GHANA
NATIONAL HEALTH ACCOUNTS
2005 AND 2010

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INTRODUCTION

* National Health Accounts (NHA) is an internationally recognized framework that measures and tracks total health care expenditures in a country, thereby providing a systematic and comprehensive method for monitoring resource flows in a country's health system.

* It does so by offering a transparent and consistent way of describing health expenditures in terms of financing sources and end uses.

INTRO. CONT

* NHA estimation allows for fiscal transparency of a country's health system.

* NHA tracks all expenditure flows within a health system, linking the sources of funds to service providers and to the ultimate use of the funds.

* NHA is to serve as a policy tool

OBJECTIVES OF THE NHA

The overall objective of this NHA study was to estimate THE in 2005 and 2010, in order to obtain data that would inform health policy formulation and development. The study had seven specific objectives:

* Estimate Total Health Expenditure (THE) in Ghana.
* Document the distribution of THE by financing sources and financing agents.
* Determine the contribution of each stakeholder in financing health care in Ghana.
* Articulate the distribution of health care expenditures by use.

OBJECTIVES CONTINUED

* Analyze efficiency, equity, and sustainability issues associated with the current health care financing and expenditure patterns in Ghana.

* Provide estimates to inform the development of the health care financing strategy and the HSMTDP II (2014-2016).

* To analyse the effect of the introduction of National Health Insurance Scheme on funding in Ghana.

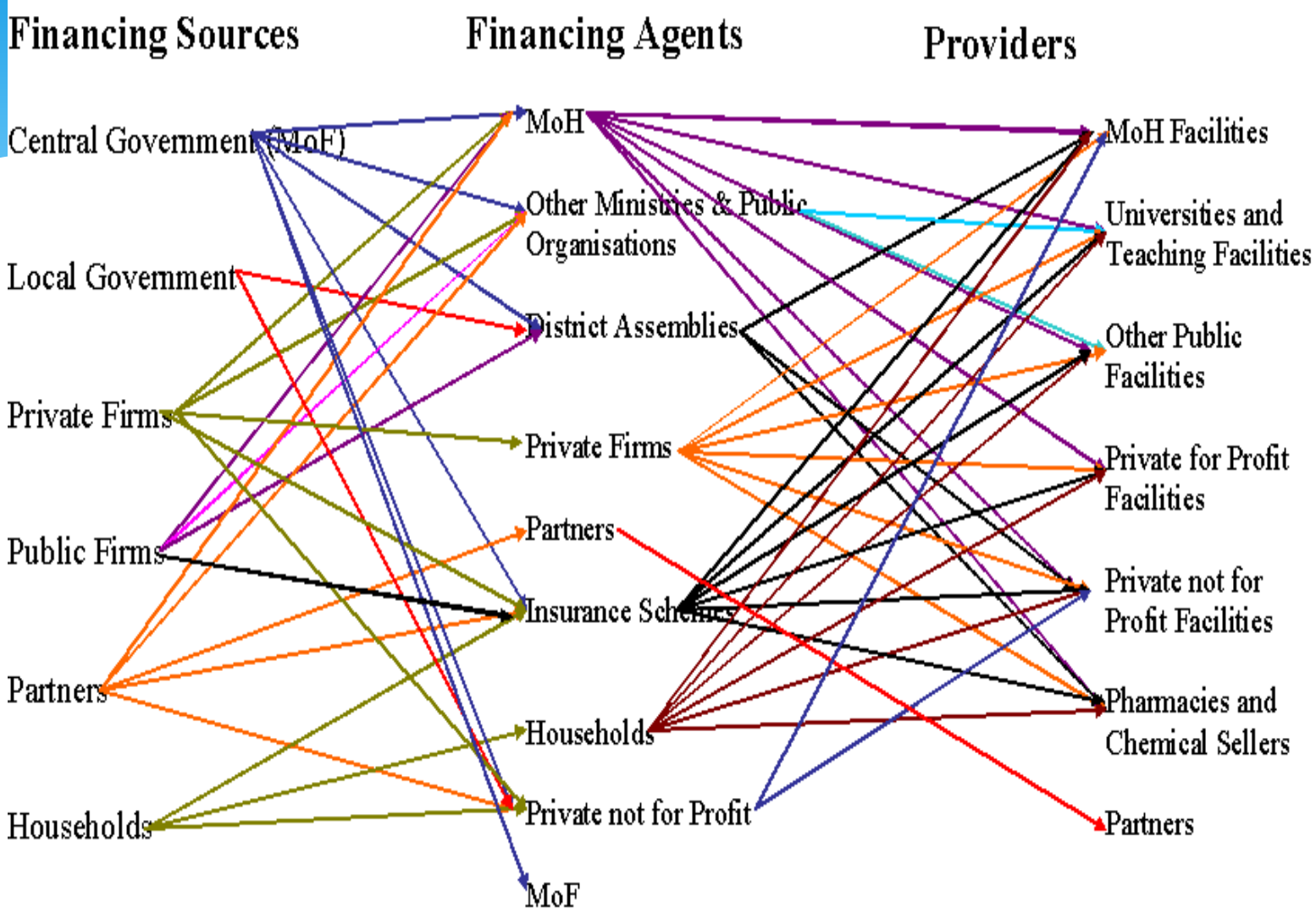
METHODOLOGY

NHA shows the flow of financing from a source of funding to a particular use or to beneficiaries following a standard classification of health expenditure.

Four dimensions are considered:

* **Financing sources**
* **Financing agents**
* **Providers**
* **Functions**

GHANA NHA – FLOW OF FUNDS DIAGRAM



* Total health expenditure is defined as expenditure related to health and health-related activities.

* **Health activities** in this study comprises the sum of activities performed either by institutions or individuals pursuing, through the application of medical, paramedical, and nursing knowledge and technology, the goals of promoting health and preventing disease; curing illness and reducing premature mortality; caring for persons affected by chronic illness who require nursing care; caring for persons with health-related impairment, disability, and handicaps who require nursing care; providing and administering public health; providing and administering health programs, health insurance and other funding arrangements.

* **Health-related activities** include capital formation for health care provider institutions, education and training of health personnel, research and development in health, food, hygiene and drinking-water control, and environmental health. Examples of health-related activities are nutritional counseling and supplementary feeding program to reduce children's malnutrition, medical education and in-service training for paramedical workers, medical research.

