
# REPRODUCTIVE HEALTH FINANCING IN GHANA

## Results from the National Health Account Study (2018-2022)

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# 1. Introduction

## 1.1 Background to reproductive and child health

Through the Millennium Development Goals (MDGs), the world expressed solidarity in support of the global agenda to benefit the world's poorest and most vulnerable [1]. On health, the goals were to reduce child mortality, improve maternal health and in a special way push to combat HIV/AIDS, malaria and other diseases [2]. For the MDG story, it was reported that in Ghana, the Maternal Mortality Ratio (MMR) fell from 216 per 100,000 live births in 1990 to 144 per 100,000 live births in 2014, even though this fell short of the global target of 54 per 100,000 live births in 2015 [1]. The inequalities between rural vs. urban residential areas persisted over the period, with Skilled Birth Attendants (SBAs) attending to approximately 27% of births in the Northern rural region as compared to 84% of births in the Greater Accra region.

Despite the achievements regarding MDGs, many countries faced numerous challenges during the fifteen-year journey of aspiration which gave birth to the Sustainable Development Goals (SDGs) that, health-wise aim at ensuring that all people live healthy lives and enjoy well-being at all ages [3] so that countries can improve reproductive, maternal and child health in addition to ending epidemics of HIV/AIDS, malaria, Tuberculosis and Neglected Tropical Diseases (NTDs) plus

Non-Communicable Diseases (NCDs) which in the end accelerate the universal health coverage (UHC).

By 2020, globally, progress in many health-targeted areas had been achieved even though more acceleration power was needed. For instance, the global maternal mortality ratio fell by 38 per cent between 2000 and 2017, from 342 deaths to 211 deaths per 100,000 live births [4] representing a 2.9% decrease compared to the targeted 6.4%.

The 6.4% annual decrease is a global recommendation to achieve the global target of 70 maternal deaths per 100,000 live births by 2030. The translation of 2017 figures meant that approximately 810 women died, daily, from preventable causes related to pregnancy and childbirth in the whole world. Strangely, of these deaths, 86% are accounted for by Sub-Saharan Africa (SSA) and Southern Asia.

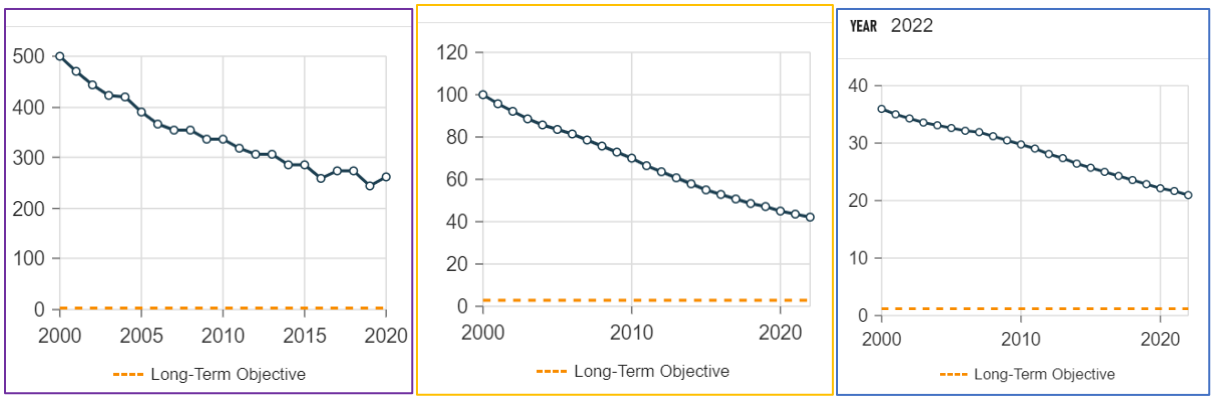
For children, the global under-5 mortality rate (U5MR) reduced from 76 deaths per 1,000 live births in 2000 to 42 in 2015 to 39 in 2018. The neonatal mortality rate (NMR) reduced from 31 deaths per 1,000 live births in 2000 to 18 deaths per 1,000 in 2018 worldwide. Regardless of this porous progress, it is still strange to have approximately 5.3 million children die before reaching their fifth birthday in 2018 alone [4] with almost 50% of these deaths (U5MR) occurring within the first 28 days of life. Again, this is headed by the SSA where 1 out of 13 children died before celebrating their 5$^{th}$ birthday which was 16 times higher than those in high-income countries [4].

