Ministry of Health Programme of Work 2002

Report of the External Review Team

Accra, May 2003

Preface and acknowledgments

This report was prepared by a team of international and Ghanaian consultants for an Annual Sector Review Steering Committee chaired by the Chief Medical Officer, Ministry of Health, Ghana. It represents the final stage of an intensive review of the first year of the Ministry of Health's Programme of Work 2002-2006. It was preceded by internal technical and managerial reviews carried out by the Ghana Health Service in the Regions and by the Ministry of Health in the Teaching Hospitals, CHAG and the sector's Statutory Bodies. These included performance hearings conducted jointly by government and aid agency staff. Two in-depth studies were to have been conducted before the external team began its work: on health insurance and fee exemptions and on private-public partnerships. In the event, this work was part of the external review and is reported in separately in three companion reports: The Proposed National Health Insurance Programme, Aligning Exemption Policy and Practice with Poverty Reduction Goals and Private Public Partnerships. This report draws on all of this work in reaching its conclusions.

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List of acronyms

ADHA	Additional Duty Hours Allowance
ANC	Ante natal Care
APR	Annual Performance Review
ART	Anti Retroviral Therapy
BMC	Budget Management Centre
BPEMS	Budget and Public Expenditure Management System
CAGD	Controller and Accountant General's Department
CEO	Chief Executive Officer
CHAG	Christian Health Association of Ghana
CHI	Community Health Insurance
CHNs	Community Health Nurses
CIMU	Capital Investment Management Unit
CIP	Capital Investment Plan
CMA	Common Management Arrangements
CMS	Central Medical Stores
CPAR	Country Procurement Assessment Review
CSPIP	Civil Service Performance Improvement Programme
CWC	Child Welfare Clinics
DA	District Assembly
DFID	Department of International Development
DHMT	District Health Management Team
DHS	District Health Service
DMS	District Medical Stores
DOTS	Direct Observed Treatment Shortcourse
DPF	Donor Pooled Fund
EDL	Essential Drug List
EMU	Estates Management Unit
EN	Enrolled Nurse
EPI	Expanded Programme on Immunisation
FP	Family Planning
GHS	Ghana Health Services
GNDP	Ghana National Drug Programme
GOG	Government of Ghana
HAART	Highly Active Anti-retroviral Therapy
HASS	Health Administration and Support Services
HIPC	Highly Indebted Poor Country
HIST	Health In-service Training
HLM	Health Learning Materials
ICB	International Competitive Bidding
IEC	Information, Education and Communication
IGF	Internally Generated Funds
IMCI	Integrated Management of Childhood Illnesses
IPPD	Integrated Personnel Processing Department
ITNs	Insecticide Treated Nets
KATH	Komfo Anokye Teaching Hospital
KBTH	Korle-Bu Teaching Hospital
LI	Legislative Instrument
LMIS	Logistics Management Information Systems
MCH	Maternal and Child Health
MDAs	Ministries, Departments and Agencies
MOH	Ministry of Health
MOU	Memorandum of Understanding

MTCT	Mother to Child Transmission
MTEF	Medium Term Expenditure Framework
NCB	National Competitive Bidding
NDF	Nordic Development Fund
NEPAD	New Partnership for Africa's Development
NHIC	National Health Insurance Committee
NHIF	National Health Insurance Fund
NHIP	National Health Insurance Programme
NMC	Nurses and Midwives Council
NTP	National Tuberculosis Programme
OHCS	Office of Head of Civil Service
OPD	Out-patients Department
PLWHA	People Living with HIV/AIDS
POW	Programme of Work
PPM	Procurement Procedures Manual
PPMED	Policy, Planning Monitoring and Evaluation Directorate, MOH
PSD	Procurement and Supply Division
PU	Procurement Unit
RBM	Roll Back Malaria
RHMT	Regional Health Management Team
RMS	Regional Medical Stores
SDP	Service Delivery Point
SOP	Standard Operating Procedures
SRN	State Registered Nurse
SSDMD	Stores, Supplies and Drug Management Directorate
SSNIT	Social Security and National Insurance Trust
STI	Sexually Transmitted Infection
SWAP	Sector Wide Approach
TB	Tuberculosis
THBs	Teaching Hospital Boards
THs	Teaching Hospitals
TMU	Transport Management Unit
TOR	Terms of Reference
TTH	Tamale Teaching Hospital
UER	Upper East Region
USAID	United States Agency for International Development
UWR	Upper West Region
VAT	Value Added Tax
VCT	Voluntary Counselling and Testing
WB	World Bank

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Report of the External Review Team

1. Introduction and overview

The year 2002 was the first implementation year of the Second Health Sector Five Year Programme of Work (2002-2006) and this report is one of four prepared by the Health Sector 2002 External Review Team. It should be read in conjunction with the other three on health insurance, exemptions and private-public partnerships. These address important initiatives being taken in the sector, each of them having considerable potential for furthering Ghana's poverty reduction objectives and the overall objective of the Health Sector 2002-06 Programme of Work, to reduce health inequalities in Ghana.

The year 2002 was a year of challenges and difficulties as well as successes for the Ghana Health Sector. The new government launched a challenging agenda of reforms in the sector and two important initiatives: the Community-based Health Services and Planning (CHPS) to bring services closer to consumers; and health insurance in an attempt to replace the imposition of fees at the point of service delivery.

However, the year began with a new and much depleted ministry team trying to come to grips with its own roles and the sector's challenges, as well as trying to find ways to move the new government's policy agenda forward. Most of the year was spent settling in the new teams in both the Ministry and the Ghana Health Service with inevitable losses in functional capacities. In particular, financial report performance dropped off sharply leading to delays in the release of Health Partner funds and creating consequent disruptions in Budget Management Centre cashflows. The loss of predictability in flows of funds, particularly, at district and sub-district levels was de-motivating for planning, service provision and reporting, seriously weakening compliance with performance budget management procedures.

The sector's difficulties largely stemmed from a legacy of partially or unresolved problems. There were remaining uncertainties about the Ministry's role, functions and staffing and little progress had been made on the full separation of the Ghana Health Service from the Ministry. Despite notable early successes from CHPS, the no progress had been made on improving the distribution of the sector's infrastructure. It had not been possible to reassign staff to more deprived areas. For these reasons there were continued misallocations of budgets and services in relation to health needs and poverty. As a result, the team could find little or no response to increased Government of Ghana funding for the sector by way of increased service volumes (outside CHPS) or quality and little evidence of progress towards the 2001-2006 Programme of Work's overall objective to `Bridge the Health Inequalities Gap'.

These sobering observations may not be surprising in view of changes in the sector in 2002. Change is always costly and, in a year of great change, expectations may have been set too high. It is a measure of the resilience of the system has a whole that service volumes and quality did not suffer more. In fact progress was made in a number of important areas and these successes should not be forgotten.

The Review Team welcomes the progress that has been made in implementing CHPS, in preparing for the implementation of the Private Sector Strategy and in improvements in planning for 2003. The Ministry of Health team has now been largely rebuilt and, together with senior Ghana Health Service staff, represent an invaluable resource for resolving outstanding problems and rebuilding the sector's management systems. This will need to be

even more robust than in the past if the government's new initiatives are to be translated into real improvements in health services for consumers, particularly for the poor, in line with Ghana's Poverty Reduction Strategy objectives. The Ministry of Health will not be the only purchaser of health services. District Assemblies will control larger budgets as a result of savings in debt servicing under HPIC, and the implementation of the GPRS. Some of these funds will be used to purchase health services. Insurers are also set to become increasingly important health service purchasers. As a result, budget managers will need to negotiate and manage multiple funding sources. This will require major improvements budget management skills and in compliance with accountability procedures by both fund managers and providers, posing huge challenges for investments in information systems and human resources: investments the Review Team believes have been seriously under-estimated.

These new challenges combined with the full resolution of outstanding issues and the need to rebuild or revitalise management systems in the sector, add up to a formidable set of tasks. These cannot be done all at once or quickly. However, there is a solid determination to tackle them. Despite the varying interpretations of the intentions of Act 525, which continue to cause difficulty, the Ministry of Health and the Ghana Health Service teams have found ways of working together constructively. Their determination to move the sector forward, together with the candour with which difficulties and potential remedies were discussed, have shaped this report. As a result, while the problems besetting the sector are itemised candidly, its main value may lie more in helping to identify what next steps need to be taken in resolving them.

Structure of the report

The next section of the report reviews indicators of the sector's performance. This is followed by a more detailed analysis of progress in the development of services with a particular focus on the main threats to health, together with a discussion on the Community Health Planning and Services initiative and on the hospitals' policy. Sections on financing, procurement, logistics and human resources follow. A discussion of issues related to organisational structure and function, together with a note on government-health partner relationships and a brief section on measurement issues in relation to the sector's management conclude the main part of the report. The final section draws some broad conclusions and highlights issues that the review team believes should be dominant in the minds of health sector managers and their donor partners.

Each section dealing with the sector's services tabulates progress made against 2002 Programme of Work targets, in response to the review team's terms of reference. Where issues require urgent attention, an attempt is made to identify the next steps that might be taken in the form of a `roadmap'. Specific recommendations are included in each section and appear in italics so that they catch the eye.

Sector-wide performance indicators

INDICATORS		2000	BASELINE (2001)	PERFORMANCE 2002
HEALTH STATUS	Infant mortality rate		57	
	Under five mortality rate		108	
	Maternal Mortality ratio		214	
	% Under five years who are malnourished (underweight)		25	
SERVICE	HIV sero prevalence among reproductive age, 15-19, 20-24 (figure represents prevalence among reproductive age group.		3	
	% Supervised deliveries (skilled attendants	51.6	50.4	
	(Corrected)	71.7	70.2	71.5
	Tuberculosis cure rate	49.3%	44.9%	48.9%
	% Family planning acceptors	13.9	24.9	21.6
	% ANC coverage	96.7	98.4	
	(corrected: see text)	137.8	133.5	133.4
	% PNC coverage	47.6	52.5	
	(corrected)	66.2	75.5	76.4
	EPI coverage - DPT3	84%	76.3%	
	(corrected see text)		105.7	111.6
	EPI coverage - measles	84%	82.4%	
	(corrected see text)		113.9	119.3
ACCESS	Number of outreach services carried out by specialist by region	134	141	158
	Doctor to Population ratio		1:22,811	1:21,086
	Nurse to Population ratio		1:2,043	1:2,079
	Outpatient visit per capita	0.45	0.49	0.48
	Hospital admission rate	34.9	34.9	33.3
	Number of community resident nurse per district/region (functional CHPS zones)		16	36
QUALITY	% Maternal audits to maternal deaths		<10%	(50-84%)
	Under five malaria case fatality rate		1.7%	
	% Tracer drug availability		70	
EFFICIENCY	AFP non polio rate		2.8	
	Number of guinea worm cases		4,738	5,545
	Bed occupancy rate	58.9%	64.6%	60.0%
PARTNERSHIP	% Recurrent budget from GOG and Health fund used by private sector, NGOs, CSOs and other MDAs		1.2%	
FINANCIAL	% GOG budget spent (allocated) on health	5.9%	9.1%	11.1%
	% GOG recurrent budget for health	11%	10.2%	11.0%
	% Earmarked/direct donor funds to total donor funds per partner		62.3%	NA
	% IGFs coming from pre-payment and community-insurance scheme		<3%	NA
	% Non-wage recurrent district level expenditure as a percentage of the total non wage recurrent expenditure).		48.6%	40.9% (6 mths)
	Total amount spent on exemptions (figure represents % of non wage recurrent expenditure spent on exemptions)		3.6%	3.2% (6 mths)

***Subject to confirmation from DHS (2003)**

2. The sector's performance

2.1 Sector-wide performance indicators

The preceding table summarises the data available to the review team on the national level indicators agreed to measure the sector's performance. From the incomplete data available, there would appear to have been some improvement in EPI coverage[1], after an earlier decline, an increase in specialist services provided to regions and substantial progress in establishing community nurses in CHPS zones. However, most other indicators of service volumes or system efficiency are stagnant and rather low. For example, the low rate of supervised deliveries is of concern given high maternal mortality rates. The low bed occupancy rates in regional and district hospitals, and anecdotal evidence of low case loads at health centres, suggest substantial over-capacity compared with demand. Given the significant increase in the share of the government budget allocated to health in 2002, it would appear that returns to these additional funds, at least in terms of increased service volumes, are yet to be realised. Based on the first six months' data, the proportion of the non-staff recurrent budget, spent at district level and below, fell in 2002 compared with 2001, although this was mainly due to delays in the release of donor funds at the beginning of the year. The full year results may be better than those shown in the table.

