies and Development Partners which manage earmarked funding, declare in an early stage:

- Which type of activities they wish to support or carry out with districts
- Which districts and/or regions they wish to support
- How they will provide support, e.g. financial, material, technical support
- Which local providers are eligible for support (GHS, CHAG, CBOs, etc.)
- Time frames, monitoring requirements, etc.

The MOH can use this information to identify "orphan" districts or regions and can provide extra financial support to those areas, ensuring that they can fulfil the package of services.

The rules for earmarked funding are:

- Declare in an early stage the mode of operation that is tied to the support, communicate through the district planning guidelines the intentions, harmonise with commonly agreed timeframes
- Buy into district plans and regional support plans, but do not maintain parallel planning processes. Stick to national agreed times for planning
- If necessary, support districts with TA to bring plans up to standard, as required by back-donor. Stick to agreed formats. Extract from district and regional plans what is necessary for submission to the back-donor
- Do not put up parallel processes of reporting, extract from district reports what is required
- Not ready to buy-in, move-out!

9.3.5 Comprehensive district health management

Each stakeholder has its own management system for day-to-day management.
Stakeholders know their commitments, they have made in the plan, and know what to implement. However, regular interaction has to be planned between managers of different stakeholders to ensure coordination.

- The GHS district health management team coordinates exchange
- All service providers provide quarterly information on agreed indicators
- Essential is the quarterly stakeholders' meeting, in which all contributors to district health services participate, as well as representatives from the District Assembly. Progress on performance is discussed and reasons for non-performance analysed.
- Quarterly plans are adjusted to realities on the ground, with consent of the stakeholders

The District Mutual Health Insurance Systems may join in the discussion n the quarterly meeting to discuss their contribution to the health system, discuss issues of accreditation, payment systems, etc.

Community participation can be enhanced, first of all through the participation of the District Assembly in the quarterly meetings, but also through participation of CBOs, e.g. representing the CHPS zones.

The regional level (RHO and regional NGOs) can participate in the quarterly district meetings and listen in. The regional level has a function in coaching and monitoring.

Six-monthly, there should be meetings at regional level to exchange between districts and to strengthen the regional collaboration.

Annually there is a comprehensive evaluation, linked to the preparation of the planning round for next year.

9.3.6 Opportunities and risks

Going back to a district system of planning and management contains opportunities and risks.

The opportunities mainly consist of:

- Re-instating professional pride of local health workers: giving them the trust and the power to do things better. Empowering people can break inertia and boost morale.
- Enabling PPP at grass-root level, giving CBOs, local NGOs a place in the health system.
- Instituting a system of mutual accountability, where hiding behind excuses is no longer possible. (Experiments in districts elsewhere have shown positive results.)
- Offering opportunities for agencies with earmarked funding to become part of a system and stop operating as a foreign body. The discussion on harmonisation and alignment can move to practical solutions and willingness to operate in team spirit.

Risks consist of:

- Lack of capacities at district level. It is possible that there are not sufficient local managers available who are able to take on this task. However, coaching systems and local technical assistance can help overcoming such problems.
- Lack of trust from the top-level, from local stakeholders, from communities, etc. This is potentially the most dangerous threat. Transparency of values and goals of participating organisations is needed to open up communication.
- Predictability of resources. Late transfer of funds, or unavailability of supplies creates enormous frustrations at grass root level. Buffer funds could ameliorate this problem.

9.4 Recommendations on governance

Institutional reform

- Pursue the IALC approach in order to enhance and enforce mutual accountability of agencies, to work on agreed sector goals

Government/DP relations

- Develop a new MOU/CMA3/Compact, which can lay down clear rules of operating, which incorporate the Paris Declaration principles. These can then be used as part of the peer assessment process described above.

District planning

- Pursue a comprehensive district management approach, as outlined in this report

10 Conclusions and recommendations of the review

After taking readers through a lot of detail on a wide-ranging set of issues, we return to our central theme. So much talent, so much commitment, so many resources, so many partners – how can all of these be pulled together more effectively to provide a health care system which really serves the people well? How can we all play our part in this? This is not the problem of one group or one agency – this is something to take as a collective responsibility, which we can collectively solve.

We think the solution starts with a district-based approach, as outlined in the last chapter, but which has to be supported by strong core services. These strong core services are the subject of the earlier sections – the public health and clinical care programmes; the human resource planning departments; the budget and finance sections, and the systems which they use to allocate and account for resources; and the NHIS, which now contributes such as significant part of Ghana's health spending.

What will drive change in Ghana? Here are six reasons for optimism:

1. The new Government is providing strong leadership for a new universal and integrated health service
2. The trend is towards enforcing collective responsibility on agency heads in the sector
3. Performance management initiatives are moving towards a system of recognising achievement and penalising failure, at all levels of the system
4. There is also a shift towards decentralising some core functions, such as HR management, and this could be taken further to provide greater financial autonomy within an output-based budgeting system
5. There has been progress in areas like planning towards simple and integrated approaches. These can be developed further. No more non-communication! No more silos!

We end with a table summarising the recommendations from the various sections.

Table 15 Summary of recommendations

Recommendations	Primary Actors	Other stakeholder
1. Service delivery		
1.1 Turn the QA programme into a crosscutting theme, in all programmes and all agencies and link the QA programme to the NHIA as multi-agency initiative	GHS, NHIA	All service providers
1.2 Bring in state-of-the-art approaches in development of clinical guidelines	GHS	All service providers
1.3 Unite the National Ambulance Service and Facility-based ambulances in one organisation and give it an important place in reduction of maternal mortality	MoH, GHS, Teaching Hospital	
1.4 Develop a policy and protocols for medical disasters and	MoH, GHS,	All service