DATA SOURCES

The choice of the period for the NHA study is informed by the following reasons:

* 2005 for baseline information on NHIS implementation
* 2010 for commencement of HSMTDP implementation

Both primary and secondary data were used

PRIMARY DATA COLLECTION

* **Private for profit facility survey**
* **Public Health facility survey**
* **National Health Insurance**
* **Quasi-government facility survey**
* **Employer Survey**
* **Non-Governmental Organizations Survey**
* **Government Ministries, Departments and Agencies**
* **Donor**

SECONDARY DATA COLLECTION

* **Government Ministries, Departments and Agencies**
* **Household Data**
* **Mission/CHAG Facility Data**
* **NHIA**
* **GHS**

DATA ENTRY AND ANALYSIS

* Data was captured using a data screen designed in Microsoft Excel.
* Secondary data was collected and used for determining ratios and in populating the NHA matrices.

Analysis of each expenditure item was mapped using the NHA classifications. The tables produced during the analysis for the NHA were:

* Financing Sources to Financing Agents (FS X HF)
* Financing Agents to Providers (HF X HP)
* Providers to Function (HP X HC)
* Financing Agents to Functions (HF X HC)

ASSUMPTIONS AND ESTIMATES

* A few development partners had different financial year periods from that used by the Government of Ghana (1st January to 31st December). Thus, effort was made to capture the actual expenditure within each fiscal year, January to December. In this case we relied mainly on monthly or quarterly expenditures from the development partners to make the necessary adjustments.

* Where funds are pooled, the expenditure contribution to the activities was assumed to be equal in equal proportions as the contribution to the total fund. The same rationale was also applied to any under spending.

* Also where detailed expenditure records of providers were not available, we assumed equal split of funds between the key activities, unless instructed otherwise.

ASSUMPTIONS AND ESTIMATES

The estimation of the household out-of-pocket expenditure on health was assessed within the framework of the Cost of Illness (COI) approach. The direct cost of illness for this study includes the following:

* direct cost of hospitalization (includes expenditure on bed, medical, clinical tests and feeding);
* amount spent on drugs;
* amount spent on consultation;
* amount spent at diagnostic centers for x rays, ECG, etc;
* Amount spent on contraceptives; and Preventive health.

* The Ghana Living Standards Survey, round 5 (GLSS 5) carried out in 2005/2006 was used in estimating the household out-of-pocket expenditures for 2005 and using the Consumer Price Index for health in 2010, adjusted the 2005 expenditures to 2010.

* In using the GLSS data, only households' health expenditure to private health facilities (private sector) was considered. The household health expenditure to public facilities (public sector) was assumed to be captured in the Internally Generated Funds (IGF) to the GHS facilities (public facilities).

ASSUMPTIONS AND ESTIMATES

- The average interbank annual exchange rate of the US dollar to the cedi was used in this study. For 2005, the rate was GH¢0.9131 to US$1 and in 2010, the rate was GH¢1.4738 to US$1.

* Health service statistics from the Ghana Health Service was used to compute the
  * Outpatient-Inpatient Ratio to split expenditure items that had both components.

* The Ministry of Health annual reports and the Strategic Plan of the National Health Insurance Authority were used to split the Internally Generated Fund (IGF) contribution from Claims received from the NHIS and household Out-of-Pocket Payment.

LIMITATIONS

* Overall, the financial information from primary and secondary data sources were aggregated, which made it very difficult to disaggregate the financial information necessary to determine certain sub-classifications, such as the distinction of inpatient expenditure from outpatient expenditure, IGF from NHIS Claims and Out-of-Pocket payment among others.

* The study utilized ratios to determine the various contributions. An effort was made to confirm the ratios with existing literature and individual consultations in the health sector.

LIMITATIONS

* Information/data from private health providers (private hospitals/clinics and pharmacy) accredited to the NHIS was very scanty due to the lack of cooperation with the private health providers during the data collection and also because the study could not map out and visit all NHIS accredited health providers. Thus expenditure from the NHIS is underestimated