These national aggregates hide continued and substantial variations in resource allocations between regions and variations in efficiency between levels of service.

Resource allocations

Tables 1 and 2 in Section VII on human resources show the continued concentration of health staff in Greater Accra Region, where 27% of doctors and 31% of nurses work, not counting private practitioners, in a region where 16% of the population lives. The reasons are well known and relate to the sector's financial incentive structure and the desirability of living and working in or near Accra with its educational and social amenities.

As a result, the financial indicator used to assess budget allocations between regions and between levels of service is misleading. Staff costs account for more than 70 per cent of government expenditure on health. Moreover, service volumes and quality are related to staff and effective non-staff expenditure follows staff expenditure. Total recurrent expenditure would be a better measure of geographical expenditure concentration and focus on primary levels of care than non-staff expenditure.

Recommendation

Use total recurrent expenditure on district level services and below as a proportion of total recurrent expenditure to measure policy concentration of primary and secondary care; and total recurrent expenditure per capita by region (district) to measure geographical service concentration.

Efficiencies at different service levels

Bed occupancy rates are only one measure of hospital efficiency. However, the data in Table 1 suggests that, outside the teaching hospitals, hospital efficiency is low, variable and not improving. The substantial range of bed occupancy rates recorded suggest that regional and

[1]. These data, and indicators related to maternal care are difficult to interpret as the ratios have been corrected for census population estimates. In some cases the result has been service coverage rates in excess of 100 per cent. This is clearly erroneous.

district hospitals are not well sited compared with demand, that they are not located to complement mission hospital services and that, overall, there is considerable over-capacity in the sector. This finding is not new and the reasons for it are largely historical and well-known but it needs to be addressed.

Table 1: A measure of hospital efficiency

Bed occupancy rates	1997	1998	1999	2000	2001
Teaching hospitals	91.3%	91.7%	91.7%	68-94%	67-92%
Regional hospitals	70.8%	71.5%	37–61%	47-79%	43-72%
District hospitals	67.2%	71.3%	54+ %	52-86%	19-120%

On the other hand, GHS financed or provided primary and secondary care in Ghana's rapidly growing cities, particularly Accra, is sparse and of poor quality. This means that urban poor people are not well served. Those who can afford to do so seek health services from the military and policy hospitals or from private providers and Korle Bu Teaching Hospital is overwhelmed by used vast numbers of un-referred patients who could be better looked after elsewhere.

The evidence for variable hospital efficiency has been extended recently by a study of hospital unit costs carried out by the GHS and due to be released shortly. Differences in service costs are substantially related to the extent hospitals are run at full capacity. However, the efficiency with which resources are managed is also important and the results of this report should help hospital managers to manage better and the GHS to establish efficiency measures by which to assess their performance.

Outpatient caseloads, at hospitals and health centres, are not used to assess the efficiency of primary care services. This is a simple and quite robust measure that could be estimated with the data already available. There is considerable evidence that, outside the teaching hospitals, outpatient case loads are quite low. This appears to have resulted from a number of factors. First, in the drive to improve geographical access, a major objective of the First Five Year Programme of Work, primary healthcare facilities were built or upgraded with either little regard for the local demand for care or without making compensating reductions in staff and facilities in areas where there was over-capacity. Second, and more recently, the introduction of CHPS, which was a major innovation to bring services close to clients, is being `added on' to the existing distribution of primary care services rather than being planned to improve the efficiency of the health care system as a whole. In some areas, CHPS is likely to result in increased caseloads at health centres and district hospitals from referrals but, in other cases, in principle health clinics could be closed and their staff moved to areas that are relatively under-served. Ghana cannot afford these inefficiencies.

Recommendations

Additional measures of efficiency should be included in the list of sector-wide indicators, certainly outpatient case loads and possible case mix data.

Staff numbers should be adjusted to match demand, as well as need, and not be only based on staffing norms for different types of facility.

In particular, the density of primary and secondary care services need to be adjusted to take into account CHPS.

2.2 Health service consumption patterns

Although consumer behaviour figures prominently in the 2002-2006 Health Sector Programme of Work and its precursor document `Health of the Nation,' devising consumer-friendly health service strategies does not appear prominently in the 2002 Programme of Work and was not mentioned in the terms of reference for this review. This is an important omission, particularly as, although consumption trends appeared to be rising from 1999 until 2001, the consumption of health services at government facilities remains low compared with a number of other countries and was rather stagnant in the 1990s.

Table 2: Trends in health service consumption

	1996	1997	1998	1999	2000	2001	2002
OPD attendances per capita	0.36	0.36	0.35	0.32	0.42	0.49	0.46
Hospital admission rate per 1000 population.	...	26.5	25.5	23.0	32.0	34.9	40.9
TB cure rate		38.1%	44.1%	49.3%	44.9%	NA	
No. of Guinea Worm cases					7,420	4,740*	4877
AFP non polio rate					2.0	2.8	
% FP acceptors		19%	16%	15%	14%	25%	
% ANC coverage		85%	87%	86%	97%	98%	77.4%
% PNC coverage		34%	38%	...	48%	54%	40.9%
% supervised deliveries		41%	41%	44%	51%	50%	32%
EPI coverage							
DPT-3	51%	60%	68%	73%	84%	76%	
Measles	53%	57%	67%	71%	86%	82%	

***in 810 villages**
Source: 2002 from incomplete data in Regional Reports

There may be a number of reasons for this pattern of low health service consumption:

- this may be an equilibrium level of consumption as Ghanaians may be more effective in self-care than in other countries or may use health services more efficiently;
- there may be unmet health needs on account of financial &/or geographical access problems;
- the private sector may be preferred by consumers (see data in Private Public Partnership report);
- there may be a preference from services supplied by military & police who make a larger contribution than is recognised;
- there may be inappropriate health care seeking behaviour from untrained providers
- this may represent a government service failure.

These reasons almost certainly apply in different measure in different parts of then country.[2] If so, the key conclusion is that a one-size-fits all government health service delivery strategy is not appropriate. Ghana is an enormously diverse country in ethnicity, geography, demography and economic status. Health strategies need to be re-thought radically, district by district, based on the dominant reasons for low service consumption. In some sparsely populated regions, it might be better to invest in better transport or roads and close some facilities. In the

[2]. See reports of Living Standard Measurement Studies and Demographic and Health Services studies for evidence.

case of the urban poor, contracting private nurses, midwives and doctors financed from an exemptions fund may be most efficient.

3. Service delivery and institutional care

Introduction

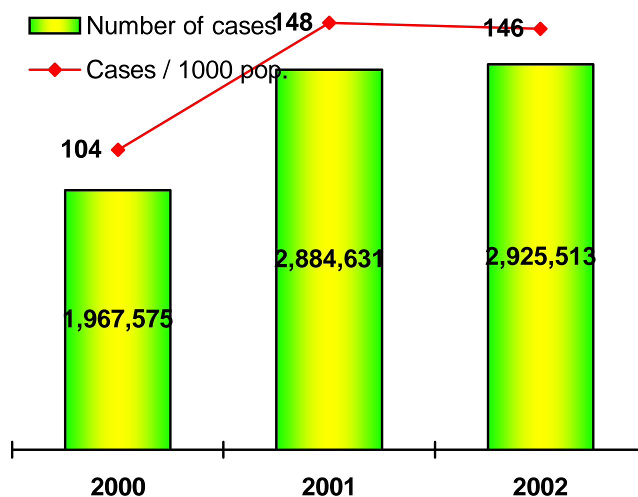
A key health policy thrust is a greater emphasis on diseases of public health importance, with particular focus on HIV/AIDS, Malaria, Tuberculosis and Guinea Worm (Health of the Nation, 2000 and POW, SPS). This section begins with a discussion of these priority health programmes, particularly for malaria, tuberculosis and HIV/AIDS. It then covers two important health service delivery challenges: the performance of hospital services and the CHPS strategy. This discussion includes an assessment of the performance of quality management mechanisms, in particular the role of maternal mortality audits. Tables detailing the progress made against PoW 2002 targets can be found at the end of this section.

Priority health problems and programmes

Non-communicable diseases

The emphasis of the PoW 2002 is primarily on continued progress in the reduction of communicable diseases on the grounds that they collectively impose the greatest disease burden and that most are easy to prevent. However, it is to be observed that the incidence of non-communicable diseases, including cardio-vascular diseases and cancer, is rising. Furthermore, injuries from industrial and road accidents and domestic violence are resulting in increasing mortality and disabilities. The costs of these incidents bear most heavily on the poor: both their direct costs in terms of treatments and their indirect costs in terms of loss of earnings. So far, most strategy discussions have centred on ensuring better emergency services without the need for `cash and carry'. Two issues are less prominent but deserve at least as much attention. The first is that small-scale insurance schemes may be unable to finance the treatment costs of catastrophic illnesses and accidents. These may be need to be financed from sector funds and there are arguments for providing publicly-funded catastrophic insurance. The second is that the promotion of healthy, safe, lifestyles, important as this may be in the case of reproductive health, is also important in terms of road and industrial safety, in terms of the avoidance of cancer and in terms of the deferral of degenerative disease.

Malaria



Malaria remains the leading cause of morbidity and mortality in the country. It accounts for 40% of all outpatient's contacts and 25% of all under-five mortality. The regional reports demonstrate highest incidence rates in Upper East and Upper West Regions (see Table 1). The alarming increase of roughly 50% during 2001 eased off during 2002 and the reported cases /1000 population even dropped slightly (see Figure 1). Interpretation of the data must be done with great caution, because the

reported cases include an unknown (but substantial) fraction of non-malaria fevers.

Table 1: Reported cases of malaria by region

Region	Cases 2000	Cases 2001	Cases 2002	Cases / 1000 Population 2000	2001	2002
Ashanti	34.718	419.526	432.135	10	112	112
Brong Ahafo	361.469	467.149	472.348	199	251	248
Central	168.195	225.702	211.242	106	139	127
Eastern	321.469	364.787	350.878	153	171	162
Greater Accra	276.492	368.827	439.247	95	122	139
Northern	267.477	308.847	263.037	147	165	137
Upper East	211.502	189.001	257.073	230	203	273
Upper West	103.080	104.159	137.550	179	178	231
Volta	185.963	217.185	217.477	114	130	128
Western	37.210	219.448	144.526	19	110	71
Ghana	**1.967.575**	**2.884.631**	**2.925.513**	**104**	**148**	**146**

Source: Regional reports 2002

Aim of the RBM Plan (2001)

" To reduce malaria mortality in children under five and pregnant women in twenty selected districts by 25% by the year 2007 through the promotion of access to prevention and treatment of malaria and strengthened partnerships between government, civil society and the private sector".