## 1.2 Reproductive and Child Health Indicators

The ambitious objective of SDG 3 is to lower the global MMR to a maximum of 70 deaths per 100,000 births, with none of the nations having an MMR that is more than multiple times the global mean to which [5] asserts that it is a major challenge in countries with limited resource setting like the SSA and Ghana in particular. Studies have found that in addition to limited financing, the other areas which are a hindrance to this goal include poor health service location, poor road networks, poor quality health care, inadequacy and absenteeism of health care workers which largely put the mothers seeking delivery services at risk [5, 6]. The trends showing Ghana's progress are shown in Figure 1.

Figure 1: Trends of reproductive and child health indicators for Ghana

**MMR** **U5MR** **NNR**




SDG 2030 Targets – MMR, U5MR & NNR

| | | |
|---|---|---|
| 01 | MMR | 70 deaths per 100,000 livebirths |
| 02 | U5MR | 25 deaths per 1,000 livebirths |
| 03 | NNR | 12 deaths per 1,000 livebirths |

Ghana has made progress in reducing MMR from 499 deaths per 100,000 live births in 2000 to 263 deaths per 100,000 live births in 2020 representing a 47% reduction (Figure 1). While this is commendable progress, it shows that the rate of decrease must be more than doubled if the global target of 70 deaths per 100,000 live births by 2030 is to be achieved which is a gigantic task. The NMR in Ghana was 21.1 deaths per 1,000 live births in 2022 while the U5MR was 43.3 deaths per 1,000 live births for the same year [7[1]] which means that 1 in every 48 children die within the first 28 days of life.

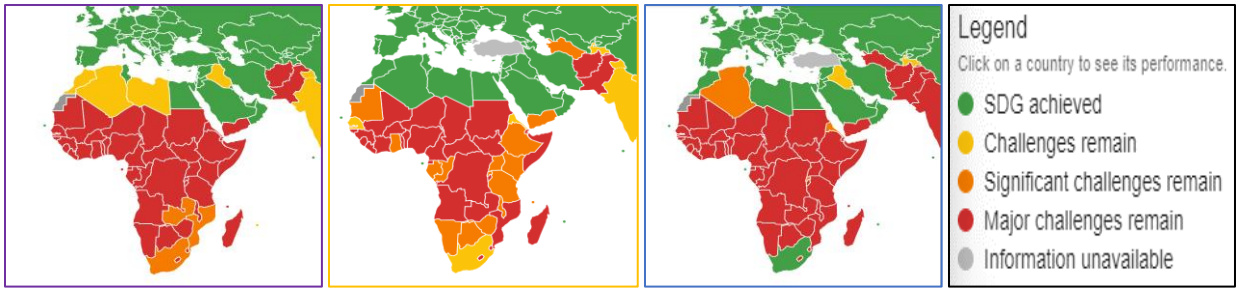
Regardless of Ghana's progress, maternal and child health issues continue to be a vast impediment which then suggests that there is a need to study the key areas which might point to the root causes and one of these is health financing towards reproductive, maternal and child/neonatal health. The comparison of Ghana's status to other countries can be seen in Figure 2 obtained from WHO[2].