epidemics preparedness and bring the lead under MoH	Teaching Hospital	providers
1.5 Reinstate the comprehensive district health management system, based on partnerships between GHS, CHAG, NGOs and private providers, that integrates vertical programmes and give districts pivot role in implementation of the under-5 Child Health Strategy, the Reproductive Health Strategy and other relevant strategies	MoH, GHS, CHAG, NGOs	All service providers
1.6 Give District Assembly and population a role in decision making on priority setting and utilisation of funds	MoH, GHS	
1.7 Map and analyse present practices of volunteerism and best practices in CHPS for harmonising community health approach.	GHS, NGOs	Interested DPs and agencies
1.8 Integrate the RHNP into GHS NCD and health education programmes, ensuring that the multi-agency, multi-sector concept remains preserved.	MOH, GHS	Other stakeholders regenerative health
Health Information Systems		
2.1 Ensure full implementation of DHIMS in 2008, including entering information from 1st January 2008	MOH, GHS	
2.2 Optimise system to enable decentralised dataflow	MOH, GHS	
2.3 Install virus software on all PCs operating DHIMS and ensure regular virus updates	GHS	
2.4 Continue education of District Information Officers to reach full coverage by end 2009	GHS	
2.5 Provide quarterly reports on implementation status and completeness of reporting	GHS, MoH	
Human Resources		
3.1 Disseminate he proposal developed by the HRDD of the MoH after the Roundtable conference to all stakeholders for inputs and buy-in. The proposal should be supported in its implementation	MoH	GHS, Tertiary hospitals, CHAG and others
3.2 Review the production strategy of human resource to reflect the future health scenario.	MoH	GHS, Tertiary hospitals, CHAG, training institutions
3.3 Enhance and support the Interministerial Posting Committee to continue with its decentralisation of health workforce management and increasing agency ownership and responsibility.	MoH, GHS, tertiary hospitals, CHAG	
3.4 Develop, as a matter of urgency, basic criteria for determining staffing norms that reflect the level of services, expected coverage and desired quality of patient outcomes and get them adopted by agencies to support the efficient utilisation, distribution and productivity of staff.	MoH	GHS, Tertiary hospitals, CHAG, training institutions
3.5 Hold national conference on human resource productivity with all stakeholders to share current experiences, define and agree on parameters of workforce productivity, and	MoH	GHS, Tertiary hospitals, CHAG, training

develop models of implementation and measurement		institutions
3.6 Develop criteria and models for agencies to work towards to ensure the successful implementation of decentralised salary management	MoF	MoH and agencies
3.7 Recognise the private sector as a credible and willing employer of the health workforce being produced. Efforts should be made to support the private sector to grow so it can absorb the workforce being created.	MoH	
National Health Insurance Scheme		
4.1 Organise stakeholders' assembly to review the NHIS, four years on from its inception, and plan for its future sustainability and success. Clear presentation of the current information, the main options and their implications: premium, structure, accountability, working relations, representation, Board composition	MoH	NHIA, GHS and other stakeholders
4.2 Resolve claims management issues: Streamline requests to MoF for Health Levy funds, Recalculate average costs per member and subsidy level per member Plan for improvement and better use of ICT Give more flexibility to DHMIS to set staffing norms Restart system whereby facilities are paid part of their claims upfront	NHIA	DMHIS, GHS, CHAG
4.3 Review the 'business process' in health facilities for handling claims to reduce the delay in presenting claims	GHS, CHAG and private providers	NHIA, DMHIS
4.4 Institute independent adjudicator and vetting committees, if necessary to resolve disputes and enforce no-payment rule	NHIA, DMHIS	
4.5 Initiate discussions on cost-control, on following: Discuss drugs to be included/excluded in tariffs Reduce over-prescribing Look at prices paid by NHIA for drugs Set DRG tariff by type of care rather than level (reduce tariffs for tertiary hospitals performing primary health care) Reinforce gate-keeping Switch to capitation-based payment systems (long-term)	NHIA, MoH	GHS, CHAG, Tertiary Hospitals, private providers
4.6 Continue accreditation programme, including quality improvement, and develop incentives and sanctions for institutions	NHIA	GHS, CHAG Private sector
4.7 Link accreditation system of NHIA to accreditation system of PHNHB and discuss where prerogative of accreditation should be based on the long-term.	NHIA, PHMHB, MoH	
4.8 Develop clear plan for M&E Define key indicators to be tracked by NHIA, DMHIS, providers; develop clear definitions for card-holder	MoH	NHIA, GHS, CHAG
4.9 Develop operational research capacity Track impact of funding from insurance on non-insured	NHIA, MoH	GHS

and on preventive health		
Financial Management		
5.1 Develop a monitorable and credible PFM Plan of Action for the health sector to be monitored by the Health PFM Group.	MoH	
5.2 Carry out a review of computer systems operating throughout its agencies and select a single off-the-shelf software for use as a standard throughout	MoH	
5.3 Create better links between PPBU and Finance, including a monthly meeting of a budget working group to monitor key aspects of the PFM plan including synchronisation of the harmonising Estimates, POW Budget and Financial Statement	MoH	
5.4 Strengthen resource allocation processes by ensuring regular quarterly meetings of the MoH HQ Budget Committee, which will also serve to strengthen PPBU links with Finance Division	MoH	
Governance		
6.1 Pursue the IALC approach in order to enhance and enforce mutual accountability of agencies, to work on agreed sector goals	MoH	All agencies
6.2 Develop a new MOU/CMA3/Compact, which can lay down clear rules of operating, which incorporate the Paris Declaration principles. These can then be used as part of the peer assessment process described above.	MoH, DPs	
6.3 Pursue a comprehensive district management approach, as outlined in this report	MoH, GHS	CHAG, other service providers
The annual review process and holistic tool		
7.1 Consider the options proposed for reducing the intensity of the annual review process, including: improving routine data sources; reducing frequency of external reviews; 'internalising' more of the analytical process; strengthening the partner reviews; and condensing the BMC review and planning cycle.	MoH, DPs	
7.2 Continue using the current holistic tool as it stands until the end o f the five year PoW, and then review it	MoH, DPs	

Annexes

A.1 Holistic Assessment of performance in the Health Sector 2008

Introduction

The holistic assessment of performance in the health sector is a structured methodology to assess the quantity, quality and speed of progress in achieving the objectives of the POW 2007-2011. The primary objective of the assessment is to provide a brief but well-informed, balanced and transparent assessment of the sector's performance and factors that are likely to have influenced this performance. The assessment is based on indicators and milestones specified in the operational annual POW, derived from the strategic POW 2007-2011 which is linked with the GPRS II. More specifically, the analysis underlying the holistic assessment is based on the following elements:

- POW 2007-2011 Sector Wide Indicators and Milestones
- Annual POW including budget
- Annual Performance Review Reports from MOH and its Agencies
- Annual MoH Financial Statement

Process

An initial assessment, in regards to realization of milestones and trend of indicators, is conducted as part of the annual independent health sector review process, following a predefined methodology. This assessment will be presented at the April Health Summit where overall performance of the sector will be discussed, taking into consideration factors which may have influenced performance. The assessment will be negotiated and agreed upon by Ministry of Health and its Development Partners during the subsequent Business Meeting, informed by discussions at the Health Summit. The outcome, regarded as the Holistic Assessment of performance in the Health Sector, will serve as an input into the Performance Assessment Framework (PAF) of the Multi Donor Budget Support (MDBS). The process is expected to facilitate establishment of consensus on the sector performance. Such consensus is regarded as important for the constructive sector dialogue and uniform approaches in budget support mechanisms.