FINDINGS

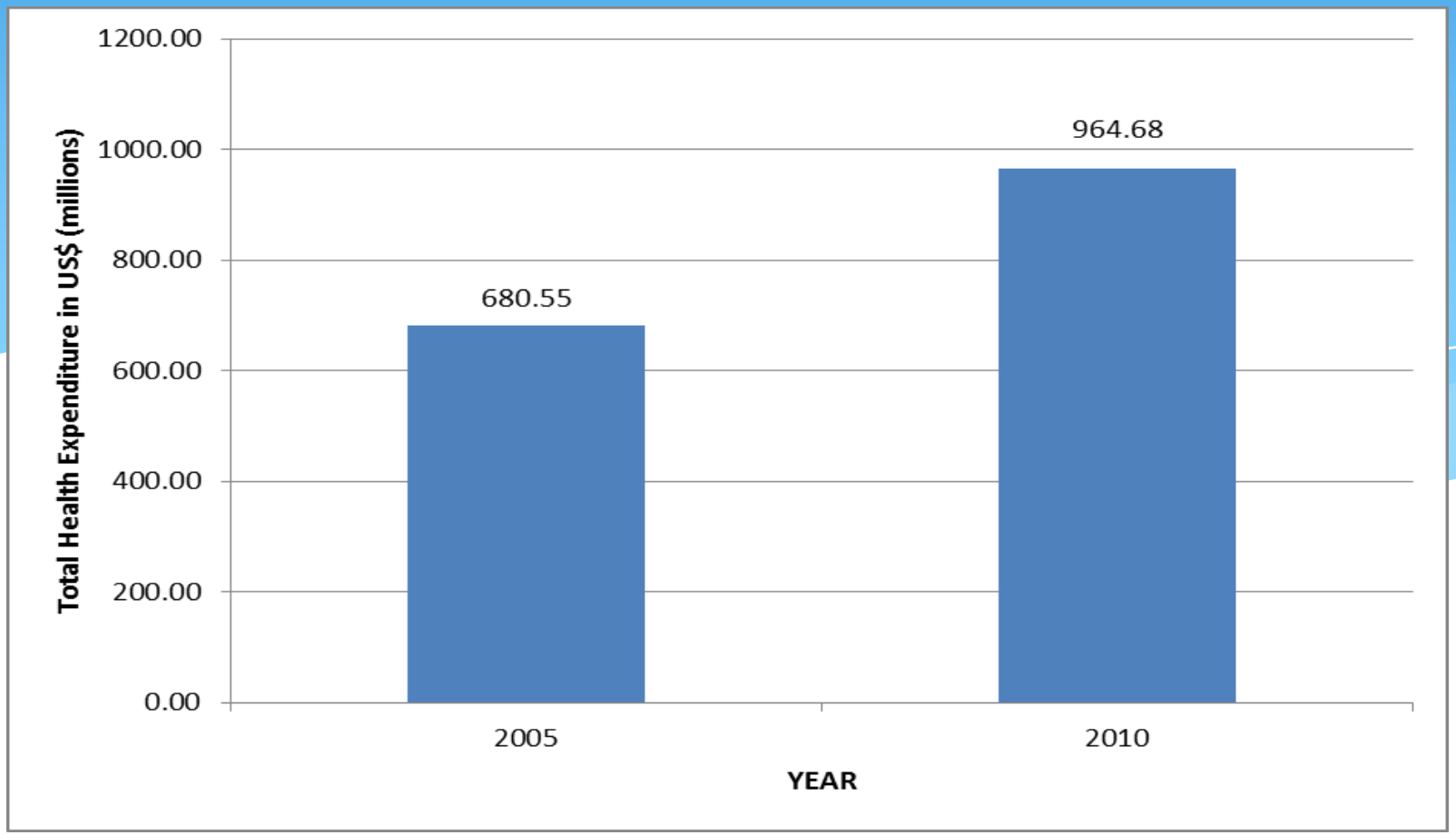
1. Total Resource Envelope for Health

* Total Health Expenditure (THE) trend for the two years under study was estimated at US$680.55 million (GH¢621.41 million) in 2005, rising to US$964.68 million (GH¢1,421.75 million) in 2010.

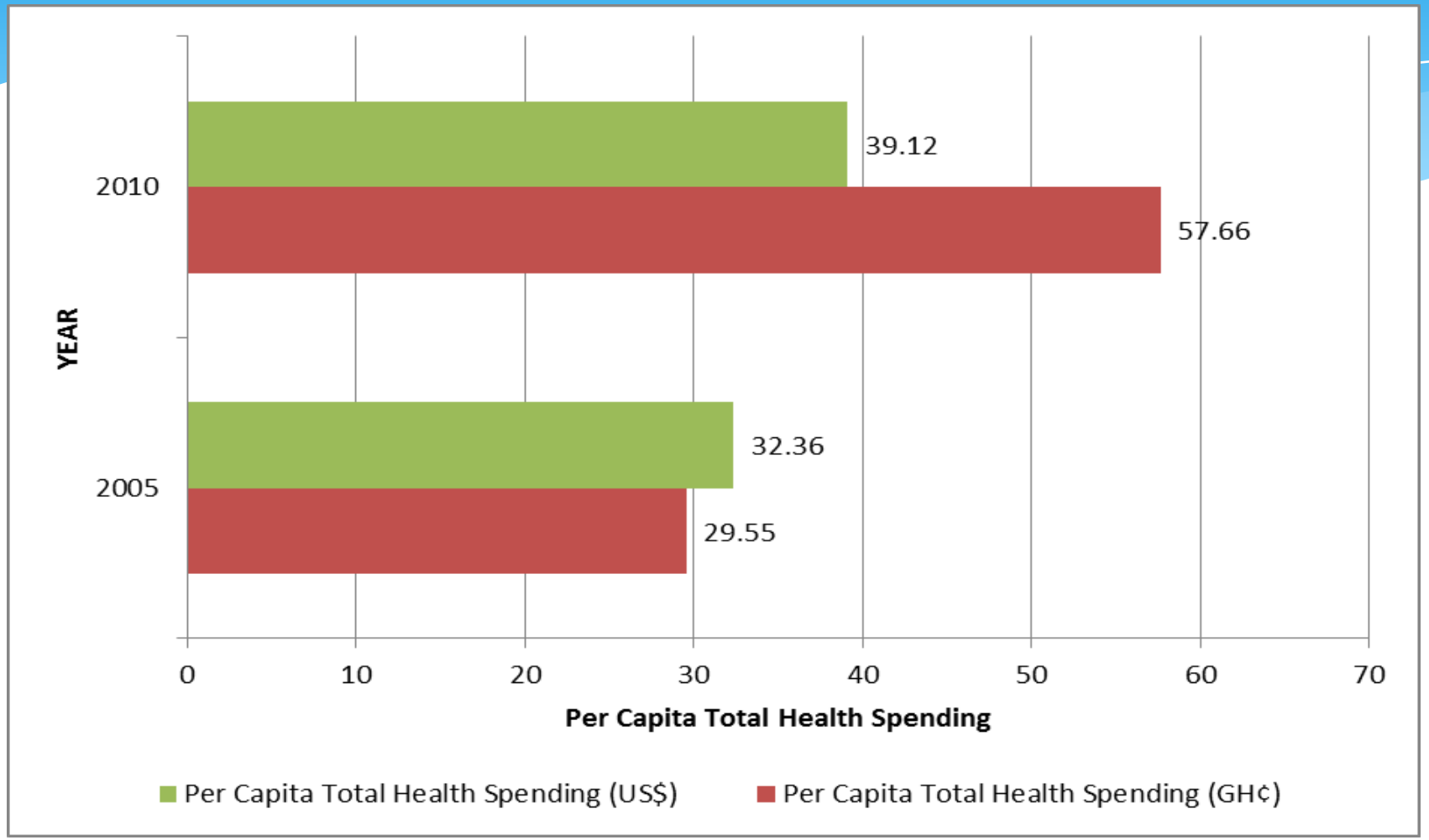
* This represent a 41.75 percent increase in THE within the five year period in terms of US dollars.

* In Ghana cedis, total health expenditure increased by 128.79 percent between 2005 and 2010, more than doubling over the period