Various control measures have been undertaken in the past with limited success. Results of a baseline study (2001) showed that only 12.2% of households had an insecticide-treated bed-net and only 4.1% of children under five slept under one. The challenge to increase the coverage and effectiveness of preventive measures such as ITNs and chemoprophylaxis is enormous. A new national strategic malaria control plan has been developed since 2001 based on the RBM principles of multiple interventions, involvement of all stakeholders and "evidence-based interventions", to be conducted at all levels, with a focus at the community level. (CHPS)

Prevention

The PoW 2002 sets the continuation of the Roll Back Malaria Programme as its main target with emphasis on prevention and environmental hygiene, including:

- use of ITMs for children under five years old and pregnant women;
- home-based care for fevers;
- capacity building of effective case management by health staff; and
- a multi-channel IEC strategy

There are signs that the distribution of low-cost ITNs has increased, but progress is slower than required and has not been well documented. A few number of field observations confirmed the presence of ITNs at district health facilities. However, the quantity of the bed nets distributed through the GHS is well below the number required despite a huge stock of bed nets at the CMS. Involvement of the CHOs in the CHPS would provide excellent opportunities to involve the community more effectively in promotion of ITNs and case management Out of the 60,000 nets received from WHO and UNICEF 59, 200 have been distributed. ITNs are also available in commercial markets. However, their quality is questionable and price may be a deterrent for the poor.

The programme has regularly conducted staff training for case management in all regions. A strategy for multi-channel IEC activities has been developed and is being implemented. The

Anti-malaria Drug Policy has been reviewed to take into account the emergence of significant chloroquine resistance.

Treatment protocols

The current national anti-malarial drug policy recommends chloroquine or amodiaquine as the first line drug of treatment for uncomplicated malaria and quinine for cases of severe malaria. It also recommends weekly chloroquine chemoprophylaxis in pregnancy. However, the non-compliance with the drugs and the increasing resistance to chloroquine, called for a critical review of the current anti-malarial drug policy.

Following a review of the existing anti-malarial drug policy, a consensus was reached that:

- there is sufficient evidence to start the process of change of policy on treating uncomplicated malaria;
- quinine should be maintained for the treatment of severe malaria;
- the available evidence supports Intermittent Presumptive Treatment (IPT) and the meeting accepted to implement IPT in pregnancy using sulphadoxine-pyrimethamine;
- a task force has been set up to carry these recommendations forward.

Conclusions and recommendations

The midterm review of the first programme of work (2000) concluded that the attention given to effective malaria control was far too limited compared to the extent of the problem. Massive support to this programme has been given, including from the GFATM, the RBM, the DFID/USAID supported ITN programme and from the SWAp basket. However, coordination between the different support mechanisms is poor, and the programme would be strengthened if there were more effective coordination.

An effective malaria control programme is based on effective vector control, chemoprophylaxis and chemotherapy, emphasising the promotion of ITN. Environmental sanitation measures such as limited larviciding and indoor residual spraying is now less favoured.

The single overall sector indicator that measure progress against malaria is the U5 case fatality rate of malaria. However, none of the regional reports provides a credible estimate for this important indicator. This suggests that the reduction in morbidity and mortality from malaria has not yet been put on an even footing with other programmes such as EPI or TB.

Although this indicator is important for the quality of clinical services, it only reflects a small range of the actions required to control malaria and raises questions about the effectiveness of the fragmented approach being adopted to malaria control. The history of other disease control programmes suggests that they have all had to go through an initial phase where vertical strategies were adopted and, only after they had been established, were they integrated.

The RBM initiative has certainly emphasised the importance of malaria. However, as one of the components of an IMCI strategy, it still does not receive the attention it deserves. National capacity, particularly at the Regional and District level) continues to be far too limited.

As a result the teams recommends that

- *there is a need for higher profile of the RBM programme, promoting malaria as the most important killer disease;*

- *there is a need to pay more attention to vector control;*
- *the capacity at the regional level to advocate and monitor district activities on malaria must be strengthened.*

Tuberculosis

The incidence of tuberculosis in Ghana is not well known. The Annual Risk of Infection (ARI) is estimated between 1% and 2%, corresponding with 100 to 200 new TB cases per 100,000 population per year. The case detection in Ghana is around 30- 40% with little change over the years. The latest data from 2002 confirm this (see Table 2).

Table 2: Case detection TB all forms per region 1997-2001 (rates/100,000 population)

	GAR	ASHANTI	EAST	WEST	CENTRAL	VOLTA	NORTH	UW	UE	BA	Total
1997	74	53	86	60	91	70	22	42	70	43	62
1998	65	54	91	79	105	74	25	5	44	40	63
1999	63	40	69	82	104	73	22	28	41	34	57
2000	67	50	67	72	98	76	22	38	39	35	58
2001	66	52	75	86	99	76	24	67	35	25	60
2002	45	47	81	79	89	75	37	53	36	39	57

Ashanti includes figures from Komfo Anokye Teaching Hospital and in Greater Accra from Korle Bu hospital

Estimated HIV positive rate of TB cases:

OPD: 10%
Inpatients: 23%
Source: NTP

Case detection rates in the Northern provinces are considerably lower in the Northern, Upper West and Upper East. Women may therefore be more at risk, because women are less likely to use formal health facilities, because of the stigma attached to tuberculosis and HIV/AIDS. The lowest case detection rates are found in Northern Region (around 21 TB cases per 100,000 population), corresponding to an estimated case detection coverage of 14%.

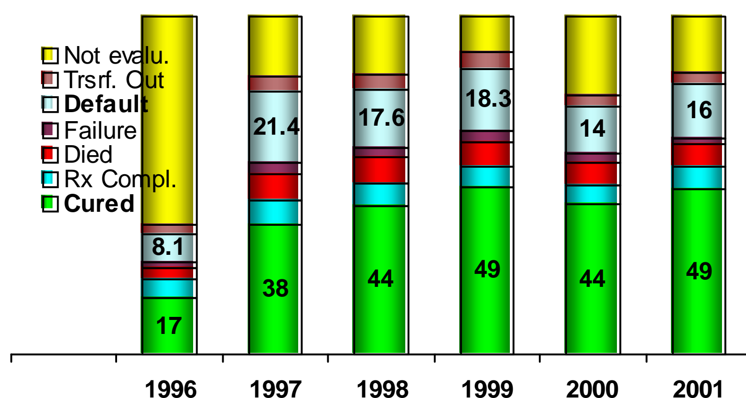


Figure 2 sumarises cure rates . Cohort analysis demonstrates that the cure rates have gradually been increased to a level of 49% for the year 2001.

The defaulter rates remain high in spite of efforts to scale up the DOTS strategy.

The main reason for the drop in the cure rate is the high rate of defaulters in the continuation phase of the standard treatment. DOTS has been introduced sector wide now, but problems with home and community based supervised therapy persist. Contrary to what happened in Zambia, the drug supply has not been disturbed during the transition in 1999 of the funding mechanism from direct programme funding to the basket funding system and drug shortages are not significant.

Two particular reasons contribute to high defaulter rates:

- Although TB patients are an exempted class, patients with TB often have to pay a significant amount to get diagnosed and receive treatment.

- There is stigmatisation by health staff and community, leading to high default rates before completion of treatment. The co-infection of TB and HIV/AIDS has made this an added hazard.

The mid-term Review of the First Five-Year Programme of Work (POW) conducted in early 2000 noted that, *"despite progress made in public health delivery, there are problems with TB control"*. The Aide Memoire of 2001 stated that *".. a reason of this failure was that priorities (such as TB) were not highlighted enough in the POW at lower levels. Besides lack of priority setting of TB, it was notified that the health sector was under-funded from MOF. On top of that*, serious *delays occurred in the release of funds (including that of donors), and delay in channelling the funds to peripheral levels. Moreover, when funds are scarce, reallocation may not prioritise TB control, therefore the new POW 2 should better prioritise TB"*.

Main shortcomings of the TB programme (WB evaluation 2002)

- Case detection is still too low, particularly for women.
- High defaulter rates in many areas.
- Qualitative supervisory capacity insufficient.
- Low diagnostic capacity and inadequate quality control on smear microscopy.
- Human resources shortages and high turnovers (particularly lab technicians).
- Drug management is inadequate at region and district level.
- Linkages with AIDS control activities, such as counselling, missing.

Within the overall programme strategic framework of the MoH, tuberculosis is included for special attention under "priority health interventions", i.e., implementing the tuberculosis DOTs strategy. In addition to plans to improve the efficiency and effectiveness of health service provision, there is a plan to replace single interventions by merging HIV/AIDS with TB, particularly because of the side effects of HAART treatment.

The POW 2002 sets improving cure rates and case holding, using the DOTS strategy, as its targets. Early case detection and reducing the high defaulter rates were are taken as an important issue. Increased decentralisation to the districts will be undertaken to ensure ownership.

POW II TB targets

- Decreasing TB mortality 50% by 2010.
- Cure rate improvement from 43% (1998-2000 value) to 60% by 2006 (POW)

The DOTS strategy has now been introduced countrywide and appears to be effective in the first two months of treatment. However, the supervision of treatment is not guaranteed in the continuation phase of first line treatment in remote areas. As a result, further decentralisation of the programme is being promoted actively.

Although it will become important to include the private sector in TB control, and there is a tendency to just detect (sometimes) and refer patients with tuberculosis to the NTP. Their role is still largely not organised. Most important problems include

- failure to report new cases;
- poor case management strategies;
- failure to adhere to case definitions.

Conclusions and recommendations

- *Scale up the DOTS strategy by promoting the role of CHOs in case identification and case holding*

- *Organise the involvement of the private sector in TB control*

HIV AIDS

Sentinel surveillance data seem to show that HIV sero-prevalence in Ghana over the past few years has been fairly stable in the range of 3-4 percent of the adult population aged 15-49, although there is a worrying increase in incidence in Eastern Region. The highest incidence is in Accra and Kumasi. Results from sentinel sites have also shown that HIV prevalence among STI clinic attendants is higher than in the general population ranging between 6-40%. Among commercial sex workers HIV prevalence is as high as 82%. Vertical transmission (Mother to Child Transmission) is reported to be 15% of HIV/positive delivering women.

Although there is no evidence of a rapid increase in HIV prevalence in Ghana during the past few years, most of the neighbouring countries have experienced such an increase and, all other things being equal, it would be surprising if the same did not happen in Ghana. The challenge is to ensure that it does not by effective promotive and preventive campaigns. However, it is clear that the number of AIDS cases and deaths will inevitably increase over the coming years as the 350,000 Ghanaians who are currently affected begin to develop, the symptoms of AIDS

Table 3: Reported new cases of HIV /AIDS by region

	Cases			Cases / 1.000.000 population		
Region	2000	2001	2002*	2000	2001	2002*
Ashanti	1667	3046	3261	461	815	844
Brong Ahafo	150	832	890	83	447	467
Central	798	519	44	501	319	26
Eastern	92	1062	1419	44	497	655
Greater Accra	1515	2284	2406	521	753	760
Northern	291	483	**	160	258	
Upper East	460	322	267	500	346	284
Upper West	166	293	42	288	500	70
Volta	532	311	175	325	187	103
Western	618	177	442	321	89	216
Ghana	**6289**	**9329**	**8946**	**333**	**480**	**448**

Government response to HIV-AIDS

The government's stated objectives are to:

- reduce morbidity and mortality from AIDS;
- protect the human rights of PLWHA;
- promote IEC about HIV AIDS;
- minimise the socio-economic impact of the disease.

The sector's responsibilities are set within the overall framework of the aids programme of the Ghana AIDS Commission (GAC)

The role of the National Aids Control Programme (NACP) is to:

- promote programmes to prevent the spread of AIDS;
- promote proper management of STDs through the syndromic approach;

- provide care and support to HIV/AIDS cases and families (VCT, MTCT, treatment of opportunistic infections, ART, home based care);
- introduce workplace policy on HIV/AIDS;
- provide technical support to other sectors;
- monitor the HIV AIDS epidemic.

Preventive measures

Preventive measures using IEC message on safe sex practices continue. However, there was no information available to the team on their effectiveness. Condoms are not advertised widely in Accra and were not available in any of the hotels or restaurants nor in any of the markets visited by the team.

Health workers have been trained on management of STD's using the syndromic approach and counselling services and home based care continue in all regions.