Method

The assessment is in three steps:
First, each indicator and milestone is assigned a numerical value of -1, 0 or +1 depending on realization of milestones and trend of indicators.
A milestone is assigned the value **+1** if the review team is provided with a note from relevant authority specifying realization of the milestone, otherwise it is assigned the value **-1**.
An indicator is assigned the value **+1** if (colour coded green):

- The indicator has attained the specified annual target regardless of trend
- The indicator has experienced a relative improvement by more than 5% compared to the previous year's value

An indicator is assigned the value **-1** if (colour coded red):

- The indicator has experienced a relative deterioration by more than 5%

- If no data is available

An indicator is assigned the value **0** if (colour coded yellow):

- The relative trend of the indicator compared to previous year is within a 5% range
- *The indicator has previously not been reported*

Second, the indicators and milestones are grouped into Goals and Strategic Objectives as defined in the Programme of Work and the sum of indicator and milestone values are calculated. Goals and Strategic Objectives with a positive score are assigned a value of +1, -1 if the total score is negative and 0 if the total score is 0.

Third, after assigning a numerical code for each of the Goals and Strategic Objectives the numerical codes are added together to determine the sector's numerical code.

Results

Step 1: Results individual indicators and milestones

Goal 1 – Ensure that children survive and grow to become healthy and productive adults that reproduce without risks of injuries or death

All indicators for Goal 1 are based on survey data. The data from the Ghana Demographic and Health Survey of 2008 have not yet been published, and could therefore not been included in this year's holistic assessment.

Goal 2 – Reduce the excess risk and burden of morbidity, disability and mortality especially in the poor and marginalized groups

HIV prevalence among pregnant women 15-24 years

*Outcome: **-1** – INFORMATION NOT AVAILABLE*

Source: NACP - GHS

2006	2007	2008
2.9%	2.6%	-

The HIV Sentinel Survey for 2008 has not been finalized and data is therefore not available. In previous years, the prevalence has ranged between 2.7 and 3.2. It is unclear why the annual target specified in POW 2008 is 4%, a value which is significantly higher than the previous many years' prevalence rates.

Guinea Worm – 501 cases

*Outcome: **+1***

Source: NGWP - GHS

2006	2007	2008
4,136	3,358	**501**

The Guinea Worm incidence has continued previous years' sharp decline to 501 cases in 2008, which is significantly below the target of maximum 2,000 cases.

Goal 3 – Reduce the inequalities in access to health services and health outcomes

Equity – Geography (Supervised Deliveries): 1.97

NR	-	21.4%	26.0%
Equity indicator	2.05	2.14	**1.97**

*Outcome: **+1***

Source: Reproductive and Child Health spreadsheet -

	2006	2007	2008
CR	54.3%	-	-
WR	26.5%	-	-
BAR	-	45.9%	51.1%

GHS

Compared to 2007 the geographical equity index (supervised deliveries) has seen an improvement by 8%. The best and worst performing regions are the same regions as in 2007, namely Brong Ahafo Region (51.1%) and Northern Region (26.0%). Both regions, however, have improved performance compared to 2007.

Equity – Geography (Nurses/Population ratio): 2.03

Outcome: +1

Source: IPPD - MOH

	2006	2007	2008
GAR	N/A	N/A	**1:952**
AR	N/A	1:1,429	**1:1,932**
UWR	N/A	1:3,225	(1:1,042)
	4.14	2.26	**2.03**

The inequality in distribution of nurses has improved by some 10% from 2007 to 2008. The lowest density of nurses is Ashanti region with 1 nurse per 1,932 inhabitants, and the highest density is found in Greater Accra Region with 1 nurse per 952 inhabitants. While the northern regions are relatively highly staffed with nurses, the figures below show that there is significantly lower density of medical and dental clinicians in these regions compared to other regions. The IPPD figure include all nursing categories, midwifes and community health nurses, but does not capture nurses working as district directors of health services or in the private-for-profit sector. Figures from 2007 should be interpreted with caution as they were calculated as a mean of HR and Clinical Care information. The sources of information differ from 2007 to 2008 and comparability can be questioned.

	AR	WR	NR	BAR	CR	VR	UER	ER	UWR	GAR	Ghana
Indiv. per 1 nurse	1,932	1,775	1,770	1,767	1,312	1,138	1,126	1,111	1,042	952	1,353
Indiv. per 1 doctor	9,939	33,461	73,257	21,685	26,887	28,806	47,130	17,837	47,130	5,431	13,499

Table 1: Nurse and doctor population rate by region. Lower is better. Source IPPD - MOH

Equity – Gender (Female/Male NHIS Card Holder ratio): 1.22

Outcome: 0

Source: NHIA

2006	2007	2008
N/A	N/A	1.22

2008 was the first year of reporting on this indicator, hence the neutral score. Not all DMHIS have reported female/male ratios, a total of 95% of all NHIS registrants have been included.

Strategic Objective 1 - Healthy Lifestyle and Healthy Environment

Milestone: Working group on safe food and water established; implementation plan completed, costed and adopted

Outcome: +1

Source: Foods and Drugs Board

Working group established, plans and budgets finalised and presented to MOH.

Strategic Objective 2 – Provision of Health, Reproduction and Nutrition Services

Milestone: Clinical protocols established for the early detection and treatment of diabetes, cardio-vascular diseases and common forms of cancer

*Outcome: **-1** – INFORMATION NOT AVAILABLE*

Source: GHS department of Non-communicable Diseases

% Deliveries attended by a trained health worker: 39.3%

*Outcome: **+1***

Source: Reproductive and Child Health spreadsheet - GHS

2006	2007	2008
44.5%	35.1%	**39.3%**

The proportion of supervised deliveries has increased with 12% from 35.1% in 2007 to 39.3% in 2008, but did not achieve the target of 60%. There are large differences between regions with 51.1% in BA and 26.0% in NR as outliers.

	NR	WR	CR	AS	VR	UWR	UER	ER	GAR	BA	Ghana
Supervised deliveries	26,0%	27,7%	34,3%	35,0%	37,5%	38,1%	40,4%	48,0%	50,2%	51,1%	39.3%

Table 2: Supervised deliveries by region. Source RCH spreadsheet.

Couple Year Protection (Short Term): 462,556

*Outcome: **-1***

Source: Reproductive and Child Health spreadsheet

2006	2007	2008
N/A	765,566	**462,556**

The CYP for short term methods has significantly decreased from 765,566 in 2007 to 462,556 in 2008. In the same period however, the FP acceptor rate increased from 24.3% in 2007 to 32.7% in 2008.