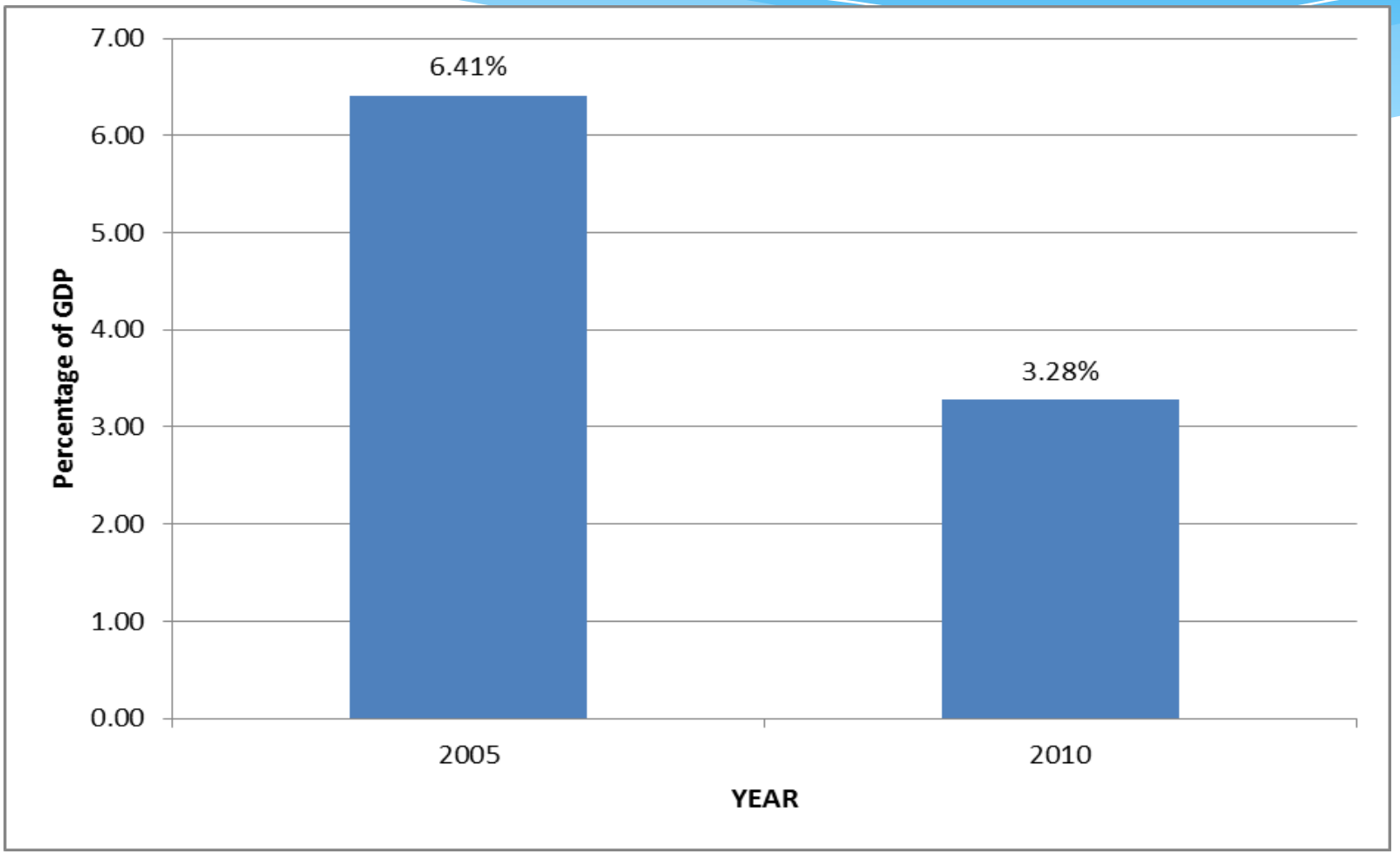
Total Health Expenditure, 2005 and 2010 (million US$)



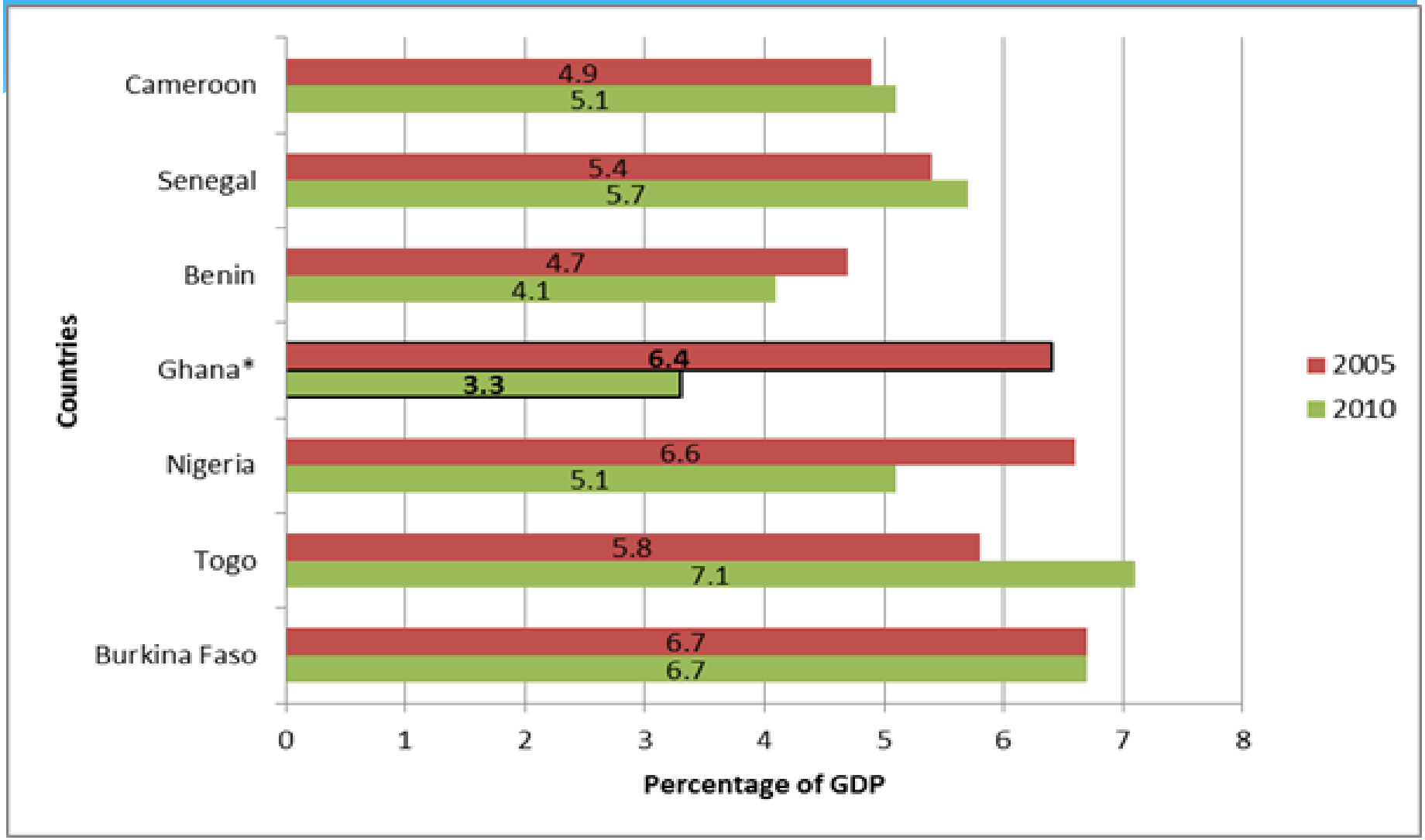
Per Capita Spending on Health, 2005 and 2010