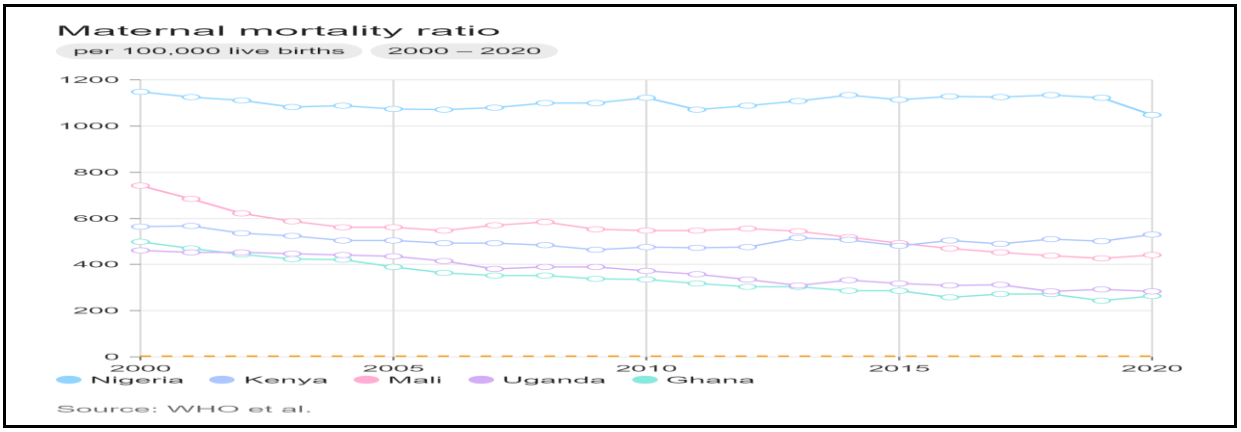
Figure 2: Cross-country comparison between Ghana and other countries on SDG indicators

**MMR** **U5MR** **NNR**

[1] https://dashboards.sdgindex.org/profiles/ghana/indicators

[2] https://www.who.int/data/gho/data/indicators/indicator-details/GHO/maternal-mortality-ratio-(per-100-000-live-births)




Evidence shows that achieving MMR and NNR SDG targets are all facing major challenges while significant challenges remain for Ghana to achieve U5MR targets. Comparing Ghana's MMR achievements with those of Nigeria and Kenya (Figure 2), Ghana must make efforts to reduce the mortality rates within the country, although this is not a unique case for Ghana.