Antenatal Care Coverage: 97.4% (62.4% with 4+ ANC visits)

*Outcome: **+1***

2006	2007	2008
88.4%	89.5%	**97.4%**

In 2007, 89.5% of pregnant women had *1 or more* ANC visit compared to 97.4% in 2008, an increase of 8.8%. 62.4% had *4 or more* ANC visits.

%U5s sleeping under ITN: 40.5%

*Outcome: **-1***

Source: Report of Evaluation of Impact of Malaria Intervention HPG/JS,

2006	2007	2008
41.7%	55.3%	**40.5%**

Compared to 2007, use of ITNs by U5s saw a decline in 2008. Regionally, the lowest proportion of children who slept under an ITN was in the Northern Region with 23.2%, and the highest region was Upper West with 69.7%. Results from the 2008 EPI programme survey, which also included assessment on ITN utilisation, reports the national median at 61.3%.

Penta 3 immunization: 86.6%

Outcome: 0 – within margin of <5% change

Source: EPI

2006	2007	2008
84.2%	88.0%	**86.6%**

The Penta 3 coverage, reported through the routine system, has seen a minimal decrease of 1.1% from 88.0% in 2007 to 87.0% in 2008. In terms of absolute numbers, 12,075 additional children were immunised.

HIV Clients receiving ARV therapy: 23.614

Outcome: +1

Source: NACP

2006	2007	2008
7,338	13,249	**23,614**

ART clients have increased with almost 80% from 2007 to 2008.

Out Patient Visits: 0.77

Outcome: +1

Source: CHIM

2006	2007	2008
0.55	0.69	**0.77**

OPD visits per capita increased by 11% from 2007 to 2008, and the indicator is well above the POW 2008 target of 0.6 visits per capita (a target which was lower than the previous year's performance). Table 4 displays large inter regional variances.

	NR	GAR	CR	UWR	VR	AR	WR	ER	UER	BA	Ghana
OPD/capita	0,49	0,51	0,68	0,70	0,73	0,73	0,86	0,97	1,01	1,30	0.77

Table 3: OPD per capita by region. Source CHIM – GHS.

Institutional MMR:

Outcome: -1

Source: Reproductive and Child Health spreadsheet

2006	2007	2008
219	224	

Available Institutional MMR data included TBA deliveries.
Information about live births and maternal deaths in facilities could not be obtained.

TB success rate: 84.7%

Outcome: +1

Source: NTP

2006	2007	2008
67.6%	76.1%	**84.7%**

The TB success rate increased with 11% from 76.1% in 2007 to 84.7% in 2008.

Thematic Area 3 – Capacity Development

Milestone: Annual workforce productivity information being used in performance management systems in all regions

Outcome: -1 – INFORMATION NOT AVAILABLE

Source: RHHD

Doctor: Population Ratio

Outcome: 0

Source: IPPD

2006	2007	2008
1:15,423	1:13,683	1:13,449

The population to doctor ration has slightly improved from 2007 to 2008. The total number of doctors in 2008 was 1,747 of which 1,230 (70%) were concentrated in GAR and AR. Regional distribution is presented in Table 1. The indicator figure from IPPD includes all clinical doctors, public health doctors and dentists who are on the *government payroll*, i.e. employed with GHS, Teaching Hospital or CHAG. Medical Doctors functioning as district director for health services are not included. Doctors working in the private-for-profit sector are not included. Regional distribution is presented in Table 1.

Nurse: Population Ratio

2006	2007	2008

Outcome: ***+1***

1:2,125	1:1,537	1:1,353

Source: IPPD

The population to nurse ratio has significantly improved from 2007 to 2008. The total number of nurses in 2008 was 17,431 including nurses, midwifes and community health nurses, but not including health technicians, extension workers etc. The figure includes only nurses who were on the *government payroll*, i.e. employed with GHS, Teaching Hospital or CHAG. Nurses working as district directors of health services could not be included in the calculation of the indicator and nurses working in the private-for-profit sector were not included. 6,751 nurses were concentrated in GAR and AR, representing 39% of all nurses. Regional distribution is presented in Table 1.

Thematic Area 4 – Governance and Financing

Milestone: Enhanced collaboration with Ministry of Manpower Development and Employment on the identification and targeting of the poor with subsidies and service

Outcome: ***+1***

Source: MOH

Several meetings were held with MMYE on expanding NHIS coverage to beneficiaries of the Livelihood Empowerment Against Poverty (LEAP) programme which is a key component of the Government's National Social Protection Strategy. Funding to cover an additional 16,000 new NHIS beneficiaries was disbursed by MOH from the 2008 budget, and the two ministries are currently finalising a Memorandum of Understanding.

% MTEF on Health

Outcome: ***0***

Source: Annual Budget Statements

	2006†	2007	2008
MTEF allocation – Health	478,654,800	563,756,400	752,233,368
MTEF allocation – Total	2,948,398,300	3,869,832,200	5,059,868,063
% MTEF allocation to Health	16.2%	14.6%	**14.9%**

While the total allocation to health, in nominal terms, increase by 33.4% from 2007 to 2008, the proportional MTEF allocation to health only slightly increased by 2.1% in the same period, which results in a neutral outcome of this indicator.

† It is not clear how the baseline for 2006 was calculated and the value might not be comparable to 2007 and 2008 (source 2007 health sector review report).

% Non-wage GOG recurrent budget allocated to district level and below

Outcome: ***+1***

Source: MOH

2006	2007	2008
40%	49%	49%

Per capita expenditure on Health (USD)

Outcome: ***0***

Source: MOH

2006	2007	2008
25.4	23.0	23.23

Budget Execution Rate of Item 3

Outcome: ***0*** *– No comparison data for last year*

Source: MOH

2006	2007	2008
N/A	N/A	**115%**

The budget execution rate of item 3 exceeded 100%, primarily because of increased NHIA expenditure on reinsurance of district schemes in financial distress. Only Health Fund and HIPC disbursements were significantly below budgeted allocations. The indicator includes the following sources:

Source	Revised budget	Disbursed	Execution
GOG	10,039	9,497	95%
SBS	39,526	39,526	100%
Health Fund	500	239	48%
NHIF	145,230	177,410	122%
- Subsidy	133,730	129,650	97%
- Distress	5,000	37,760	755%
- MoH	6,500	10,000	154%
HIPC	3,243	1,556	48%
Total Item 3	**198,538**	**228,228**	**115%**

Table 4: Budget Execution Rate by Source

% of annual budget allocations to item 2 and 3 disbursed by end of June

*Outcome: **0** – No comparison data for last year*

Source: MOH

2007	2008
N/A	N/A	23%

The proportion of budget allocations to item 2 and 3 disbursed by end of June has not previously been reported, therefore no trend can be analysed.