Total Expenditure on Health as a Percentage of GDP, 2005 and 2010

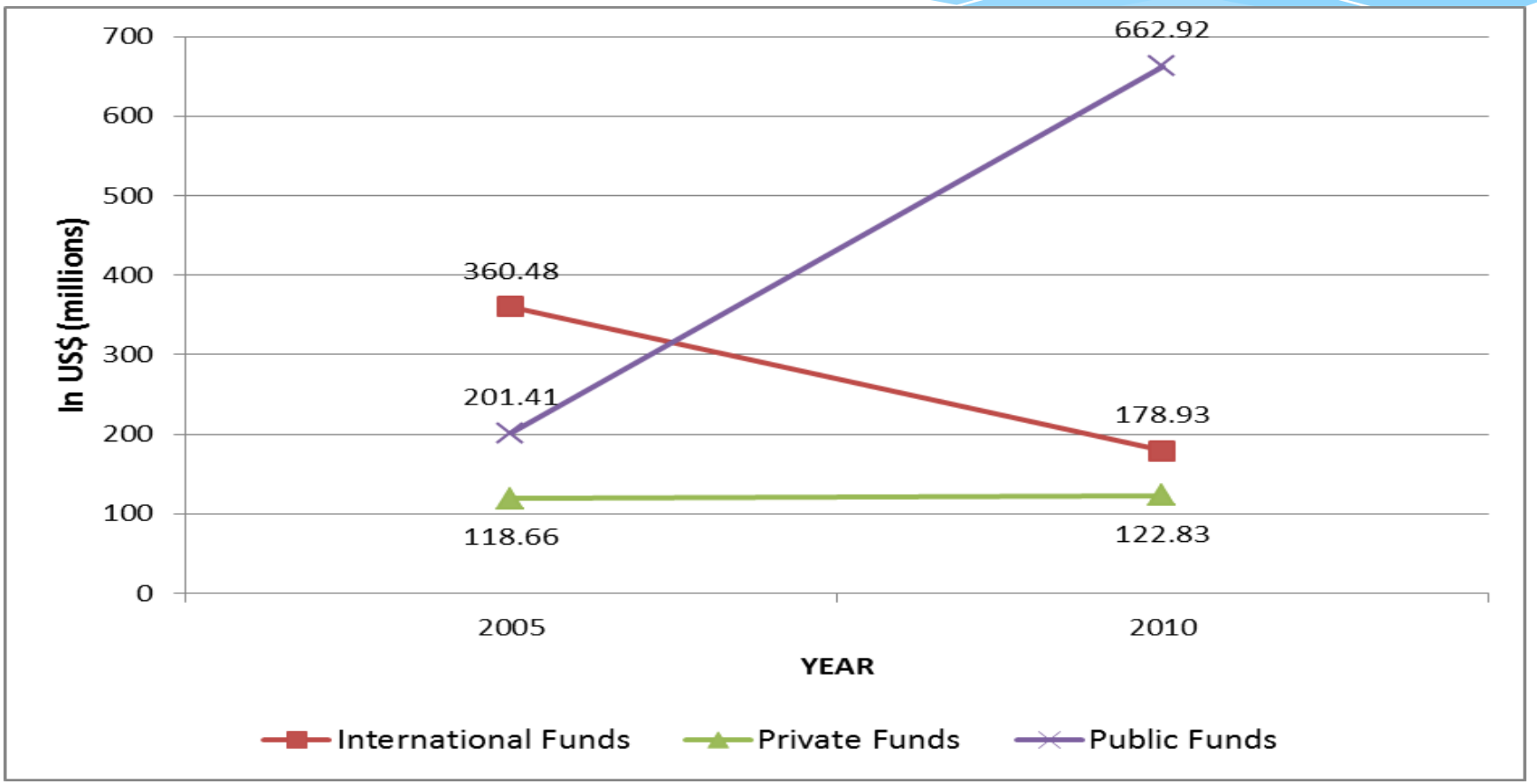


THE as a Percentage of GDP in Selected West African Countries, 2005 and 2010



2. Who Funds Health? : Financing Sources

* Total Health Expenditure Breakdown by Financing Source, 2005 and 2010 (Million US$)