The use of ART to reduce mother-to-child transmission is being piloted in two institutions in the Manya Krobo district in the Eastern Region. Other regions have selected sites for this to commence and post-exposure prophylaxis is being tested in the two teaching hospitals

Voluntary Counselling and Testing (VCT)has being initiated in two district hospitals in the Eastern Region and in the two teaching hospitals. A more systematic approach to comprehensive clinical and community based prevention and care has been achieved in Atua Government Hospital and St. Martin's Hospital in the Eastern Region where VCT and MCTC are being piloted.

The public sector scaling up target is for the number of official VCT service points to increase from the current level of 4 to 24, with at least one point in each region fully operational for ART treatment by 2006. From there the coverage of ART centres will be further extended with the aim of having at least one in every district. Implementation is dependent on availability of external funding.

Anti-Retro-Viral Therapy (ART)

The NACP aims at scaling up from zero in 2002 to a target of 6000 PLWHA s receiving ART annually by the year 2006.[3] This target is partly based on the expected availability of funding and on the capacity of extension to provide it properly. With a current level of around 9000 new cases annually this will only cover a small proportion of all HIV cases. The MoH will use the WHO clinical selection criteria for eligibility of treatment.

The MoH drafted standardised treatment guidelines for ART in 2002. These are expected to be finalised soon and disseminated shortly.

Readiness criteria for introduction at facility level of ARTs

- Leadership
- Services
- Programme protocols, management evaluation
- Experience and staffing
- Laboratory capacity
- Drug procurement and management

CHAG is strongly committed to a more prominent role for ART, but is depending on the supply of drugs and testing materials through the NACP.

Results of an assessment on the readiness for the introduction of ARTs, using six readiness criteria show that, the eight selected facilities, six are formally ready to start providing ART.

3. HIV/AIDS Strategic Plan 2002 -2006

Aside from the activities in the public sector there are also initiatives in the private sector, supported by USAID and the Royal Netherlands Embassy. These aim to assist private treatment facilities in the introduction of ART in Accra for use by private employers, and negotiations are underway with the Ashanti Goldfields and Unilever about supporting HAART at their corporate facilities[4].

VCT services (for HIV/AIDS) can be an entry point for other services, such as TB treatment and prevention. All HIV-positive clients should be asked about cough and other symptoms of TB, and referred for TB testing if necessary (VCT and ARV guidelines, NACP). Staff of the TB control program should be trained in maintaining confidentiality of HIV test results, and the importance of maintaining a respectful attitude to all TB/HIV clients (VCT guideline, NACP)

Workplace policy

As VCT counsellors may be exposed to diseases in their work, they should receive routine preventive health screening, especially for TB. The workplace policy for the health sector, developed by the NACP in 2002 and due to be disseminated, aims at providing access to preventive services such as medication to prevent opportunistic infections, TB preventive therapy and ongoing medical support (ARV guideline, NACP).

Technical assistance to other sectors

The NACP will provide technical assistance on medical aspects of HIV/AIDS control at the request of other sectors.

Epidemiological surveillance

The NACP is monitoring the HIV/AIDS prevalence through the 24 sentinel posts, spread over the country. It intends to extent this number to 30 in the coming years. Special attention is paid to high-risk groups like mineworkers.

Conclusions and recommendations

If above strategies can be put in place the NACP will consider that it has fulfilled its sector-wide responsibilities for HIV/AIDS. However, the real test of their effectiveness will be a decline in the sero-prevalence. This is likely to require a significant intensification of preventive effort, more effective targeting to high-risk groups and a more detailed understanding of the strategies that are most effective in changing sexual behaviour.

Health and education

Although the school health programme over the years has undertaken a number of activities to address the health needs of school children it as recognised that these needed to be strengthened and made more coherent. Under a recently formulated strategic framework Recently, including the Ghana Education Service, Ghana Health Service, Local Government and Social Welfare; non-governmental organizations and bilateral development partners have formulated a strategic framework focussed on nine key thematic areas:

1 An audit of the current meal provision in school and food security among school-age children 6 – 13 years

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4. Preparing for the Management of Antiretroviral Drugs in Ghana – Findings and recommendations of the ARV Assessment team (Draft April 2003)

2 Assessment of the current health and nutritional status of a representative sample of school-age children in Ghana
3 Targeted intervention to address the health and nutritional needs of high risk groups
4 Formulation and possible implementation of a School Nutritional guidelines and school feeding programme (initially as a pilot programme)
5 Focus on adolescent and reproductive health with specific reference to HIV /AIDS in the school community including both pupils and teachers. A project focusing on nutrition intervention as a therapeutic strategy for HIV/AIDS has been designed.
6 Water and sanitation intervention programme following the earlier audit, in all districts in the country
7 Continuous professional development in school health through targeted training workshops and short courses to build capacity in school health delivery
8 Further integration and harmonization of collaborative activities involving all stakeholders in school health via the intersectoral team approach.

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In addition a database has been developed for assessing current service provision which impact on health in schools throughout Ghana. A research instrument has also been designed to specifically audit school meal provision and food security among the school-age community in all 110 districts of the country. A number of targeted training workshops aimed at building capacity of school health teachers and coordinators across the country have been run with success. These trained individuals are now resource persons for further school health activities.

School health activities can also act as powerful tool for prevention of HIV/AIDS both in school and communities.

Hospital care

Role of hospitals

For many years, the delivery of health services in Ghana has been conceived and implemented within a hierarchical organisational structure. Sub-district and community structures would to provide preventive and primary care. Sub-district Health Centres would provide comprehensive primary care services, handle minor medical and surgical cases and deliver MCH/FP and laboratory diagnostic services

District hospitals would serve as referral facilities for sub-district and district primary care facilities, and provide inpatient care, and technical supervisory and quality expertise to support primary care services. Regional hospitals serve as referral facilities for district hospitals and provide high levels of expertise for comprehensive secondary level health care, including specialised services in surgery and medicine as well as technical supervisory support in the clinical services in the region.

The Teaching Hospitals would provide advanced clinical services, including specialized care in such as in cardiology, nephrology and vascular care. They would also be final referral level in the service delivery hierarchy. In addition to providing clinical services teaching hospitals would offer facilities for teaching nurses, undergraduate medical students and postgraduate residents and for research. It was envisaged that patients could not access Teaching Hospitals except through a well laid down referral system.

This differentiation in role has not been realised, nor do the way hospitals operate support the service as a whole. Tertiary institutions are overburdened with primary and secondary level functions, reducing their efficiency and their capacity to provide quality tertiary and teaching services. Field observations in Kumasi and Accra confirmed that the two teaching hospitals

are overcrowded with self-referred patients in need of primary or secondary care that could have been given at a lower in the system.

Several factors that have contributed to this state of affairs. The two teaching hospitals are located in the two largest metropolitan areas in the country, which are least well served with primary and secondary level facilities. Much attention has been paid to the development of rural primary care services at the expense of urban primary health services and the development of clinical services under the GHS, the private sector and the teaching hospitals have not been formulated in an integrated way. The absence of an effective referral system makes it possible for the population of Accra and Kumasi to bypass urban policlinics and hospitals. Clients are even prepared the pay the marginally higher costs in search of `better' services at the Teaching Hospitals delivery. A second round effect is that the two teaching Hospitals employ about 30% of all medical officers in the country, sucking service delivery capacity from other parts of the country.

Conclusions on problems with Hospital services

- Poorly defined roles of and types of hospitals in both public and private sector
- Lack of clarity of definition of essential services
- Poor referral systems
- Poorly defined public needs and demands
- Lack of guidelines for the introduction of new technologies
- Lack of guidelines for emergency management at all levels

Source: Concept Hospital Strategy 2001

Bed occupancy rates and OPD consultation rates demonstrate great variation but, in general, substantial over capacity at the district and regional hospital levels. Moreover, although the cost per patient day in regional hospitals is roughly three higher than in district hospitals, spare capacity is greater at the district level than the regional level.

In summary, Ghana's hospitals are generally performing poorly, having excess capacity at district and regional levels and being overcrowded at the tertiary level, largely with patients who could be treated more efficiently elsewhere.

Quality of hospital services

Serious problems also exist with the quality of hospital services. Field observations confirmed obsolete basic hospital equipment and shortages. There are also severe staff shortages outside the two teaching hospitals, particularly in remote areas.

Progress against targets

The POW 2002 refers to the role of teaching hospitals and to the thrust on the completion of a total of ten technical policy documents and clinical guidelines, ranging from laboratory services, accident and emergency care policy and a quality assurance strategy to a policy on prosthetics. Most policy and strategy documents appear to be `final draft' form although most of the concept papers had been finalised. This suggest quite serious difficulties in reaching agreements on what feasible measures can be taken to improve matters (see a discussion of the Hospital Strategy below).

The GHS is currently disseminating the national guidelines for Quality Assurance (QA), and training clinical care teams at the district level. Results so far are not very apparent.

Safe motherhood

Given the high incidence of maternal mortality in Ghana, there has been a great deal of emphasis on the preventive and promotive aspects of care in the Safe Mother-hood

Programme. However, to be effective, this requires effective emergency obstetric care support. The implementation of maternal mortality audits has been promoted. The sector wide indicators for safe motherhood include the percentage of the maternal audits conducted. Interviews with the staff of the two teaching hospitals suggest that maternal deaths are systematically audited and incorporated in teaching material for medical students. Also the CHAG hospital visited showed that maternal deaths have been taken seriously, although documentation was restricted to registering the diagnosis. However, the effectiveness of maternal audits has not been assessed nation-wide and is poorly documented.

It is pertinent to note that supervised deliveries most often cover uncomplicated deliveries. The real problem lies with the care of complicated deliveries, which the primary and many lower levels are unable to handle. However, data about the outcomes of emergency obstetric care is not required.

Clinical Indicators for the Central Region show 27% of deliveries are complicated, and pregnancy related complications rank No.4 in the top ten causes of death. Out of 3,129 complicated cases recorded in the Eastern Region 2,875 (91%) went to Caesarean Section and in the Brong Ahafo region, of 2273 complications 1881 (83%). These ratios are far too high. Moreover, only six of the 325 facilities providing emergency obstetric care have blood banks. Where there are blood banks there is no guarantee that blood is available when required for emergency transfusions, a major way of reducing the incidence of maternal deaths.

The Hospital Strategy

There have been many attempts in recent times by the Ministry of Health to reverse the deteriorating service standards and efficiencies in the country's hospitals. It initiated the development of a National Hospital Strategy under the First Five-Year Programme of Work, which was intended "*to re-orient secondary and tertiary care to be supportive of primary care and to seek a reasonable balance between PHC and hospital services*". It was also meant to determine what services would be affordable for the country and the national priorities for future hospital development.

The deliverables were to include:

- a framework to agree on future rehabilitation, expansion and construction,
- the prioritisation of future capital investment in line with projected available resources (human and financial)
- the demonstration that investment decisions are made with due regard to equity and rational planning based on the most effective use of available resources
- the ToR for a programme of hospital reform for improved management.

The first draft of the `Concept of Hospital Strategy' was finalised by the MoH in October 2001. It provides a critical review of the distribution of hospitals and the inefficient use of (predominantly) human resources. The strategy document concludes that most regional hospitals are under-utilised and has no doubt that there are too many hospital beds relative to demand. This conclusion supported by data about low bed occupancy rates (40 –60%). The increase in number of both public and mission hospitals (often under political pressure) has contributed to this problem. It identifies the following five outstanding areas to be considered in future:

- costing of Hospital services
- financing of health programmes
- HRD
- access to information and
- determination of recurrent cost implication of future infrastructure requirements.

The MoH has made an important first step towards redefining the roles of hospital services and improving hospital management. The functions and roles of district, regional and teaching hospitals are described in detail. It includes a definition of the average population to be served and the number of beds needed for an extensive package of services to be provided at the three levels. The costing study has already been carried out by the GHS. In addition, a model has been developed for linking capital expenditure with recurrent costs. However, capital and recurrent budget planning is still not fully integrated (see Section IV).