% Population with valid NHIS card

*Outcome: **+1***

Source: NHIA/CHIM

	2006	2007	2008
Active Members	3,955,203	8,291,666	10,417,886
Population	22,303,947	22,933,235	23,582,502
% Active Members	17.7%	36.2%	**45%**

The total number of card holders increased from 8,291,666 in 2007 to 10,417,886. NHIS coverage has apparently not been adjusted for population growth in the previous review reports, hence the difference in 2007 and 2006 coverage compared to earlier reports.

% of claims settled within 4 weeks

*Outcome: **-1** – INFORMATION NOT AVAILABLE*

Source: NHIA

2006	2007	2008
N/A	N/A	N/A

% of IGF from NHIS

*Outcome: **+1***

Source: Financial Controller - MOH

2007	2008
N/A	N/A	66.5%

Step 2: Grouping of indicators and milestones and group score calculated

GOAL 1 NOT INCLUDED	N/A
HIV prevalence	-1
Guinea Worm	+1

GOAL 2 TOTAL	**0**
Equity – supervised deliveries	+1
Equity – Nurses to population	+1
Equity – Gender	0
GOAL 3 TOTAL	**+2**
Milestone	+1
STRATEGIC OBJECTIVE 1 TOTAL	**+1**
Milestone	-1
% supervised deliveries	+1
Family Planning – CYP	-1
ANC	+1
%U5s use of ITN	-1
Penta 3	0
HIV+ receiving ART	+1
OPD per Capita	+1
Institutional MMR	-1
TB success rate	+1
STRATEGIC OBJECTIVE 2 TOTAL	**+1**
Milestone	-1
Doctor to population	0
Nurse to population	+1
STRATEGIC OBJECTIVE 3 TOTAL	**0**
Milestone	+1
% MTEF on health	0
% non-wage recurrent to districts	+1
Per capita expenditure on health	0
Item 3 budget execution rate	0
% item 2+3 disbursed by end June	0
% population with valid NHIS card	+1
% NHIS claims settled within 4 weeks	-1
% IGF from NHIS	+1
STRATEGIC OBJECTIVE 4 TOTAL	**+2**

Step 3: Combined initial assessment

The outcome of the initial combined assessment of the health sector's performance in 2008 is positive with a score of +4.

GOAL 1	N/A
GOAL 2	0
GOAL 3	+1
STRATEGIC OBJECTIVE 1	+1
STRATEGIC OBJECTIVE 2	+1
STRATEGIC OBJECTIVE 3	0
STRATEGIC OBJECTIVE 4	+1
Combined initial assessment	**+4**

Discussion and recommendations for indicator adjustments

Effort has gone into identification and documentation of stable and reliable sources of information. The Holistic Assessment Tool is based on trends of indicators, and comparable year-on-year data is critical. Below is a discussion of problems encountered during the 2008 assessment and recommendation for adjustments.

Equity – Gender (female/male card holder ratio). The DMHIS do not report gender ratio of card holders to the NHIA, and this year's assessment relies therefore on the reported *registrants* rather than *card holders*. It is recommended to change the definition of this indicator to reflect availability of data.

Family Planning (Contraceptive Prevalence Rate). The indicator for Family Planning specified in the Holistic Assessment Tool booklet is "Contraceptive Prevalence Rate for modern methods *(CYP used as a proxy)"*. A target for the indicator in POW 2008 is specified for Contraceptive Prevalence Rate and *not* CYP. It is recommended to either specify target for CYP in the next POW or rather use the Contraceptive Prevalence Rate as indicator for the Holistic Assessment Tool.

Antenatal Care Coverage: The definition of the ANC indicator in the 5YPOW implies an assessment of women who have 4 or more ANC visits during pregnancy. Previous sector reviews, including the 2007 review, reported the proportion of pregnant women *registered* for ANC, i.e. attending only *1* or more ANC visits. It is recommended that next year's assessment will be based on the original definition of this indicator, i.e. proportion of women having 4 or more ANC visits.

Institutional MMR: The MCH calculation of institutional MMR for 2008 included TBA deliveries, representing 24% of all recorded deliveries, in the denominator. It is not clear whether the numerator, i.e. total number of maternal deaths, also includes death recorded by TBAs outside facilities, and it is unclear whether the indicator for institutional maternal mortality previously has included TBA deliveries in the denominator. Inclusion of TBA deliveries in the denominator has a risk of deflating the institutional MMR figure and reducing the usefulness and consistency of this indicator. The dataset provided by MCH does not allow for calculation of a strict institutional MMR because neither the number of live births (only total number of deliveries) nor the number of maternal deaths are disaggregated into TBA and strict facility based events. It is recommended to tighten up the definition of this indicator to exclude TBA deliveries and community deaths.

% Non-wage GOG recurrent budget allocated to district level and below: It is not clear how the value of this indicator is calculated.

Per capita expenditure on health (USD): It is recommended to specify whether beginning-of-year, mid-year or end-of-year population figure is used. The GHS to USD exchange rate should also be specified (source, beginning-of-year, mid-year or end-of-year). This figure is based on the Financial Statement, which currently excludes some NHIA expenditures which are not reported to the MoH.

Budget execution rate of Item 3: There is no specified target for budget execution rate of item 3. It is recommended to define a *target range*, e.g. 95%-110%. Any trend towards that range would be regarded as a positive trend.

% of annual budget allocations to item 2 and 3 disbursed by end of June: It is unclear whether disbursement is defined as the date of submitting memo for disbursement, date of actual disbursement from MOH accounts or date the funds end up in the recipients account.

In 2008, the date of submitting disbursement memo has been used for the analysis. It is recommended to specify the definition of disbursement.
% Population with valid NHIS card: NHIS coverage has apparently not been adjusted for population growth in the previous review reports. It is recommended to adjust for population growth on annual basis.

Discussion and recommendation for the holistic assessment tool

2008 was the first year for which the holistic assessment tool was applied in its final form. The assessment was done as part of the independent sector review of the 2008 Programme of Work.

Despite efforts from the Ministry of Health and its agencies, the larger part of necessary information for the assessment was not available at the beginning of the review, and the much time was spent on information collection and double checking data reliability.
The grouping of indicators and milestones creates some imbalances in relative weights of individual indicators and milestones. An example is the milestone for Strategic Objective 1, which is the only milestone/indicator for this objective and therefore carries the full weight in determination of the aggregate score for strategic objective 1. This is compared to strategic objective 3 with 8 indicators and 1 milestone all equally influencing the aggregate score of this strategic objective.