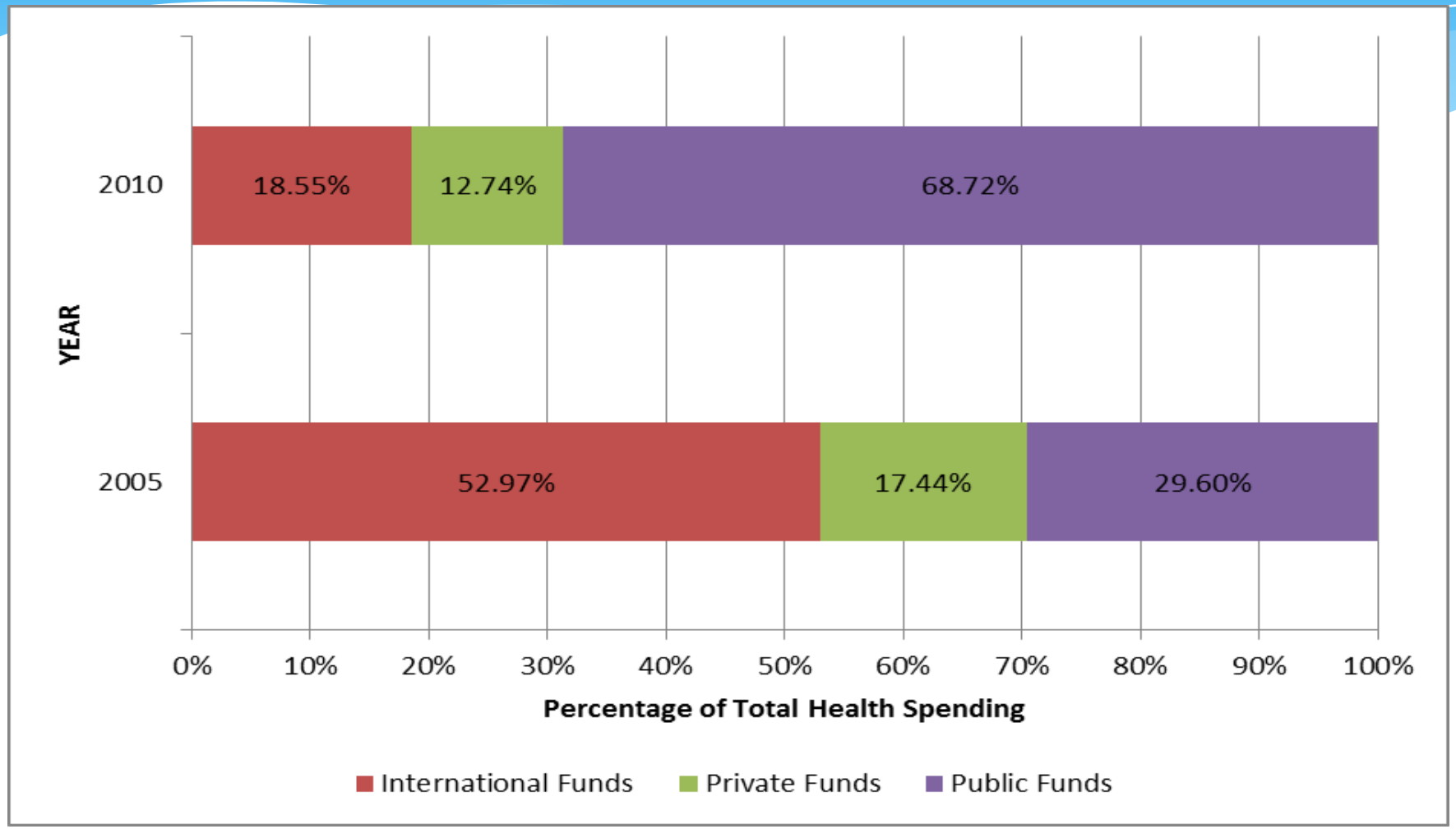


Show Table 4.1

Percentage Change among Financing Sources, 2005 and 2010

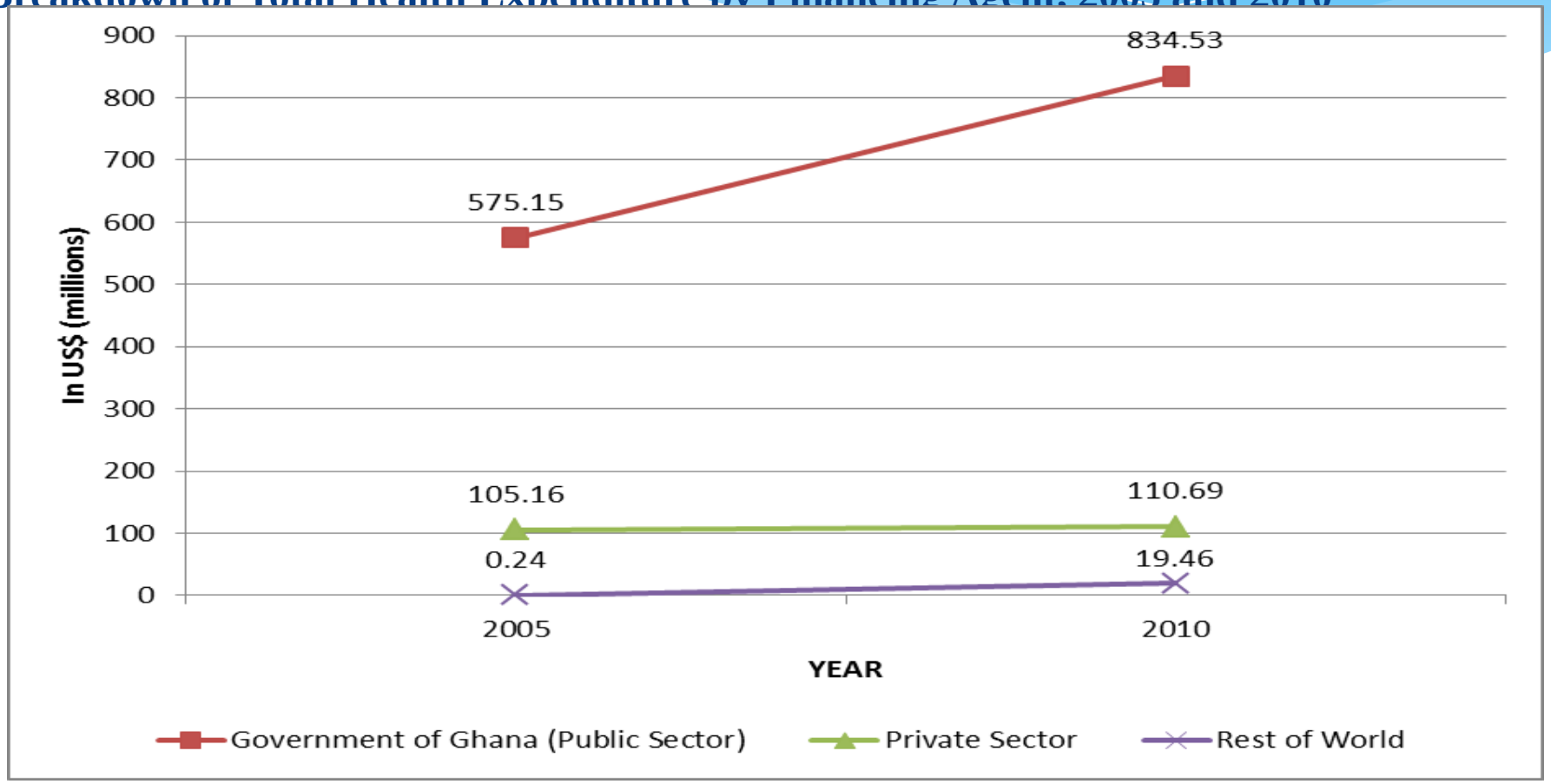
Financing Sources	2005 (US$)	2010 (US$)	Percentage Change
International Funds	360,479,692.54	178,932,270.64	-50.36
Private Funds	118,661,796.53	122,831,726.54	3.51
Public Funds	201,408,758.71	662,918,655.69	229.14
Total	680,550,247.78	964,682,652.87	41.75