The `Concept of Hospital Strategy' does not fully resolve the differentiation of functions between service levels. Referral functions are mixed with the primary functions: teaching hospitals are also supposed to continue to assist in providing basic health care. As a result, MoH keeps the door wide open to the inappropriate use of teaching hospitals for primary care.

In addition, the strategy document principally covers the 'providers' point of view of service delivery, including reform of hospital administration. The consumer's perspective is largely underdeveloped although a `supermarket' approach to service provision gives sufficient room for clients to select the services they want most pick from the proposed package, provided that efficient communication mechanisms for client consultation will have been established.

The expectation that a national hospital strategy will result, on its own, in more rational hospital planning and utilisation is unrealistic. Planning of new facilities can never be on the basis only of defined capacity and the types of services to be provided. Hospitals have a specific role in a multi-tiered system and their functions need to be specified in that context. An alternative approach would be to take a geographic perspective, in which the roles and functions of the different providers in a certain geographic area (region or district) are defined in the most efficient, equitable and responsive way and links created between them. Moreover, changes need to be made outside the hospital sector for improvements to occur. In particular, much more attention needs to be paid to improving primary care in urban areas.

In addition, consumers need to be given information and incentives to use hospital services more efficiently. Un-referred, non-emergency cases presenting at secondary and tertiary facilities might be subject to much higher fees than at present. However, this requires good quality alternatives. Using the organisation of the urban health services in greater Accra, which is the least efficient system of health care provision, for this purpose would provide excellent opportunities for modelling the rationalisation of hospital care, and could be used as a start for the development of integrated systems for urban health services.

Although a hospital strategy can provide a broad framework for improvement, real progress will only be made on a facility-by facility basis. More needs to be done to improve hospital management and financial management than is discussed in the hospital strategy document. This is the more important with the prospect of insurers and District Assemblies becoming additional purchasers of health services. In this regard, it is urgent that intentions of the Ministry regarding the autonomy of hospitals are clarified. Last year the MoH initiated a process of Business Planning in larger hospitals. If the preparation of solid Business Plans and related management improvements were preconditions for autonomy, this might provide strong incentives for managers to make the changes required to improve efficiency and services that were integrated with other levels.

Conclusions and recommendations

- *Review the incentives consumers have to use facilities inappropriately*
- *Proceed with the implementation of the proposed additional studies mentioned in the `Concept of Hospital Strategy'*

- *Start to set up an effective referral system, that will sanction non-emergnecy cases entering the system at too high levels, without proper referral*
- *Conduct an urban health care development strategy for Accra metropolitan area as a model for area-based integrated health service planning*
- *Support the continued development of Business Plans by larger facility managers.*

CHPS

The CHPS strategy

The Community Health Planning and Services initiative is one of the government's main strategies for bringing services closer to clients, particularly in rural areas. The concept is based on work done earlier in Navrongo.

The Navrongo Community Health and Family Planning Project (CHFP) was originally launched by the Navrongo Health Research Centre (NHRC) as a pilot study aimed at realizing Ghana's long standing commitment to improving quality of and access to primary health care. The Navrongo experiment demonstrated convincingly that community mobilization combined with community-based deployment of the nurse represents a cost- effective way to enhance service coverage. In addition this experiment demonstrated that service strategies can greatly improve the quantity, efficiency and quality of health and family planning care. The CHPS initiative was subsequently designed to translate these research findings and innovations into policy for a national community health care programme.

Achieving health sector reforms that increases geographic access to health care delivery remains a central priority of the health sector reform in Ghana, and therefore the CHPS strategy has been incorporated into the Ministry of Health's POW II which looks to reduce health inequalities and promote equity of health outcomes by rolling out the Community-based Health Planning and Services as a strategy for empowering communities to improve health status and access to quality basic health care. The CHPS strategy is an effort to place community health workers directly in the communities to deliver services rather than attaching them to difficult to access fixed health facilities (GPRS 2002). The Ghana Poverty Reduction Strategy (GPRS) identified CHPS as a key element in providing pro-poor health services.

The CHPS service delivery package

Family planning
EPI
Malaria prevention and treatment
Antenatal care
The supervision of uncomplicated deliveries

Evidence from the Nkwanta District in the Volta Region and Abura-Asebu-Kwamankese District in the Central Region confirms the expected improvements in access to health care and marked improvement in coverage indicators in communities where CHPS has been initiated. Various sector performance reviews have also commended CHPS as an appropriate way to deliver health care to communities in undeveloped and deprived areas far from health facilities.

The service package provided under the CHPS programme includes a limited number of clinical interventions of recognised cost effectiveness. However probably more importantly its aim is to mobilise local communities and develop capacity to play an active role in preventing and managing commonly occurring diseases. However, the role CHPS can play in the DOTS strategy is not defined.

The CHPS approach involves an overall reorientation of the District Health Systems in Ghana aimed at

- Establishing Community-based Health Planning and Services (CHPS) in all Districts
- Strengthening the Sub-district Health Systems to support CHPS
- Revamping District Hospitals to provide the requisite referral support for the sub-district level

In 2002 with technical assistance from Prime II, the Ghana Health Service conducted an exercise to determine the cost of placing Community Health Nurses in a `CHPS Zone' and the annual recurrent costs needed to sustain them in the community. Cost data was gathered from 16 zones in five districts from Central, Eastern, Western, Volta, and the Upper West Regions. On the basis of 1,570 CHPS over the next five years (2002-2006), depending on the choice between constructing or rehabilitating a facility and the possibility of the need for installing solar power equipment, placing one CHO in each community would require an initial investment of $12,500. This includes costs of 1 motorbike, 6 bicycles and costs of a radio communication system. A phased implementation plan was developed and adopted by the Ghana Health Service on this basis. The plan proposes about three hundred (300) Community Health Officers will be installed that each year. This phased plan takes into consideration districts with small populations and those with a sparse distribution of communities while not losing sight of the scarcity of funds and human resource.

Implementation progress

The PoW 2002 does not define specific targets for the implementation of CHPS although it is mentioned as an important strategy for increasing access to health services. In spite of the absence of specific targets, the GHS has made steady progress with preparations for the scaling up of the system, including a national strategy and finalisation of technical guidelines for the setting up of CHPS. The concept has gained international attention from the Commission for Macroeconomics and Health.

Monitoring and evaluation data available from the CHPS M&E Secretariat of the PPME Division of the Ghana Health Service, indicates that as of September 2002, almost all districts in the country had started implementing components of CHPS, although many have been unable to complete their 'zones' due to lack of resources. In particular, progress has been hindered by the scarcity of funds to construct community health compounds and provide logistics and manpower.

The implementation policy of CHPS defines carefully all steps that must be taken before the decision will be taken whether or not a CHPS unit will be opened in a community. The two most crucial elements to success and sustainability of the CHPS strategy are:

- to integrate it from its inception into the programme plan and budgets of the districts,
- to ensure that the community is involved in its ownership

Compromising on these steps would seriously affect the initial concept of CHPS, being the provision of community health care, in contrast to medical care. There is a danger that, unless CHPS is integrated into district health plans and the impact of community services on higher level services is assessed and anticipated, CHPS will become a layer `added on' to primary care, absorbing budgets and creating a new layer of inflexible cost sinks.

Conclusions and recommendations

The Medium Term Health Strategy identified geographical access as a major barrier to health care and as such, the first five-year program of work (POWI), among other things set out to improve geographic access to services by the provision of new facilities to expand the

government owned and staffed institutions. Health Centres were to be upgraded to district hospitals with the view to each district having a district hospital, and each region a regional hospital. The number of facilities has doubled over the first five-year program of work (1st 5YPOW) of the health sector.

In addition the Ministry of Health shifted more resources towards the periphery (district level and below) for preventive and primary health services. As a result, during the first five-year program of work (1997 – 2001) there was a noticeable shift in share of non-wage recurrent expenditure towards the district and sub-district levels with increased flexibility in their use.

Table 4: Outpatient visits per capita by Region

	2000	2001	2002
Ashanti	0.50	0.56	0.45
Brong Ahafo	0.61	0.62	0.62
Central	0.34	0.41	0.41
Eastern	0.44	0.45	0.47
Greater Accra	0.45	0.53	0.40
Northern	0.36	0.33	0.20
Upper East	0.53	0 .52	0.64
Upper West	0.49	0.49	0.49
Volta	0.39	0.39	0.36
Eastern	0.43	0.49	0.34
National	**0.45**	**0.49**	**0.46**

However, despite this focus on improved access to primary care, immunisation rates and OPD attendance per capita did not increase significantly between 2000 and 2002. The use of OPD services actually declined by 8% between 2001 and 2002. This decline is particularly striking in the Greater Accra, Northern and Eastern regions. The overall implication is that the costs of supplying publicly-funded primary health services has risen greatly, without much improvement in their consumption.

Overall, the use of OPD services in Ghana is low compared to neighbouring countries with similar characteristics. Various studies have concluded that the introduction of user fees (IGFs) has been the major cause of low OPD service use, as a large proportion of the population, especially the rural communities, is unable to pay for health services. An exemptions policy was introduced to help mitigate the effects of user fees but this has been largely ineffective and may actually be regressive: that is, the evidence suggests that it may have benefited the rich more than the poor (see companion report on exemptions).

However, this explanation may be too simplistic. An equally plausible one is that people are by-passing government services that they perceive to be inconvenient and of low quality in favour of non-government services, even if they have to pay. It is probable that many factors contribute, to a greater or lesser extent in different localities. The first section of this report emphasises the importance of analysing the factors determining the consumption of health services in different parts of the country and creating district health plans which take these factors, and the services supplied by all providers into account. While the introduction of CHPS is to be applauded, it should not become part of a one-size-fits-all strategy. Moreover, it should reduce costs, not add further to them.

As a result the team's recommendations are as follows:

- *District teams need to rethink in a creative way about what determines the consumption of health services their districts and develop (business) plans which reflect the behaviour of consumers and their health needs and how government and non-government services can meet these needs most cost-effectively*

- *CHPS should be used as one strategy when its benefit-cost profile adds efficiency*
- *Its effects on other services (possibly increased demand for referral services and reduced demand for other primary services) should be assessed and adjustments in supply made*
- *The implementation of CHPS should follow carefully the systematic steps defined for its development*
- *CHPS should be scaled up after careful preparation and at a pace the community can absorb*
- *The CHPS concept should be valued as much for its contribution to improving quality as to improving geographical access*
- *Approaching the CHPS development from the perspective of the community through the local government systems, instead of the health sector might be a valuable alternative for enhancing sustainability*

Health services: progress against 2002 PoW targets

Objective	2002 PoW targets	Achievements	Comments
TUBERCULOSIS Improving cure rates and case holding using the DOTS strategy	Improving cure rates Improving awareness of TB and importance of treatment compliance. Early Case detection Reducing high defaulter rates Increase decentralisation to district	Cure rates declined Case detection rate declined Defaulter rates remained high	Supervisory capacity inadequate Low diagnostic capacity and inadequate quality control on smear microscopy. Human resources shortages and high turnovers (particularly lab technicians). Drug management inadequate at region and district level. Good data for 2002 not available
MALARIA Prevention of malaria Improve management of malaria	Vector Control Proper management of complicated and uncomplicated malaria A multi-channel IEC strategy Increase home based care of fevers	The distribution of low-cost ITNs has increased 59,200 ITN's distributed to under fives and pregnant mothers The programme has regularly conducted staff training for case management in all regions The Anti-malaria Drug Policy has been reviewed to take into account the emergence of significant chloroquine resistance A strategy for multi-channel IEC activities has been developed and is being implemented	Small decline in the number of cases per 1000 population The progress made with use of ITNs is largely unknown.
REPRODUCTIVE and CHILD HEALTH Reduce infant mortality and Maternal mortalty	**Increase delivery of family planning services** **Integration of STI management services for men** **Increase life saving skills of health workers** **Increase Emergency obstetric care in levels B& C** **Increase growth monitoring skills of professionals** **Increase IMCI services**	CYP for both long and short term methods fell below expectation Capacity building of doctors nurse and midwives in mini-laparotomy, family planning counselling, IUD insertion Nothing reported 11 doctors and 61 midwives from sector trained in Safe Motherhood Clinical Skills 20 resource team members trained as trainers for Safe Motherhood IE &C Not much progress has been made IMCI Facilitation Skills Training IMCI Case management Training	Emergency obstetric care should be given more attention. Funds for scaling up, equipment, training, etc are a big challenge