## 2. Reproductive Health financing in Ghana (2018-2022)

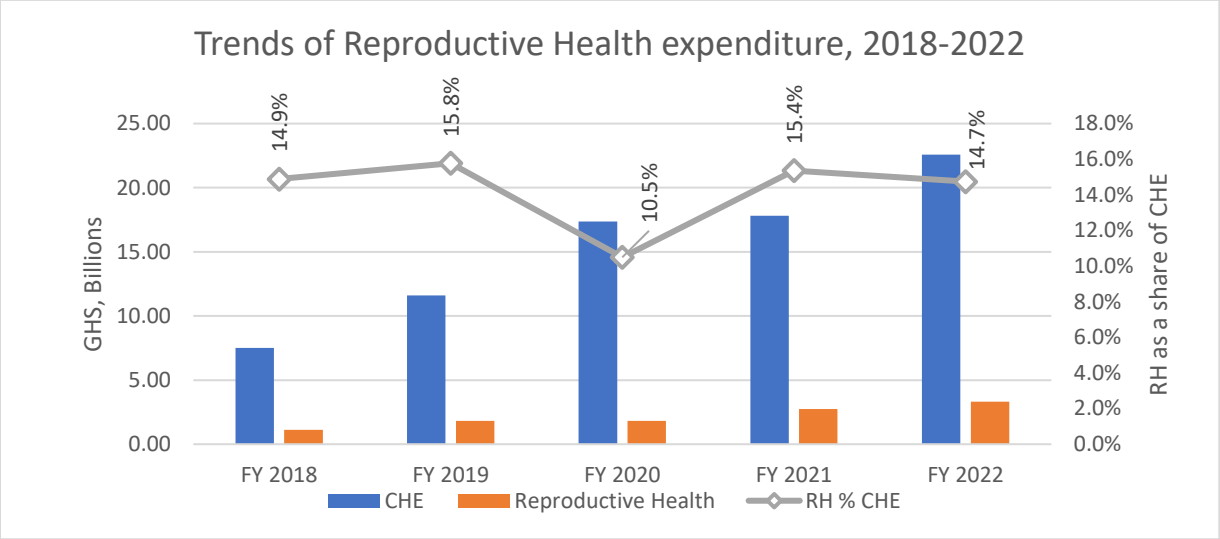
### 2.1 General Health Financing

Ghana's Total Health Expenditure (THE)[3] increased from GHS 9.9 billion in 2018 to GHS 23.1 billion in 2022. The highest increase was between 2019 to 2020 (50.9%), which could have been due to COVID-19, while the least percentage change was between 2020 and 2021 (4.7%). The Current Health Expenditure (CHE), on the other hand, increased from GHS 7.5 billion (US$1.5 billion) in 2018 to GHS 22.6 billion (US$ 2.6 billion) in 2022.

Of the CHE, reproductive and health programmes registered a proportion of approximately 14.9% for 2018 which increased steadily to 15.8% in 2019 and was at the lowest in 2020 (10.5%) possibly due to the COVID-19 impact. This aligns with the findings of Julie et al. (2020), who noted that COVID-19 compelled facilities in many countries to rapidly repurpose, restructure and reallocate resources within an inherently limited budget (Figure 3).

[3] Total Health Expenditure (THE) is the summation of Current Health Expenditure (CHE) and Health Capital spending (HK)

Figure 3: Trends of expenditure on RH in Ghana




The trend of RH expenditure in Ghana, which seems to have increased since 2018 (Figure 3), when translated into per capita terms shows that the amount allocated to women in fertility age (WIFA) in Ghana increased from GHS 332.86 in 2021 to GHS 395.29 in 2022. It is important to note that the dollar equivalent of the per capita expenditure reduced from US$ 55.38 to US$ 46.07 in the respective years which shows the impact of a depreciating cedi on the health of the population (Table 1).

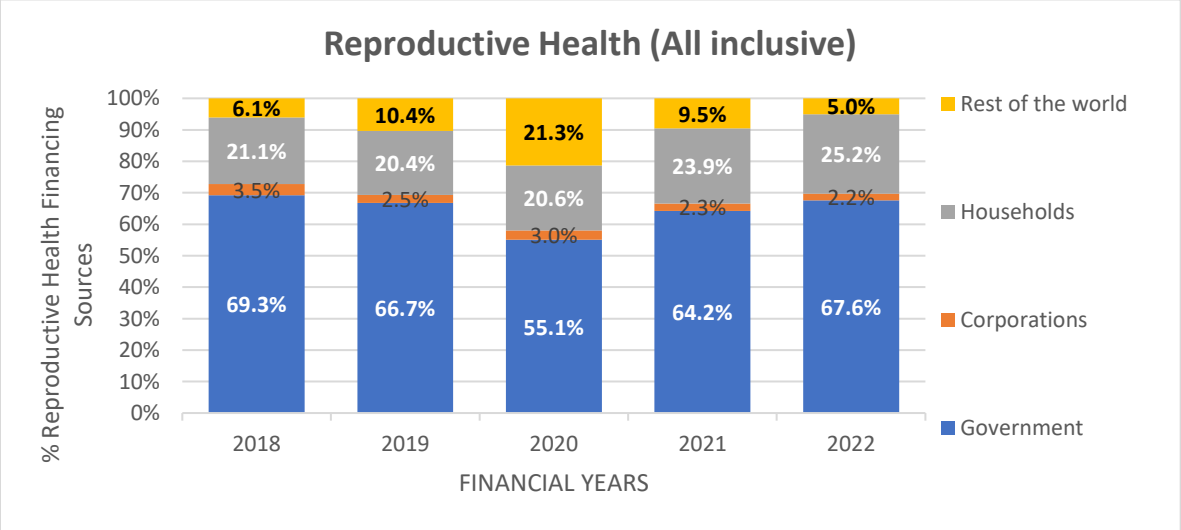
Table 1: Trends of expenditure on RH in Ghana (detailed)