Total Health Expenditure Breakdown by Financing Source, 2005 and 2010

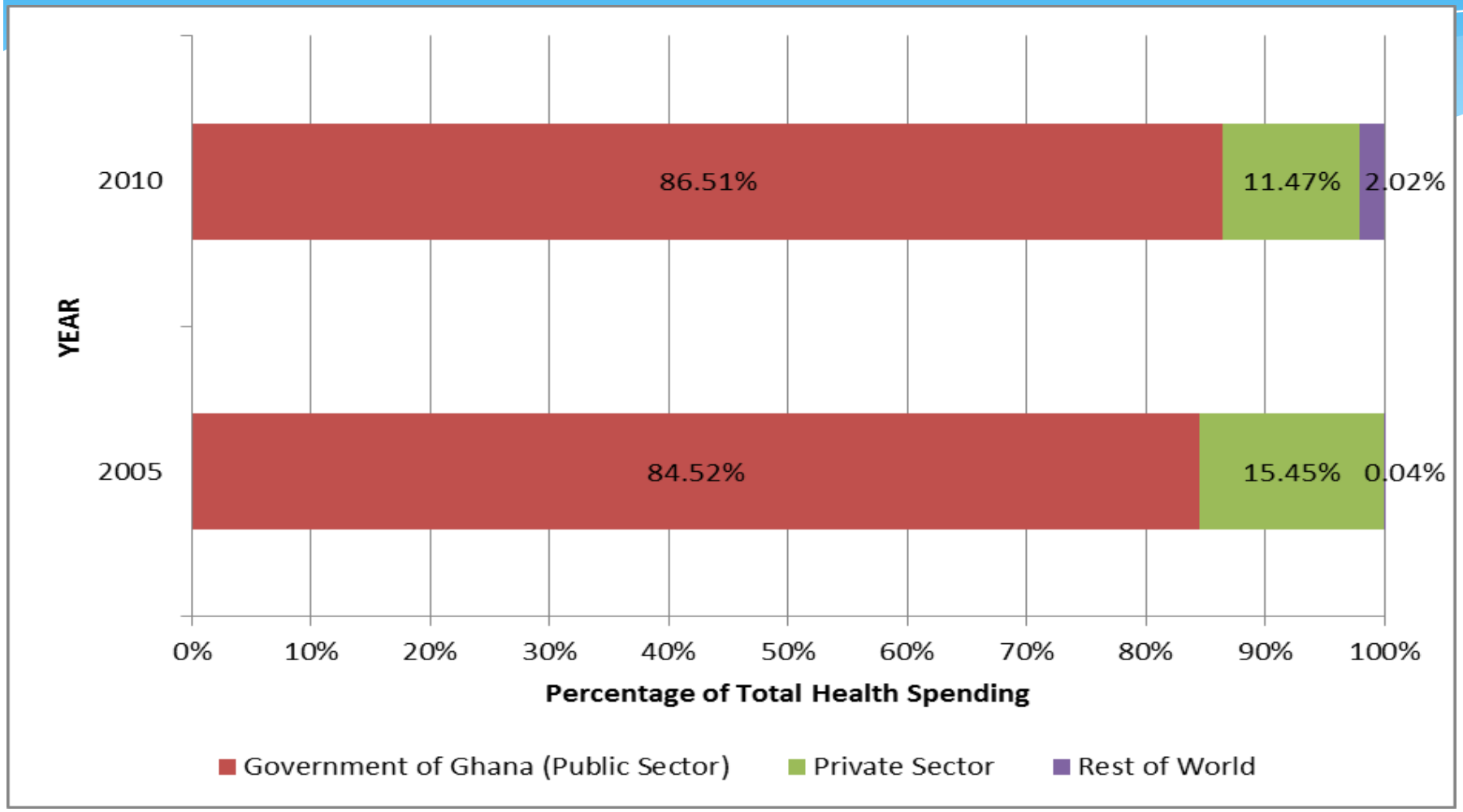


3. Who Manages Health Fund? - Financing Agents of Health Care

Breakdown of Total Health Expenditure by Financing Agent, 2005 and 2010



Financing Agent Contribution to Total Health Expenditure, 2005 and 2010



Percentage Change among Financing Agents, 2005 and 2010

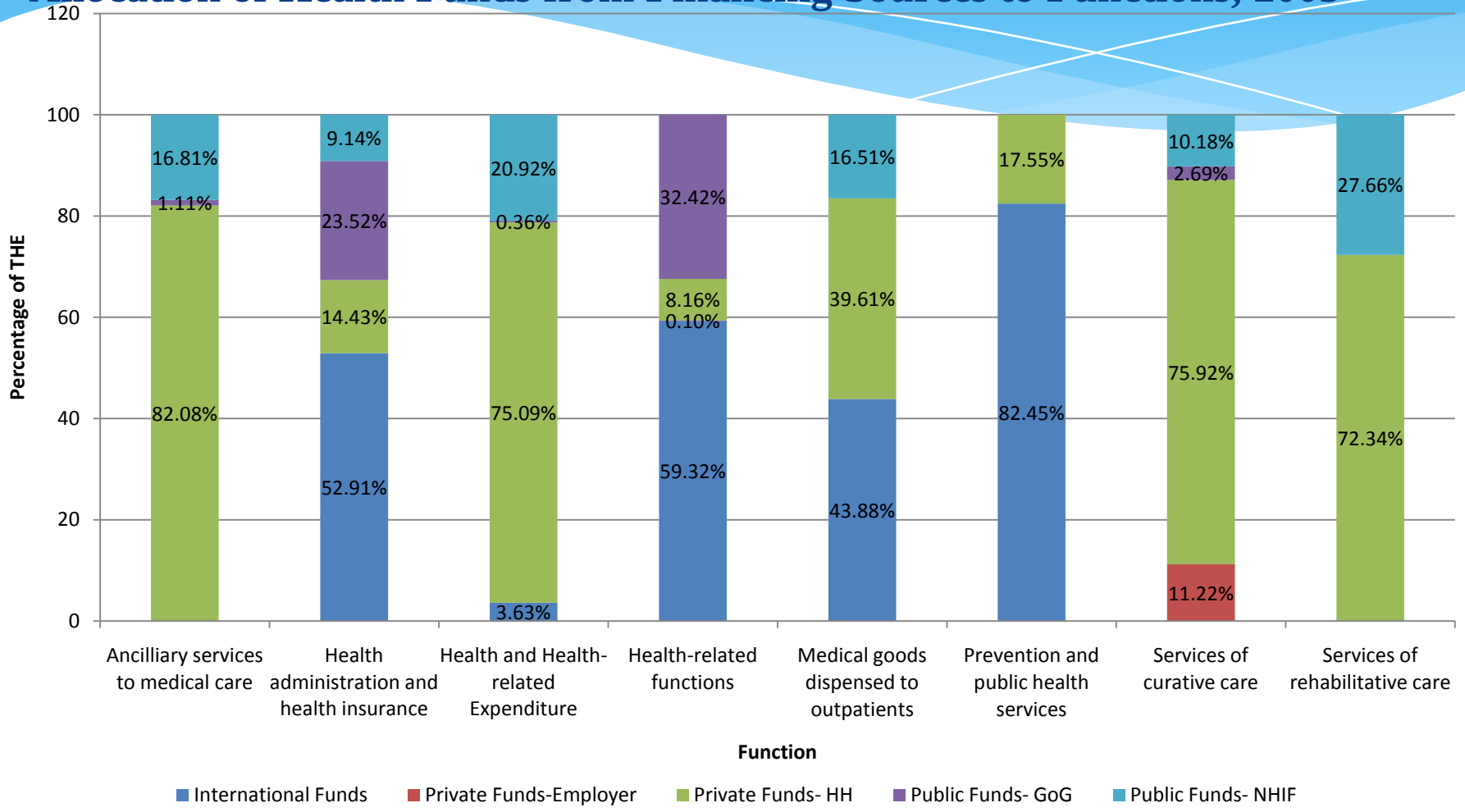
Financing Agent	2005 (US$)	2010 (US$)	Percentage Change
Government of Ghana	575,149,994.89	834,534,782.18	45.10
Private Sector	105,156,994.84	110,690,131.64	5.26
Rest of World	243,258.06	19,457,739.06	7898.81
Total	680,550,247.78	964,682,652.87	41.75