	Improve Adolescent Reproductive health services **Cervical Cancer Screening**	A draft Adolescent Health Lay Counselling manual produced 132 Resource persons were trained as trainers in ADRH from Eastern, Central and Greater Accra regions Draft RH Policy and standard were developed 2 sites operational- Ridge Hospital and Amasaman health centre At Ridge Hospital -5716 clients screened,12.7% positive (dysplasia),14biopsies, 4 cancer cases, 1 died. Amasaman health centre – 2443clients screened, positive rate 7.6%. No cancer so far. 5 biopsies done. Nurses trained – 6 for Ridge, 4- Amasaman Supervisors (doctors) – 2 Korle-Bu, 3 Ridge Prevention of Mother-to-Child Transmission (MTCT) of HIV/AIDS phase-in programme, being implemented in 2 facilities in the Manya Krobo district A manual for health workers on PMTCT has been developed	
EPI	EPI Increase coverage of all antigens to at least 80% Introduce pentavalent vaccine Measles supplementary	Overall Coverage of all antigens above 80% Pentavalent vaccine introduced	2002 census population figures do not tally with projected population figures and so reflect on as very high coverage figures although low performance exists in some districts especially with island communities ; Concern about measeles outbreaks as reported in the BAK district, in spite of high measles coverage rates for many years
HIV/AIDS/STDs Promote preventive activities and increase care and support programs	Promote Safer Sex Provide Effective Management of STD Reduce MTCT Promote VCT Introduce ART	IEC continues nationwide Training of health staff in syndromic management of STD Attach STD clinic services to FP clinics MTCT pilot in 2 districts in Eastern Region VCT at four sites ART policy completed Implementation mechanisms being finalized	

CLINICAL SERVICES Develop and establish systems and programmes that will ensure access, quality, efficiency and effectiveness of clinical service delivery	Laboratory services policy Accidents and Emergency care policy Hospital Development strategy Quality Assurance Strategy Mental Health policy Accidents and Emergency care policy National Oral Health Policy Policy on prosthetics and Orthotics Policy and Guidelines for nurses Guidelines on catering services Blood Safety policy Accident and Emergency Care manual Quality Assurance manual Nursing Management standards Laboratory standards for patient care Establishment of District clinical care units Decentralisation of specialist outreach programme Institutionalise dental, eye and psychiatric outreach services	Final draft of lab policy QA Policy and strategy documents completed Maternal audits being undertaken in several institutions Draft oral policy & 5yr strategic plan Policy on institutional feeding launched National guidelines on clinical use of blood launched QA manual printed and in use District Clinical Care units established Outreach still centralised Final draft of lab policy Infection prevention & Control policy developed to final draft stage GHS code of ethics printed Patients' Charter printed	Policy guidelines and strategies and manual targets may have been overambitious Maternal audits should be qulalitative and not quantitative and should report actions taken
EMERGENCY CARE	Establish effective primary level of Emergency Care: Accidents, Obstetrics/Gynaecology	Not much achieved	Severe Human resource constraints And lack of equipment

CHPS Increase Community based services	Identify new Districts and prepare them for CHPS Expand within lead districts and support them with adequate logistics	100 of 110 districts (91 %) have started implementing the CHPS program and are at different stages of implementation Most zones have started stages involving planning or community entry. Few districts have completed the entire CHPS process in an existing zone.	The implementation of CHPS should carefully stick to the systematic steps defined for its development process Scale up of CHPS must be done carefully at a pace the community can absorb The CHPS concept must be valued as much for its contribution to improving quality as to improving geographical access Approaching the CHPS development from the perspective of the community through the local government systems, instead of the health sector might be a valuable alternative for enhancing sustainability
Hospital services	Hospital strategy document	Hospital strategy document still under review	
	Teaching Hospitals Appointment of substantive heads of organizations	Completed	

4. Health service financing and expenditure[5]

4.1 Trends in health sector financing

Information on the core sector wide financial indicators is set out in Table 4.1. The data are incomplete for a number of reasons. One is that reconciled financial statements were only available for the first six months of 2002. More complete data were available from GHS on service (item 3) and DPF funding only. A second problem concerns the consistency of regional reporting. While most of the regions provide some financial information this is not presented in a standard format. It is also evident that some regions interpreted the core indicators in different ways possibly because they were not given precise definitions of what to measure.[6]

Table 4.1: Financial sector-wide indicators

	MOH baseline - (1999-2000)	MOH target - 2006	2001	2002 Budget	2002 actual	2003 Budget
% GOG budget spent on health system	5.9%		9.1%	10.3%	11.1%	11.5%
% GOG recurrent budget spent for health	11.0%		10.2%	10.5%	11.0%	12.0%
% GOG recurrent health spending on non-salary items (2 &3)[7]			12.9%	30.2%	17.8%	16.1%
% of earmarked/direct donor funds to total donor fund		40.9%	63.0%		NA	
% IGF from prepayment schemes			NA		NA	
% spending on district and below (items 2 & 3)		42%	48.5%	33.3%	40.9% (6 mths)	47.8%
Total % spending on district from DPF & GOG3			41.0%		24.6%	
Total exemptions for regions (based on 6 regions[8])					14.36	
% of exemptions spent on ANC					37.6%	
% of exemptions spent on aged					16.9%	
% of exemptions spent on under-5 years					43.3%	
% of exemptions spent on the poor					1.6%	

Source: Programme of Work, 2002; Regional annual reports, 2002; Ministry of Health Financial Statements 2001 and 2002 (quarters 1 & 2); GHS data and budget resource allocation 2003.

There have been improvements in GoG funding of health services, with a greater share of the overall GoG budget going to health. This is partly attributable to debt relief initiatives whereby resources can be redistributed from the statutory payments to the discretionary component of the budget. Government has committed itself to giving priority in the use of these additional discretionary spending funds to the social sectors.

Based on the limited available data, it is estimated that expenditure on health care from all funding sources in 2002 was about ¢1,100 billion [9]. Total government spending in 2002 was

5. See financial annex for supporting data and details related to this section.
6. For instance in reporting IGF revenue some report total government budget or expenditures for the region. It may in fact be more useful to ask regions only to report inflows and outflows using a standard format plus the spending on exemption categories and then for the MOH to collate and work out indicators using a consistent format.
7. This has not been defined as a POW sector-wide indicator but is useful in monitoring the allocation between recurrent items.
8. Northern, Ashanti, Greater Accra, Central, Brong Ahafo and Upper East.
9. 2002 out-turn is only available for GOG expenditure (660 bn). Spending on the health fund was roughly 289bn while earmarked aid pool funding (inflows) were around 30.5bn.

around 41 percent higher than budgeted (in 2001 it was 27% higher) largely due to increases in the salary line (item 1). Thus, it appears that the budget-MTEF does not impose a hard fiscal constraint on the sector.

The result of the increasing government allocations to the health sector, driven by salary increases, is that there has been a shift in the share of different sources of finance. When focusing on the donor : GoG split (i.e. excluding IGF revenue), there has been a relative shift from almost 55% of funding coming from GoG sources in 1998 to over 70% from this source in 2002.

A new funding mechanism that could benefit the health sector is that of HIPC funds. In 2002, almost ¢200 billion of HIPC poverty reduction funds were disbursed. Most of this funding was made available to district assemblies, with the only condition attached to this funding being that it had to be spent on education, health, water and/or sanitation. The majority of these resources were dedicated to the education sector during 2002. Nearly ¢1,100 billion in HIPC poverty reduction funding is available for 2003. This is almost equivalent to the total health sector budget, both GoG and donor funds, for 2003. Once again, these resources will be channelled primarily through DAs.

Recommendations

Maintain pressure for an increasing share of GoG funds to be allocated to the health sector to achieve the target of 15% share for health services, as committed to by African Leaders during the NEPAD Meeting in Abuja.[10]

The POW II goal to improve collaboration between the health sector and DAs should also be prioritised in order to access a fair share of HIPC funds for health sector activities.

Improve spending efficiencies (section 3)

Build DA's capacity for managing budgets ahead of new financial responsibilities

4.2 Trends in health care expenditure

Distribution of health care expenditure by line item

The proportion of the GOG budget spent on staffing has increased from around 55% in 1998 to more than 80% in 2002. The budget for 2003 allocates only 16 percent of the government health budget to non-salary items. Comparing data for the first two quarters of 2001 and 2002, there was a 9% increase in real per capita expenditure on personnel emoluments (item 1) and a 4.5% decrease in real per capita non-salary expenditure (items 2-4). This suggests that the much needed salary increases and ADHA are starting to 'squeeze out' critical non-salary expenditure (purchase of drugs, facility maintenance etc.).

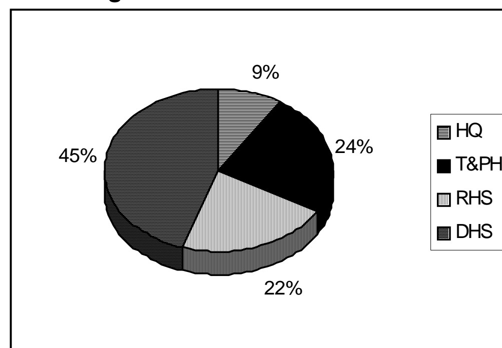
Information on year-end direct donor payments and IGFs is not yet available, but was estimated at 152.7bn based on the first 2 quarters' results.

[10]. Ghana Health Service. 2003-2005 Policies and Priorities: Draft. 2003.

Distribution between levels of the health system

Figure 4.1 indicates the distribution of expenditure in the first 2 quarters of 2002 between different levels of the health system. The MTEF allocation for 2002 was very similar to actual expenditure in the first two quarters for district health services and regional health services. Expenditure on headquarters (MoH and GHS) was slightly lower than budgeted, while expenditure at teaching and psychiatric hospitals (24% of total expenditure) was considerably above the MTEF allocation (19%).

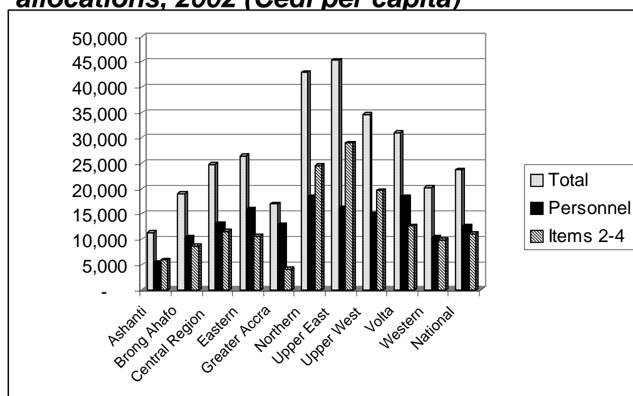
Figure 4.1:Expenditure on different health system levels during 1st six months of 2002



Distribution between geographic areas

Despite the POW II commitment that the "resource allocation formulae [should be] revised to include health needs, poverty and gender issues", only minor changes have been made to the resource allocation formula to date and no needs-based indicators have been included [11]. However, considerable efforts have been made to redistribute resources to some of the most deprived regions through taking a 'top-slice' from the GHS budget for targeting to these regions before the other allocations are made.

Figure 4.2: Per capita MTEF regional allocations, 2002 (Cedi per capita)



Unfortunately, due to the lack of expenditure data, the extent to which budgetary shifts have been translated into resource changes on the ground could not be assessed. However, Figure 4.2 indicates that most of the attempted redistribution of resources relates to items 2-4, rather than to personnel emoluments (item 1). The three northern belt regions have considerably higher per capita MTEF projections for items 2-4 than for item 1, whereas the reverse is the case in almost all the other regions. It is unlikely to be feasible for the northern belt regions to absorb resources allocated for administration and services adequately and efficiently without staff first being redistributed to these regions.