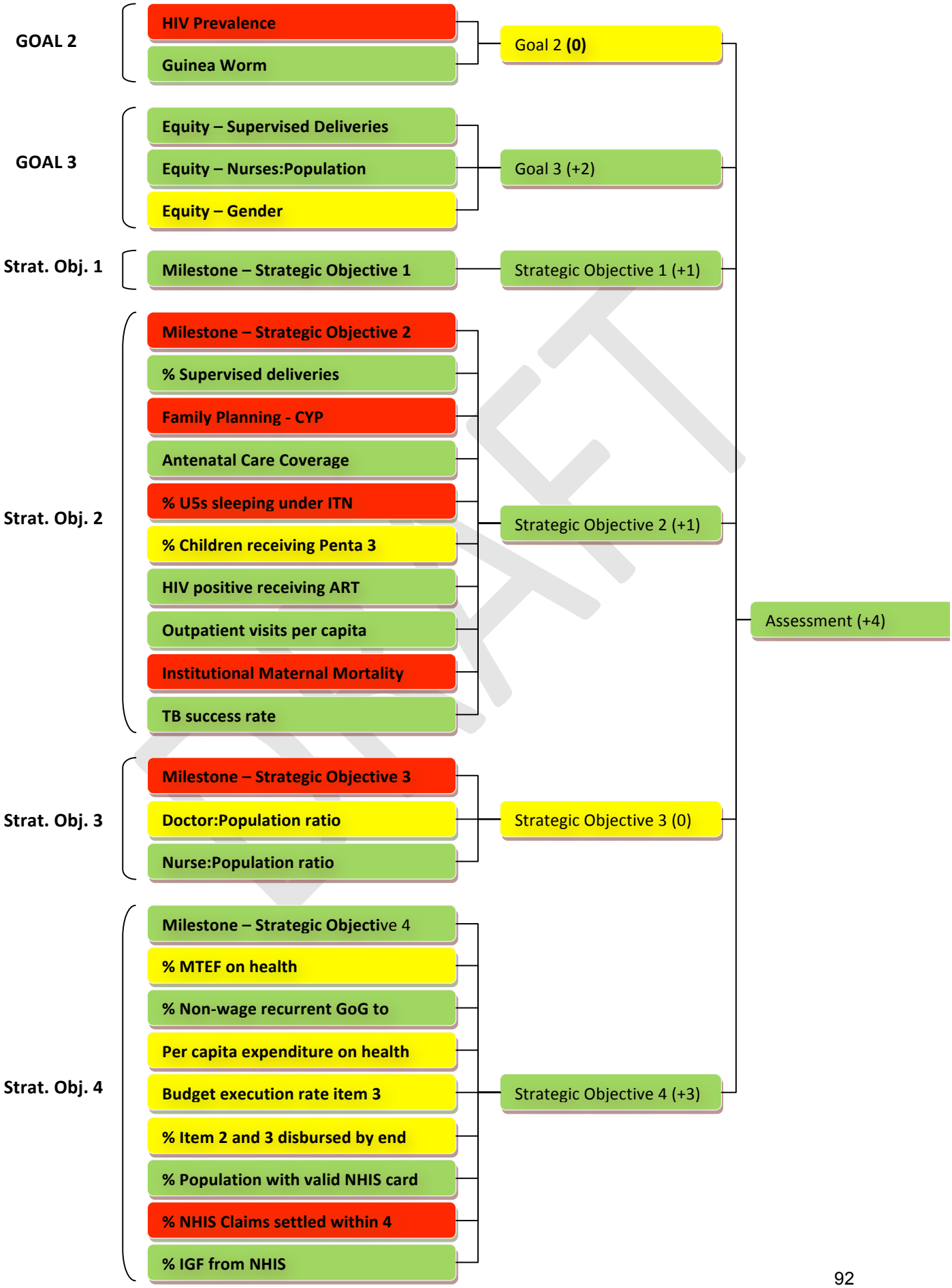
In the holistic assessment, achievement of the annual target of any indicator precedes over trend of the indicator. Critical and rigorous annual target setting is therefore a precondition for the assessment to be meaningful.

Increased complexity of the tool will not necessarily lead to increased reliability and despite limitations with respect to weighing of indicators and definition of positive trend, it is recommended to repeat the use of the holistic assessment tool in its current form for the remaining years of the 5-Year Programme of Work 2007-2011.

A future version of this tool could concentrate more on indicators which bear more implicit quality, like percentage fully vaccinated children by 12 months, or percentage of women visiting antenatal clinics at least four times.

The review team considers the holistic assessment tool to be an interesting and innovative approach to broaden the base for sector performance and MDBS level. Compared to previous practise of basing the MDBS evaluation of the health sector on development within few selected indicators, it is believed that the outcome of the assessment will be more representative for development in the sector as a whole.

Colour Coded Assessment



Definitions and calculations for 2008 holistic assessment

Indicator	Numerator	Denominator	Source	Calculation 2008
HIV Prevalence among pregnant women 15-24 years	Newly diagnosed HIV positive pregnant women at NACP sentinel sites	Total number of pregnant women test at NACP sentinel sites	National AIDS Control Programme. Sentinel Surveillance report.	N/A
Incidence of Guinea Worm	New cases	N/A	National Guinea Worm Programme annual report	N/A
Equity Index: Geography (supervised deliveries)	Proportion of deliveries attended by a trained health worker in best performing region	Proportion of deliveries attended by a trained health worker in poorest performing region	Maternal and Child Health Unit annual report	
Equity Index: Geography (nurses: population)	Number of nurses by total population in best performing region	Number of nurses by total population in poorest performing region	IPPD – Ministry of Health. Population data from CHIM	
Equity Index: Gender (NHIS registration)	Number of women registered with NHIS	Number of men registered with NHIS	NHIA	6,526,065/ 5,339,328
% deliveries attended by a trained health worker	National number of deliveries supervised by trained health worker	National number of expected deliveries	Maternal and Child Health Unit annual report	370,400/ 943,350
Family planning - Couple Year Protection (Short term methods)	One CYP = 13 cycles of Pill = 4 doses Depo = 120 Condoms = 120 VF Tabs = 5 cans cream/jelly.	N/A	Maternal and Child Health Unit annual report	N/A
Family planning – Contraceptive Prevalence Rate	Number of FP registrants	Target population (0.24 x total population)	Maternal and Child Health Unit annual report	1,824,720/ 5,660,099
Antenatal care coverage	Number of pregnant women registered to	Expected number of pregnancies	Maternal and Child Health Unit annual report	919,008/ 943,350