| | | **FY 2018** | **FY 2019** | **FY 2020** | **FY 2021** | **FY 2022** |
|---|---|---|---|---|---|---|
| CHE | *GHS, Million* | 7,498.70 | 11,603.74 | 17,375.41 | 17,822.85 | 22,574.34 |
| Reproductive Health | *GHS, Million* | 1,116.68 | 1,830.26 | 1,823.39 | 2,737.57 | 3,328.15 |
| RH % CHE | *Percentage* | 14.89% | 15.77% | 10.49% | 15.36% | 14.74% |
| | | | | | | |
| RH Population | *Million* | 7.61 | 7.77 | 7.82 | 8.22 | 8.42 |
| USD Exch. Rate | | 4.82 | 5.53 | 5.76 | 6.01 | 8.58 |
| RHE per capita | *GHS* | 146.74 | 235.46 | 233.31 | 332.86 | 395.29 |
| RHE per capita | *USD* | 30.44 | 42.58 | 40.51 | 55.38 | 46.07 |

## 2.2 Financing Sources for Reproductive Health

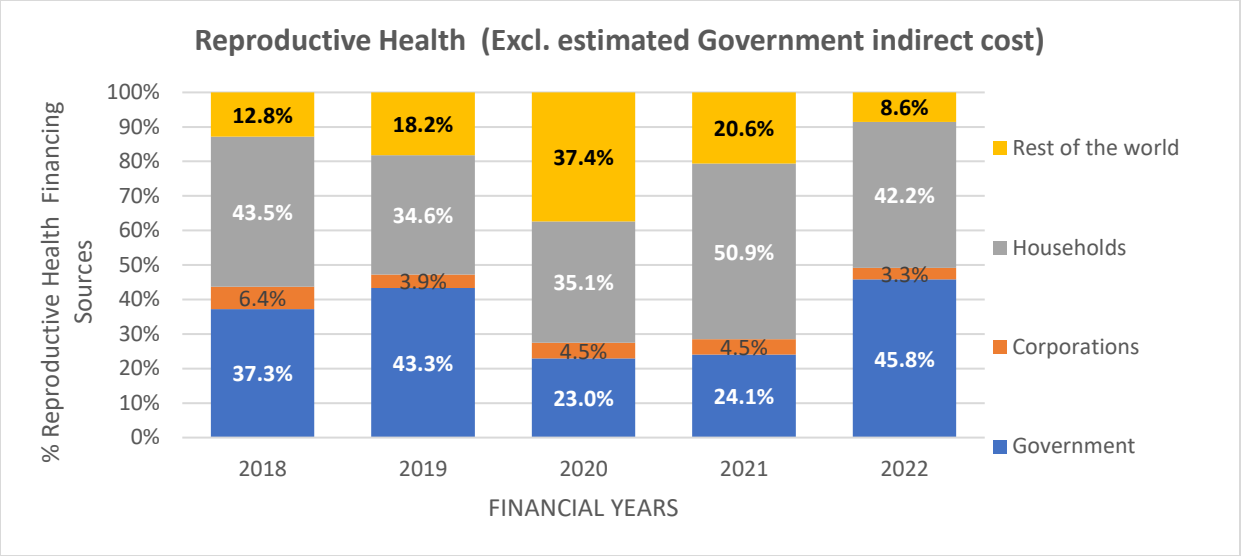
NHA findings (Figure 4) show that Reproductive Health was largely financed by government resources, followed by household and rest of the world respectively for the years 2018-2022. Government contribution was on a slight decline from 2018 to 2019 but the decline was sharp between 2019 and 2020 (first year of COVID-19 pandemic) when all health expenditures was focusing on COVID-19 and increased in 2021 when conditions started normalizing as people started patronizing health services again. In 2020, contributions from rest of the world doubled (21.3 per cent) compared to all the years to compensate for decline in government expenditure. Although there was an increase in government expenditure on Reproductive Health from 55.1 per cent in 2020 to 67.6 per cent in 2022, it did not return to the level seen in 2018. This highlights the need for increased government commitment to meet reproductive health targets.