Recommendations

The relative distribution of expenditure between line items must be closely monitored to ensure that non-salary expenditure is not squeezed out.

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[11]. Ghana Health Service 2003 Resource Allocation in the Ghana Health Service. Draft, 2003.

In order to ensure that the POW II targets of increased spending on the district and below level are achieved, steps must be taken to ensure that these levels receive priority in early fund disbursements so that budgetary allocations can be translated more effectively into actual expenditure.

Priority attention should be given to redistributing staff between and within regions, rather than the current emphasis on attempting to redistribute the much smaller budget categories for items 2 and 3. This requires considerable efforts to find mechanisms for attracting and retaining qualified health professionals to currently under-served areas.

4.3 Financial management issues

Cash flow issues

Interviews with staff at all levels of the system suggest that the release of cash over the last few years has been slow, unpredictable and below budgetary expectations. Problems are largely confined to line items 2 and 3 since salaries appear to be largely paid on time. As in the past, more funding was released in the second half of the year than in the first half for all BMCs. For DPF and GOG item 3 (i.e. service) combined, disbursement in the first six months was 44% of the total.

One factor contributing to these cash flow problems is that a number of donors held back disbursements to the DPF in 2002, due to the late production of financial statements by the MoH. Final releases for 2002 by donor partners are still being made more than three months into next financial year. This has led to a sharp reduction in the value of the total cash balances held in the donor pooled health accounts[12].

An issue of considerable concern is that certain levels of the health system (region and above) appear to have been able to access available funds more rapidly and to a greater degree than others (district and below). By the end of 2002, the proportion of budget allocations actually disbursed from headquarters was equivalent to 75% of GoG item 3 and 85% of DPF budgets for regions and above, but only 60% of GoG item 3 and 40% of DPF budget allocations for districts and below. In 2003 releases to regions will be sent as a lump sum to region, which will then write cheques according to an agreed schedule. It is hoped that this will speed up the initial release process although getting funds to districts and BMCs is still a problem.

The ability of BMCs to develop and implement business plans that are in accord with national policy is strongly affected by existing budgeting and cash flow problems. Cash flow uncertainties are impacting adversely on district and lower levels in particular and it is these levels that need particular attention in future.

Capital planning and budgeting

Considerable progress has been made in improving the process of capital planning for the sector. A plan for 2003-2006 has recently been prepared which clearly emphasises investments in services at district and below[13]. However, while the capital plan covers civil works

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12. Mensah P.K. (2003) Comments on Ministry of Health 1st and 2nd quarter 2002 financial statements, for Danida Health Setor Support Office.
13. Ministry of Health (2003) Republic of Ghana Health Sector Overall Capital Investment Plan and Budget 2002-2006, Accra.

requirements in detail, there is relatively little information on vehicle and equipment requirements. There is also no consideration of other investment requirements such as project 'start-up' costs of human resource investments and systems development.

Additional recurrent costs estimated to be 24.5-36.8 billion cedis of 1,100 bilion cedis
While the capital investment plan describes a model that can be used to predict the recurrent cost implications of civil works, it appears that there is insufficient interaction between the CPU and MoH PPME. There has also been no consideration of how capital investment undertaken by DAs using HIPC funds will be taken into account by the CPU or their recurrent cost implications by health district offices.

Recommendations

Urgent steps need to be taken to avoid the withholding of funds by donor partners. On the donor partner side, it may be necessary to give greater consideration to the complexity of regular financial reporting and to explore alternative mechanisms of financial monitoring (e.g. drawing on reports of actual disbursements to BMCs in some quarters and only requiring full financial statements at year end). On the MoH and GHS partner side, financial information systems require improvement to move towards routine production of full financial statements.

There should be a detailed investigation of why the regional level and above are able to access fund disbursements earlier and to a greater extent than the district and lower levels. In addition, there must be a clear policy of prioritising of disbursements to districts and sub-districts.

At a minimum, providing district BMCs with better information, not only on the dates of disbursement but also on revisions to their expected budget and resulting cash flow, is a priority.

It is essential to link the capital plans of district assemblies with the health sector investment strategy.

In addition, project start-up costs, such as investments in human resources and systems, should be incorporated into the capital investment plan.

Improved mechanisms of accounting for the recurrent cost implications of capital costs is also needed.

4.4 Key health care financing initiatives

Exemptions[14]

The exemption system is not functioning effectively at present, with a growing number of facilities no longer providing fee exemptions, other than in exceptional circumstances. The main reason for this break-down in the exemption system is that reimbursements have not reached most facilities for more than 8 months and facilities are heavily reliant on IGF revenue for continued service provision.

The other aspect of current fee exemption implementation that is of considerable concern is that the major beneficiaries are children under 5, pregnant women and the elderly with almost no exemptions being granted to the poor. With almost 40% of the Ghanaian population being defined as poor and 27% as extremely poor (i.e. cannot even meet their basic nutritional

14. See also companion report on exemptions.

requirements), the current lack of targeting of the poor is unacceptable. While this is partly attributable to difficulties in identifying the poor, it is also due to the attempt to do too much with too few resources. In particular, it is not feasible to exempt all people in particular groups (e.g. under-fives and the elderly) from certain services and to exempt all services for the poor within the constraints of resources currently available for funding exemption reimbursements.

Recommendations

The primary beneficiaries of fee exemptions, and subsidies for insurance contributions as health insurance coverage expands, should be the poor.

In contrast to the current system of waiting for the poor to present at health facilities and apply for exemption status, there should be a process of pre-identification. This activity should be undertaken by local committees with significant community representation.

Adequate resources should be made available to fully cover the costs of fee exemptions and insurance contribution subsidies. This requires detailed costing and may call for an increasing share of non-salary GoG and DPF resources being directed to this activity.
These resources must be equitably allocated. The primary indicator to determine allocations between geographic areas should be the number of poor (or extremely poor) individuals in each area.

Appropriate and effective mechanisms for distributing these resources must be identified. In the short-term, it is critical that the existing fee exemption reimbursement channel (from GHS headquarters to regional offices and then to individual facilities) is improved as a matter of urgency.

Clear information on the new exemption system, and on insurance contribution subsidies, should be widely disseminated to health service providers and to communities to strengthen effective implementation.

Health Insurance

The government has launched a major initiative to replace user fees with health insurance. The country already has a small but rapidly expanding Community Health Insurance sector. These independent organisations purchase care for members at low cost, and offer a high degree of accountability to members; hence their appeal. The Government hopes to marry this model with a national system that will bring in the formal sector, as well as cross subsidies to boost equity.

However, several important design and implementation questions remain open; for example, how will the benefit package be determined, what sorts of services will it contain, and what will it cost? It is also unclear what the overall effect of the programme will be upon poverty. This could be positive or negative, depending upon its design, although in either case existing anti-poverty strategies will need to continue.

This report's companion report `The proposed National Insurance Programme' explores these questions. Its overall conclusion is that revolutionising health sector financing means addressing many major issues and a rushed design could lead to havoc. The central funding and regulatory bodies, for example, need great care in their preparation. Their tasks will be multiple and complex, while loss of public trust in them could lead to the programme collapsing. The report's main recommendations are designed to maximise the chances of success. They are summarised below.

Recommendations

Proceed with prudence to avoid dangers that would be brought by 'full steam ahead'!
Devote significant human resources to NHIC/ NHIF: their tasks are multiple and complex.
Design a package that is attractive to the formal sector
Take clear decisions on the scope of the benefit package based on good financial modelling, else the dangers of insolvency will be great.
Provide more support for existing CHIs
Energetically jump-start further CHIs
Capitalise on the diversity of Ghana's CHI experience, analyse and learn from it but'Let a thousand flowers bloom'
Ensure that the NHIP is pro-poor

4.5 Options for rationalising funding flows and allocation mechanisms

The funding of health services and particularly public sector services faces various changes:

- With the introduction and expansion of national health insurance, the health providers will need to work with these new purchasers of services, whilst the numbers of individual patients paying for services by cash and carry will gradually reduce.
- Additional resources can be expected through the levy and SSNIT funding that has been agreed as part of NHI development. It is hoped that a substantial share of this will be used to fund exemptions for the poor, eventually through subsidising their enrolment in insurance.
- With the allocation of HIPC funds to District Assemblies, these will also fund services (initially to pay for deliveries, as announced recently). According to the 2003 budget statement an increasing amount of resources will be channelled through the districts), to deepen decentralisation.
- With the growth in direct budget support anticipated, more donor funds are likely to flow through GOG budgets rather than through the DPF system (as envisaged in the POW[15]).
- At the same time there are new or increasing funding sources earmarked to health such as the Global Fund to Fight AIDS, TB and Malaria (GFATM) which anticipate clear accountability that resources provided are used for specified purposes.
- In addition, the implementation of the Ghana Poverty Reduction Strategy is expected to bring in more international funds.

Current funding arrangements

As the earlier sections indicate, the vast majority of GOG recurrent funding is used for salaries and allowances, with some funding for exemptions. IGF largely funds the materials for treatment such as drugs and operating expenses. With some simplification, DPF and earmarked programme support provide most of the other non-staff recurrent requirements including for preventive and priority activities such as drugs for TB, vaccines, etc, (some in kind e.g. contraceptives) plus some for exemptions.

Thus the Government health budget (which includes donor funds provided as budget support) is largely funding the fixed costs of service delivery, particularly health workers, capital, and also management and systems development aspects. The variable costs of treatment can then be funded from cash and carry or insurance payments and exemptions, so that the level of funding available will be responsive to use of services, as it needs to be. The DPF and earmarked programmes then focus on funding the activities which are public goods and of

15. The POW2 figures envisage a fall in the share of donor funds earmarked to health from 44% in 2002 to 33-37% by 2006.

public health importance, which individuals are likely to under-invest in, and support to poorer areas/families.

This has a logic and allows MOH and GHS to look at how to improve the allocation of staff across regions and districts (one of the priorities in the current budget year). But it also carries risks.

- If salary levels are inadequate, then the performance of staff may be disappointing and in particular, informal charges may continue or even escalate; this seriously undermines the effort to phase out fees at point of use as a barrier and hence improve access for the poor.
- Staff have little incentive to be responsive to patients if they will be paid anyway.
- The amount for exemptions tends to get squeezed by unbudgeted changes in salaries or lower releases of funds than budgeted.
- Reliance on external funds for public health supplies and activities and for exemptions brings vulnerability if those funds do not arrive as expected (e.g. the delay in DPF contributions this year). Furthermore, if the shift to general budget support continues, then the amount earmarked is liable to decline, as envisaged in the second POW.
- Subsidies are uneven across different providers, especially between government, mission and private providers. This makes it harder for them to compete on a 'level playing field' for insured patients.
- As more funds flow through district assemblies, there are also likely to be increasing differences across different districts depending on preferences and priorities of district assemblies.

Options for future financing arrangements

Priorities for public spending

In thinking about options for managing public resources intended for health, it is useful to consider the priorities generally accepted for public spending in health:
- improving equity in health and in access to essential services.
- addressing public health priorities (particularly 'public goods', since individuals are unlikely to invest sufficiently in these).
- the management and stewardship role of Government in health, especially in the face of a growing private health sector.

Based on this, it could be argued that Government should allocate its resources towards these goals. This would suggest focussing funding on:
- exemptions to support the poor and vulnerable groups;
- enabling poorer districts to catch up in terms of geographic and financial access to services and quality;
- priority public health work such as TB control, HIV prevention, immunisation;
- sector leadership and stewardship, including partnership building, policy, quality assurance and regulation, and system development (including health insurance system development).