	received ANC			
Antenatal care coverage	Number of pregnant women with 4 or more ANC visits	Expected number of pregnancies	Maternal and Child Health Unit annual report	588,468/ 943,350
% U5s sleeping under ITNs	Number of surveyed U5s sleeping under ITN the previous night	Number of surveyed children	Malaria Control Programme annual report	1,558/3,850
% Children receiving Penta 3	Number of children who received Penta 3	Expected number of children 0-12 months	EPI programme annual report	817,154/ 943,326
% Children fully immunized by age 1	Number of surveyed 0-12 months being fully immunized	Number of surveyed 0-12 months	EPI programme annual report	?/?
HIV positive individuals receiving ART	HIV positive individuals receiving ART	N/A	NACP annual report	N/A
Outpatient attendance per capita	Number of OPD encounters (GHS, CHAG, Teaching Hospitals)	Total population provided by CHIM - GHS	CHIM – Ghana Health Service	18,075,258/ 23,582,502
Institutional Maternal Mortality Ratio	Number of maternal deaths at government and CHAG institutions, excluding TBA deliveries	Number of live births in government and CHAG institutions, excluding TBA deliveries	Maternal and Child Health Unit annual report	955/359,286 (MCH calculation including TBA deliveries)
TB success rate	Number of patients proven to be cured of TB after completion of therapy	Number of patient commencing anti-TB therapy	National TB Programme annual report	?/?
Doctor: Population ratio	Number of doctors registered at IPPD/MOH	Total population provided by CHIM	IPPD – MOH. Population data from CHIM	1,747/ 23,582,502
Nurse: Population ratio	Number of nurses registered at IPPD/MOH	Total population provided by CHIM	IPPD – MOH. Population data from CHIM	17,431/ 23,582,502
% total MTEF on Health	MTEF allocated to health. Sources: GOG +	Total MTEF for GOG	Current year's GOG Annual Budget Statement	

	Donor + IGF + HIPC + NHIS			
% non-wage GOG recurrent budget allocated to district level and below	This figures is calculated by the MoH. Further clarification is being sought on which funding flows this % applies to (GoG, SBS, Programme Funds etc.)			
Per Capita Expenditure on Health	Total expenditure on health in USD, exchange rate from Bank of Ghana per 01.07.2008	Total population provided by CHIM - GHS	MOH Financial Statements. Population data from CHIM	
Budget Execution Rate of Item 3	Item 3 disbursements from GOG + SBS + HF + HIPC + NHIS (subsidies + distress + MOH allocation)	POW item 3 budget (same sources).	PPME – MOH	
% of annual budget allocations to items 2 and 3 disbursed by end of June	Disbursements for item 2 and 3 by end of June. Sources: GOG and SBS.	Total budget allocations for item 2 and 3 (same sources)	PPME – MOH	
% Population with valid NHIS Membership	Total number of active NHIS members (valid NHIS card holders)	Total population provided by CHIM - GHS	NHIA annual report. Population data from CHIM	
Proportion of claims settled within 4 weeks	Number of claims reimbursed (disbursed from DMHIS accounts) within 4 weeks of reception by DMHIS	Total number of claims received by DMHIS	NHIA annual report.	N/A
% IGF from NHIS	Total claims amount paid by DMHIS	Total IGF	NHIA annual report. MOH financial statements.	

A.2 2008 POW agency-specific expected results and main reported performance

Expected results (PoW 2008)	Reported results (agency presentations)
Ministry of Health	
Approved 2009 POW and Budget Improved compliance to financial regulation (reduction in audit queries) Effective execution of budget (predictability and variance) Reduced lead time in procurement Broad and inclusive policy dialogue (representation at partners meetings) Stronger evidence for policy and accountability (timeliness of reporting) Medicines and logistics supply security	Draft 2009 POW and Budget developed and approved by stakeholders No report on other priorities (though additional activities reported, e.g. establishment of Inter-Agency Leadership Committee
National Health Insurance Authority	
One hundred and forty-six (146) operational schemes Increased coverage of total population Increased coverage of indigents, aged and under 18s Reduction in fraudulent registration Reduction in number of distress schemes Increased compliance with conditions for referrals	145 operational schemes Increased coverage from 8 million to 9 million active members (card holders) No information on exempt groups, fraud, number of distressed schemes, or referrals presented
Ghana Health Service	
Coverage of key health interventions Proportion of health institutions meeting accreditation criteria Timeliness and completeness of surveillance reports Quality of midwifery care	Increased OPD visits per capita Decreased under 5 malaria case fatality rate Increased TB treatment success rate Increase in number of people on ART Number of guinea worm cases declined by 85% Proportion of guinea worm cases contained 85% No deaths from measles since 2003 Targets for key surveillance indicators achieved

	Increased antenatal care coverage Increase in skilled deliveries Decrease in number of maternal deaths Decrease in Institutional MMR
Christian Health Association of Ghana	
Professional staff recruited An operational HMIS Timely and accurate monthly, quarterly and yearly financial reports	Due to the effective collaboration between GHS and CHAG, all service data are reported at the district level. GHS data thus includes that of the CHAG institutions. Establishment of management support systems Performance monitoring Human resource development Strengthened data base on CHAG HMIS Improving knowledge management and sharing Capacity development in claims management, leadership training, and financial management Strengthened the establishment and use of health management information systems An overview of CHAG staff on the government payroll was made. This led to the introduction of a new policy on staffing In June 2008, CHAG and UNFPA initiated a study aimed at improving emergency obstetric care and ASRH services in 10 CHAG facilities in the Volta Region. Ready support to member institutions on issues of health insurance, budgeting, and human resource
Korle Bu Teaching Hospital	
Increase in number of referred cases as against OPD cases Physical structures modernized and rehabilitated Financial management practices and internal controls improved Staffing levels improved New equipment provided to replace obsolete ones	Modernization of structures + new equipment in progress Financial management improvement in progress
Komfo Anokye Teaching Hospital	
Improved care outcomes (reduced institutional deaths) Increased efficiency in use of resources (optimal use of hospital beds and other resources)	Mortality audit meetings conducted Hospital QA committee strengthened Directorates QA committees strengthened