Figure 4: Financing sources for RH Ghana, 2018-2022




Over the years, the HA analysis on Ghana has portrayed that donor is the main financing source for Reproductive Health. However, the 2018-2022 NHA analysis has shown that Government and Households are the main financing sources as shown in Figure 5 below. The new SHA-2011 methodology allows for the inclusion of previously unaccounted indirect costs such as compensation and capital investment in the analysis. This has thrown light on the total government contribution to reproductive health.

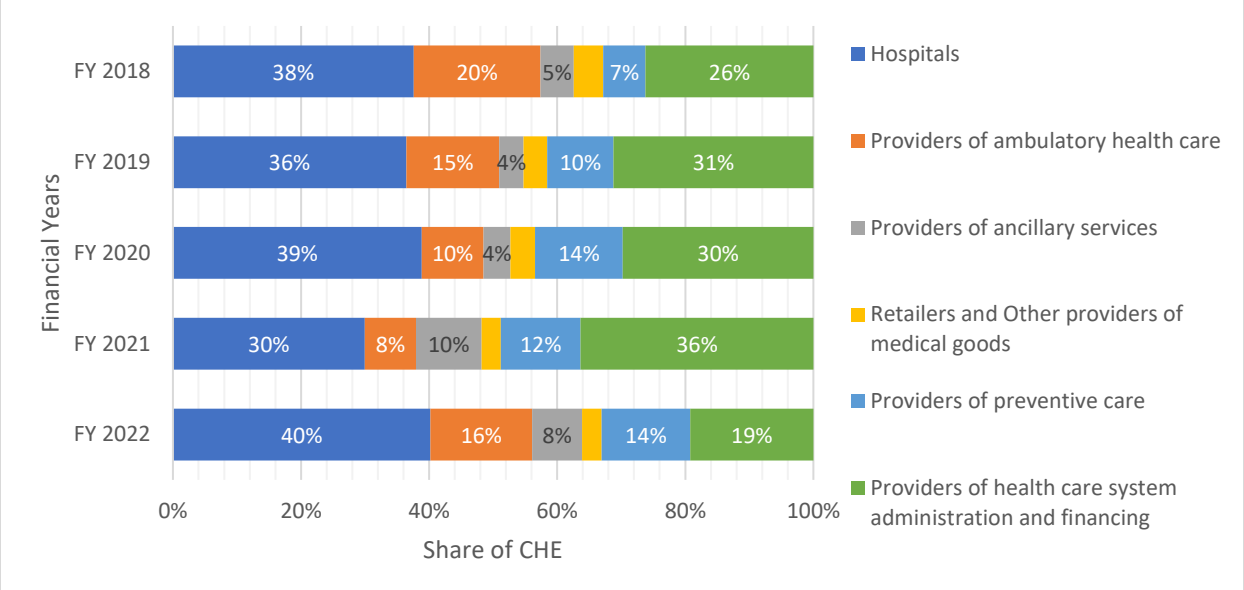
Figure 5: Financing sources for RH Ghana (excl. estimated government indirect cost), 2018-2022




## 2.3 Providers of Reproductive Health Services

Hospitals remained the key providers of reproductive health services taking 28% of all RH expenditure for 2018 which increased to 40% in 2022. This was followed by healthcare system administrative and financing management consuming 26% in 2018 which reduced to 19% in 2022 as shown in Figure 8.