4. Who Uses Health Funds to Deliver Care? - Providers of Health Care

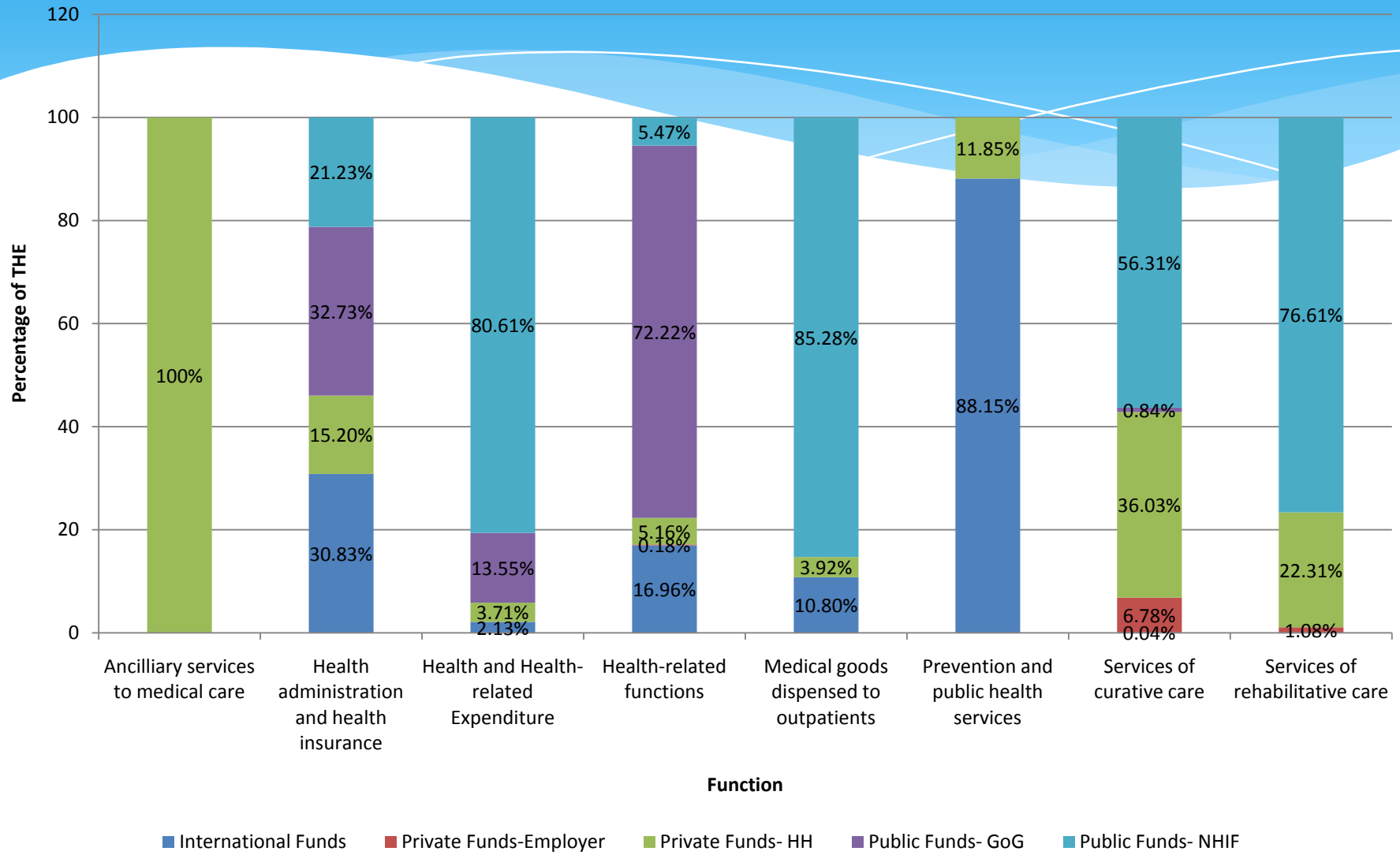
5. Services and Products Purchased with Health Funds –Functions

6. Who Spends on What? - Financing Sources by Functions

Allocation of Health Funds from Financing Sources to Functions, 2005



Allocation of Health Funds from Financing Sources to Functions, 2010



CONCLUSION

* THE increased by 41.75 percent in terms of US dollars over the five year period studied.
* increased from US$680,550,247.78 (Ghc621.41 million) in 2005 to US$964,682,652.87 (Ghc1,421.75 million) in 2010.
* This was however not reflected in THE as a percentage of GDP.
* 2010 saw the GoG become the leading financier of health in the country in addition to managing the largest amount of health resources.
* The health system also benefited from increased contributions and involvement of other stakeholders, particularly the NHIS and households.

* Cost of general health administration and insurance increased from US$211,317,559.32 in 2005 to US$428,162,648.69
  * over a 100 percent increase.

* Also expenditure on provision and administration of public health programme fell drastically from US$228,429,903.05 in 2005 to US$46,529,858.30
  * a 79.63 percent reduction.

* direct out-of-pocket payments to public health care facilities fell within the five year period.

* Expenditure at the hospitals increased from US$146,260,840.18 (21.4 percent of THE) to US$376,687,101.54 (39.1 percent of THE)
  * representing over 100 percent increase between 2005 and 2010.

RECOMMENDATIONS

* the cost of general health administration and insurance is very high. Effort will have to be made to reduce this cost by streamlining administrative work to avoid duplication of work which will also help remove inefficiencies.

* Expenditure on provision and administration of public health programmes will have to be increased. This will help reduce the cost of curative care in the medium to long term. The NHIA should also consider providing resources for preventive care and not curative care which is currently being provided the health facilities through claims payment.

* Monitor household expenditures to assess their financing burden to maintain equitable access for all Ghanaians to health care. In this regard, regular and routine household health and expenditure data is warranted.

* Strengthen links with the private sector, particularly companies and insurance schemes. Encouraging companies to invest in their employees' health care is a possible area of resource mobilisation.

* improve resource tracking mechanisms of health, particularly in the private sector, so that NHA becomes a routine government function and more directly linked to budgeting and planning processes.
  * Institutionalisation of NHA will require improved routine resource tracking efforts, particularly for private health providers (private hospitals/clinics and pharmacy) accredited to the NHIS

Thank You.