Improved critical care services (human resource for critical care developed) Operational research activities increased	6 major research activities conducted Series of workshops on project design and management organized Financial Monitoring & Controls strengthened IGF increased by 25.01% above budget IGF increased by 25.615 over 2007 Ratio of Cash & Carry/NHIS 3:7
Tamale Teaching Hospital	
Management practices improved (new management structure with designated sub-BMCs created) Staff numbers increased Revenue generation improved Emergency services functional	Four Directorates operationalised (sub-BMCs) Draft HR strategic plan available Draft MOU discussed with UDS Motivational plan at developmental stage Emergency services not set up IGF almost doubled Internal Audit office established
Psychiatric Hospitals	
Coverage of outreach services Number of psychiatric nurses and psychiatrists trained/recruited Functional detoxification unit established for Pantang Functional laboratories for all facilities Increase in IGF	Mental health bill – not passed but accepted as priority of the MoH HR development: ▪ 1 psychiatric resident enrolled ▪ 1 diasporean psychiatrist returned from abroad ▪ Trained 5 Medical Assts for psychiatry Expansion by PPME of Psychiatric NTC intake Started discussions with Hampshire Trust to train MAPs and CMHOs Embarked on specialist outreach services to NR, UE, UW, WR and GAR Alcohol and drug rehabilitation – started at Pantang Promotion and prevention – ongoing Began work on establish of Mental Health Information Systems in collaboration with MHaPP Collaboration with NGOs pursued Started discussions with GNPC (procurement centre) to include newer psychiatric medicines on EML
National Ambulance Service	
Six new ambulance stations established/number of districts with functional ambulance services	Five new ambulance stations fully operational

One hundred EMT-Bs trained and 45 EMT- Bs upgraded Immunisation of 100% EMTs against hepatitis B	Twelve proficiency enhancement training workshops were held for Emergency Service Providers UHF communication system operational in Sekondi and Tamale GOTA communication system operational in all the Ten regions Seven simulation exercises held with stakeholders - GNFS, Military, Police, NADMO, Ghana Aviation Authority, Sport Council EMTs provided with a set of uniform and accoutrements Salaries of all staff mechanized All EMTs have been screened for hepatitis B All EMTs have completed the 1st round of immunization Expand ambulance service to new districts not achieved
Food and Drugs Board	
Guidelines on food and drug safety developed Improved knowledge in basic food safety among food processors and handlers Increased surveillance activities on safety of food and medicinal products	Guidelines submitted for approval Various sensitization activities carried out Surveillance activities carried out
Nurses and Midwifes Council	
Staff numbers of the Council is improved Supervision strengthened through increased visits to training schools and sites New curricula for post basic nursing programmes developed Two zonal offices of council established	Staff of council increased Supervisory visits conducted Public health nursing curricula reviewed 2 zonal offices established
Medical and Dental Council	
The capacity of the council to pursue its mandate is improved (update of register to reflect actual numbers of doctors and dentists practicing in the country) Training Institutions' curricula reviewed 10 district and 2 regional hospitals accredited for housemanship training Standards and guidelines of professional practice updated	No results presented
Pharmacy Council	
Increase number of licenses issued to pharmacies and chemical sellers in deprived areas	No information given

Percentage population knowledgeable in RUM increased	
Traditional Medicine Council	
Effective structures for the regulation and practice of Traditional Medicine in Ghana At least **500**TMPs registered and certified and **300** licensed practice premises	Draft documentation of organisational structure awaits finalisation No traditional medicine practitioners were accredited Staff have been recruited A draft LI for Act 575 has been produced
Private Hospitals and Maternity Homes Board	
Private healthcare facilities database updated Revised and Amendment legal instruments Functional council established	Database update ongoing No info on other priorities
Centre for Scientific Research into Plant Medicine	
Increased use of herbal medicinal products developed at the centre in health facilities, including public health institutions Internship programme for Medical Herbalist streamlined. Two satellite centres for clinical services established	Curricula being developed for students, interns and traditional health practitioners No satellite centres established

A.3 Background information on PFM in Ghana

The current GoG programme of PFM reform is encapsulated in the Short and Medium Term Action Program (SMTAP) which is approaching the end of its three year implementation period 2006-2009. The SMTAP is an umbrella PFM programme which encompasses actions in nine areas including budget formulation/preparation; budget implementation; aid and debt management; payroll management; the financial regulatory and management framework, including computerised accounting systems; revenue management; and capacity development. As SMTAP ends, a fresh programme is likely to be developed by the new government. While there may be shifts of emphasis, the key issues are unlikely to change, and it will be important to align public financial management reforms in the health sector with the national programme as it develops.

The last national assessment of Public Expenditure and Financial Accountability was in 2006, and of 28 indicators 2 scored a "A", 7 scored a "B", 15 scored a "C" and 3 scored a "D". 1 indicator was unscored for lack of data. Significantly in respect of issues that arise in the health sector, the "D" scores at national level include poor budget predictability at the sector level; poor internal audit; and inadequate information on resources reaching the service delivery level. A further PEFA is planned for the current year.

Relevant recommendations of the 2009 draft ERPFM

At the sectoral level, it is recommended that a sectoral budget review committee be (re)-established to co-ordinate sectoral policy and review effectiveness of budgets and resource use against these policies. They would also review and approve the sector's MTEF expenditure strategy. These committees would comprise senior officials from across the sector, including planning and budget departments. The sector budget committee may be supported by a technical level sector working group.

Strengthen links at the sectoral level between policies and budgetary allocations. The main focus of the bottom up analytical process of linking budget resources to policies should become more strategic, with the preparation of sector expenditure strategies, which would set out sectoral expenditure policies, specific intra-sectoral priorities and the associated expenditure implications over the medium term, including expenditures from all sources of funds and covering all inputs, within the aggregate resource constraints provided by MoFEP. The intra-sectoral allocations could be shown according to broad programmes/objectives, for example, by service level for the education sector. For example, the Annual Sector Operational Plans, such as those produced by MoESS, provide a useful start in this regard and could be expanded to cover the medium term and include analyses of the impact of recent spending decisions. As part of this process, MDAs should plan and prioritise their intra-sectoral and intra-MDA expenditures according to different scenarios (e.g. in the event of particular percentage reductions in revenues during the year). It would also aim to review the cost effectiveness of on-going policies and identify potential areas of efficiency savings.

Restructure the budget format. This process would involve moving towards viewing trade-offs across and within broad programme areas for all line items (for which service delivery

and new policy objectives may be made) and away from trade-offs in terms of line items (e.g. making budget choices between items 1 vs. items 3 and 4). This would involve a shift in thinking by MDAs and the ability to prioritise and address expenditure trade-offs between/amongst policy areas covering all sources of funds together. If desired, detailed activity-based operational plans could be prepared by MDAs and, if necessary, used by CAGD, although in time greater management discretion should be provided to MDAs to manage their own resources within broad parameters; expenditure control would then focus on expected performance.

Simplicity in programmes works most effectively. It is important that information requested from sector ministries is not overly detailed, time-consuming or unlikely to be credible. E.g. three-year allocations for detailed activities are unhelpful when the first priority should be to get broad resource allocations more in line with sector strategies.

In the medium-term, once there is a more effective strategic budgeting framework in place, sectors and MDAs can being to introduce new elements (such as performance indicators). International experience[25] would caution against introducing such indicators too quickly (see below).

[25] See annex on lessons from international MTEF experiences.

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