Figure 8: Providers of RH services, 2018-2022



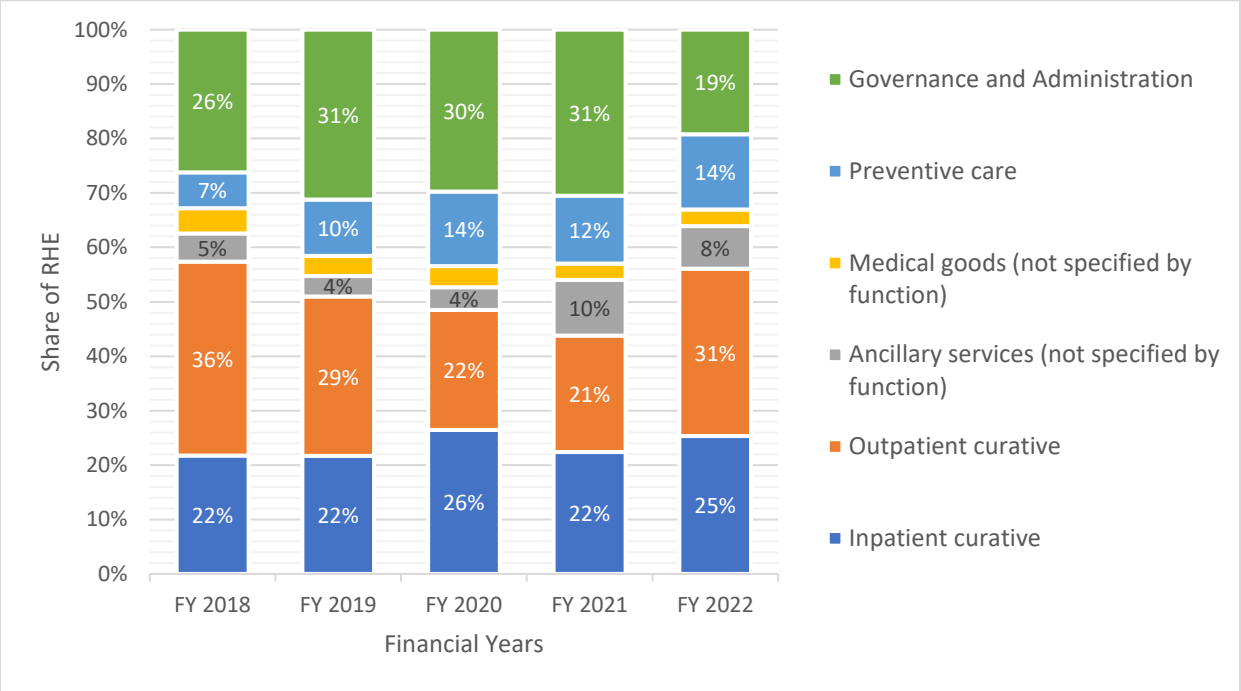

The providers of ambulatory care took a share of 20% in 2018 but has since reduced to 16% in 2022 while the exclusive providers of preventive care in reproductive health have increased from 7% in 2018 to 14% in 2022. Providers of ancillary services (not specified by function) as well as the providers of reproductive health medical goods remained the least for the period under study.

Expenditure on reproductive health (RH) administration appears to have been relatively high, particularly in 2021, suggesting that a substantial portion of resources was allocated to health-related services such as cleaning, sanitation, and security, among others during COVID-19 pandemic.

## 2.4 Reproductive Health Services Provided

From the service perspective, curative care consistently consumed most of the resources allocated to reproductive health in Ghana. This was, largely, inpatient and outpatient care services which consumed 22% and 36% of RHE in 2018 alone. These shares increased for inpatient care to 25% while they reduced for outpatient care to 31% in 2022 (Figure 9). This was followed by governance and administration services whose share reduced from 26% in 2018 to 19% in 2022.

Figure 9: RH services provided, 2018-2022

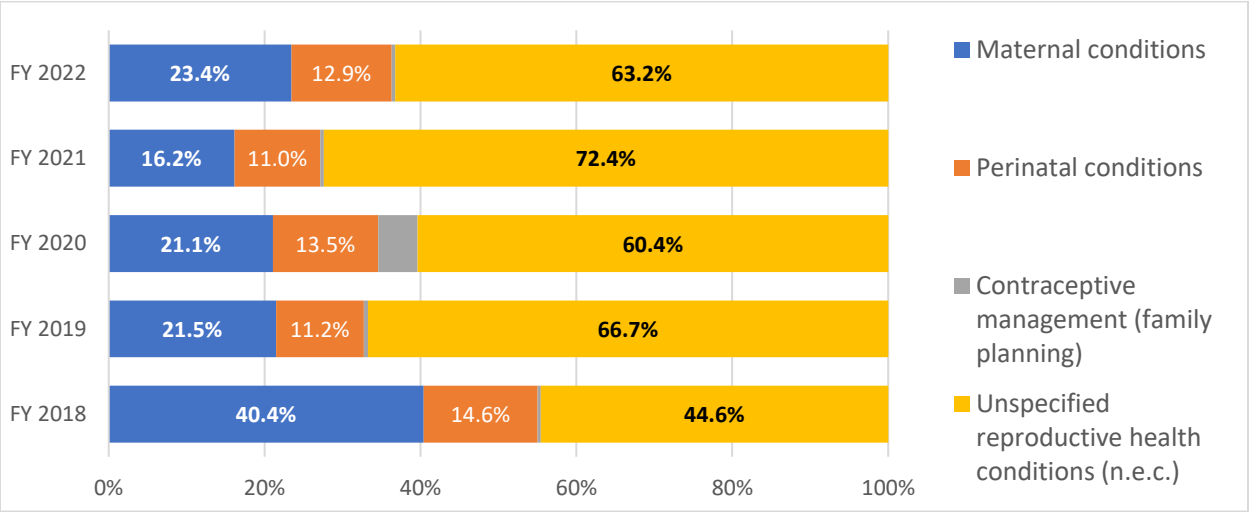



When compared to curative care, preventive care for reproductive health is quite at a low-scale. There has been a steady share of medical goods (not specified by function) at an average of 4% and these are largely over-the-counter health goods. The focus on preventive care should be adopted due to its multifaceted benefits that have a lasting impact on the population's behaviour as well as reducing expenditure on curative aspects of health care. Douglas and Fenton (2013) argue that a more comprehensive sexual health promotion message, emphasizing the right and responsibility to make healthy choices, is more likely to address concerns relevant to individuals and, as a result, be internalized and acted upon by them.

## 2.5 Reproductive Health Components Financed

On the reproductive health components, SHA-2011 provides the international standard categories namely: maternal conditions, perinatal conditions, contraceptive management and unspecified reproductive health conditions. Most of the RH expenditure was allocated to the last category of "unspecified reproductive health conditions" and the least share was for "contraceptive management/family planning as shown in Figure 10.

Figure 10: Expenditure on RH components in Ghana, 2018-2022




While it could be true that the least funds or resources go to contraceptive management activities, most of the expenditure on unspecified reproductive health conditions is more of a data-missing problem. It is important to note that while the expenditure data is not missing, the specific details of how the funds for RH were allocated are not available. Therefore, it is essential to improve data collection and allocation of resources to help disentangle RH-specific information from the program managers at all levels of service delivery in the country.

## 3. Discussions

It was observed that as Current Health Expenditure increased from GHC7.5 billion in 2018 to GHC22.6 billion in 2022, there was a corresponding increase in expenditure on reproductive health from GHC1.1 billion in 2018 to GHC3.3 billion in 2022.

Results from the analysis indicated that the government is the major financing source for Reproductive Health when estimated indirect costs such as storage, compensation, transportation, etc. are considered. Nevertheless, when indirect cost is excluded, households become the main financing source with a share of 20% to 25.5% over the period.

Even though government schemes for reproductive health were higher compared to household OOP schemes, the rate of growth in household out-of-pocket (OOP) schemes was faster.

Results from the analysis revealed that expenditure on preventive care for reproductive health was lower compared to curative care.

It was observed that the majority of the Reproductive Health component financed was classified under unspecified RH conditions signaling a lack of disaggregation in the collected RH expenditures data.

## 4. Policy recommendations

- Although family planning has been added to the NHIS benefit package, efforts should be made to ensure its full implementation nationwide across all levels of healthcare. This would help address the rising household out-of-pocket payments for reproductive health.
- It is therefore recommended that expenditure on prevention care for reproductive health should be prioritized for a long-term impact while saving more resources from curative care.
- There is a need to improve data collection on expenditures on reproductive health components to be able to disaggregate expenditures classified as “other and unspecified diseases (not elsewhere classified)” and also conduct reproductive health costing studies to support the NHA process.

# 5. References

## REFERENCES (Introduction)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