These are all included in the existing roles of Government funding, and consistent with the POW2 and GPRS. However, it may be appropriate to shift the balance between the elements. For example, funding for exemptions has had a limited budget and even less in practice (see 3.? above). In the context of the GPRS, this is a priority that needs increased and more reliable funding. The current arrangements leave the exemptions budget liable to being cut back. Mechanisms to increase and protect this budget could include earmarking a particular source for exemptions, e.g. the VAT type levy envisaged under NHI could be earmarked for this purpose, and/or a share of HIPC funds.

A second aspect is the reallocation of funding to enable under-served districts to catch up. The need to develop allocation formulae that reflect need rather than existing facilities has been identified; it is clear that implementing it will require reallocation of staff as well as non-staff funds.

The idea of clearly earmarking funding for public health activities may raise concern that this is a suggestion to move back to vertical programmes. This is not the intention. There is however a need to ensure that there are *incentives* and *resources* to carry out public health activities within an integrated system. This is likely to involve performance management to ensure key activities take place and resources (such as TB drugs, trained health workers) to enable them to take place. This might be reflected in clear budget allocations as well as performance indicators for priority services, for example in the MTEF and in the agreements between MOH and GHS and between GHS to regions.

These priorities could be reflected in the budget structure, with clear budget components and performance indicators for exemptions; additional support to under-served districts; public health; and system management and regulation.

Increasing the role of health insurance

Once the health insurance system becomes well established, and develops capabilities in effective purchasing and quality assurance, there could be a move towards channelling more of the resources for health service delivery through the insurance system, rather than expecting the insurance to cover only variable costs of services. There would still need to be a public health budget to support other roles of public health, stewardship and sector policy and monitoring. Exemption funds could come direct to insurers or through districts.

If the insurance scheme was funding a larger share of the costs of health care, this would have advantages in terms of enabling different types of services to participate in health insurance on a more equal basis, while also reducing the risk that the health insurance funds will be ‘captured’ by private providers which charge higher fees than public providers.

The transition to such a system would need to be phased and carefully managed, as it would require a change in the employment and management arrangements of service providers. This is a longer term option, but may be worth considering as part of the longer term vision both in planning for insurance and for decentralisation.

Decentralised allocation

A third option would be to move to a more decentralised approach, with the budget allocated taking into account population and needs to districts in a more flexible way, and leave them to decide how to allocate the resources between exemptions, subsidies through insurance; direct service funding and other activities. Again this would require close performance management to clarify the outcomes expected, and it may also be appropriate to start with some earmarking of funds to the major categories. In order to achieve the benefits of this decentralisation, the regions and districts would have to have managerial control over staff as well as the ability to vire funds between staff and other types of expenditure.

5. PROCUREMENT

5.1 Markets for health goods and services

The need to provide a framework to regulate public expenditure on goods and services for health has led to procurement regulation in Ghana. The advantages are obvious of choosing suppliers based on competitive criteria (bids chosen on high quality at low price) to include new market entrants who meet the criteria, and excluding monopolies or price-making cartels. It is frequently argued that bulk-purchasing at discounted prices justify the presence of large importers. However, this begs the question as to whether they should be publicly or privately owned. More generally, it is a moot point whether publicly administered procurement systems offset inefficiencies from market failures more effectively than more open purchasing arrangements, say, by District BMCs. An analysis of the relative efficiencies of publicly administered procurement compared with procurement by multiple agents in private markets is beyond the scope of this study. However, the evidence summarised below suggests that it is an issue that needs to be addressed.

The World Bank has taken the technical lead in developing the legal and regulatory environment in which public procurement takes place. It has assisted the Ministry of Health in the creation of a legal framework and, as a result, the Procurement Bill is awaiting approval by the Attorney General. However, criticisms have been made about its restrictions on local competition, the lack of advantages it gives to local manufacturing and the weak incentives it offers for further private market development. However it is a fact that the private sector is active in this sector and, with public encouragement or not, it will develop further.

The Common Management Arrangements (CMA) were drawn between the GoG/MOH and health partners to define sector priorities and unify efforts in working towards equality and poverty reduction and set contracted procurement capacity to administer procurement. Other achievements started in developing in-house procurement capacity. A Procurement Unit has been established at the MOH (under the Procurement and Supply Directorate (SSDM/PSD) and has successfully conducted both International and National Competitive Bidding (ICB and NCB) with WB technical assistance. A Procurement Procedures Manual (PPM) was reviewed and printed in November 2002 and Standard Bidding Documents have been developed. The Standard Operating Procedures (SOP) for Regional Medical Stores (RMS) to Service Delivery Points (SDPs) is currently under implementation.

Procurement Committees, Procurement Plans and the appointment of procurement or supply officers at major BMCs add to the achievements in procurement during 2002. However, External Audits observe that although these new modalities exist it is not clear to what degree committees are active, procurement plans are used and officers trained.

Disbenefits have occurred in applying the legal framework such as having to expand the vehicle makes of the transport fleet to meet competition requirements, making the fleet vulnerable to the availability and price of spare parts and maintenance know-how. For 20 years the Transport Unit restricted the makes to Toyota, Nissans and Mitsubishi and trained their mechanics to service them. As a result of ICB procedures other makes have been introduced and training is yet to be undertaken.

One of the key reasons for seeking international procurement is the choice of goods available in the global marketplace at prices, quality and range usually unavailable domestically. However in the case of Ghana, given the local procurement directives, the price advantage gained at the border is not passed on to the consumer as a result of excessive mark-ups. As a result, there is no substantial advantage for the consumer who in the health sector pays similar

or higher prices for drugs. A recent study (Nyonator, F et.al. 2002) in Volga region suggests that the mark-ups range widely from 11% to 275% and prices as a result tend to be higher than those in the private sector. Furthermore, hospitals seem to mark-up commodities higher than the health facilities.

The prices of drugs brought into the country under ICBs are a third of the price of those drugs bought through NCB or purchased from private wholesalers. Customers pay inconsistent and unreasonable mark-ups at SDP level as a result of a mark-up policy, which governs the percentages allowed to be added at each step of the supply chain. The CMS adds a 45% to ICB price for transport and distribution, administration and packaging costs and 15% for locally sourced drugs and supplies. Regions and districts add a 10% mark up, whilst the facility adds a further 5%. By the time the client purchases the drug there has been a 70% mark-up from the international (ICB) price. However, these mark ups are inconsistent throughout Ghana.

5.2 Strategic development and decentralisation

Thus far, the GoG/MOH procures goods and services for its health system. These are purchased both centrally (through the health fund) and at peripheral units (through BMCs budget, revolving funds and IGFs). Major capital investments (including vehicles), drugs and non-drug consumables and services are budgeted and purchased at the central level. However BMCs can also procure all of the above within their budget ceilings. The rationale behind centrally procured goods and services is the capture of economies of scale. This is an important consideration. However, in Ghana once goods (drugs and non-drugs) are in country the price advantage seem to disappear.

As budget decentralisation proceeds, and the possibility arises that large big items might also be procured locally, a number of strategic issues emerge.

- The clarification and justification of what procurement should occur at different levels.

In theory BMCs can use their revolving funds or IGFs to purchase essential drugs and non-consumables either from the CMS/RMS or from private retailers but the CMS/RMS is supposed to be the preferred supplier. If medical stores are unable to provide items, they issue a “Certificate of Non-Availability’ (which simply be stamped “NIL” on the requisition). This certificate authorises the BMC to purchase drugs in the open market under the expenditure limits set out in the PPM. Centralised procurement with the freedom for BMCs to purchase either from CMS/RMS or in the private sector would place a downward pressure on prices and an upward pressure on product quality. It would also place the CMS under more competitive pressure, although it might retain a comparative advantage in the supply of large ticket items. In fact the policy of giving preference to procurement from CMS/RMS is not enforced and as long as BMCs keep within their allocated budget ceilings.

- The analysis of the relative efficiencies of multiple procurement units.

  The newly adopted practice of procurement committees and appointed resource people is an asset to the community. However, these attract additional costs. The benefits need to be commensurately greater than alternatives.

- The examination of price formation for pharmaceuticals particularly in the light of a chaotic yet thriving private sector.

The application of the public mark-up policy is inconsistent with economic theory. Generally it seems excessive but theory also suggests that the further from the source of supply, the

higher should be the prices. This however does not apply in Ghana as a recent study suggests (van Haperen 2002) the highest mark ups were in Greater Accra Regional Medical Stores (20% for non-drug consumables) compared with drug price mark-ups at RMS' of 10%. Interestingly however, health facilities in Greater Accra also faced the highest mark up in their drug prices (20%). The intention of policy may be to tax proximate consumers in order to subsidised remote ones but this need to be clarified.

If some of this mark up covers distribution, packaging, fuel and transport costs, and if costs are to be covered by BMC budgets, the prices ex RMS should fall. Over 50% of the IGFs are drug sales (see the Financial Management Section) so it is important to acknowledge the reasons for the protected mark-ups. Moreover, it is feared that under the new distribution system. distribution and fuel costs will be passed on to the customer making drugs even less accessible. Competition should be allowed to drive prices as the private sector has aggressive marketing strategies to sell products at 5% under the current market level. Public procurement has to match this to be efficient.

- Education of prescibers to make choices within the EDL.

An undated survey report on the 'Impact of Decentralisation and Integration in the Performance of Health Logistics Systems in Ghana' (p18) shows that 46% of the facilities surveyed bought drugs outside the EDL in the last 12 months of the survey. It is worth noting that facilities were more likely to buy outside the EDL (60% of regional hospitals and 76% of district hospitals). Significantly none of the RHMTs, according to the survey, bought outside the EDL but some DHMTs do. Prescribers' preferences for non-EDL items were the main reason given in 95.2% of the facilities. This rather undermines the argument that public procurement is justified to limit procurement to EDL items.

5.3 Building capacity for planning and procurement management

During 2002 three-week procurement training was provided to 27 participants drawn from seven regional health administrations, teaching hospitals (KATH, Tamale and Korle Bu) two regional hospitals and Pantang Psychiatric Hospital. At the central level four procurement unit staff (MOH/SSDP) were trained together with the accountant of GNDP, the Pharmacy Council and the Nurses and Midwives Council.

In addition, a three day training on Logistics Management Information Systems (LMIS) is currently under way for DHMT staff, service providers and SDP storekeepers. Three trainers from each region undertook a training of trainers (TOT) and completion of the regional training plan is expected in the summer. Training is funded from MOH's health funds but the development of materials and funding of the TOT was done through USAID.

This training programme overlooked Central Medical Stores personnel and procurement staff at district level both at the DHMT and district and mission hospitals. As there has been reported a shortage of skills in procurement, CMS should take priority in this technical skills upgrade. Staff working within the sphere of Capital Procurement has not been considered, thus far for skills upgrade, neither have those with planning and monitoring procurement responsibilities. The strategies to achieve the objectives of The Capacity Development Programme for Planning and Management (2nd 5 year POW) need to target all health staff which work on procurement including accounting staff, pharmacists, medical engineers, estate officers, transport managers, stores personnel, EPI programme managers, family planning co-ordinators, etc.

Recommendations

- *Revise the capacity development document to include all health staff with procurement responsibilities in their plan of action for training not only for LMIS for capital and non-capital items.*
- *Train the rest of the regions and all district BMCs on procurement and logistics practices.*
- *Include basic logistics practices in the in-service training curricula.*
- *Disseminate the 2nd Edition of the Procurement Procedures Manual (November 2002).*
- *Extend capacity building activities to cover health facility staff as their work relates to procurement activities.*

5.4 Management of procurement services

Procurement services have been duplicated within the current MOH/GHS management arrangements. This might be justified on a number of grounds but which justification is being invoked is unclear. These structures are vertical with informal relationships across them resulting in confusion and a lack of accountability. Furthermore, as the Ministry of Health moves into a contracted procurement model, roles will be required to be defined much better and streamlined. It is also pertinent to note that some of these management cells are still to be resourced (such as the PU at the GHS), have no current head (CIMU) or a head that is functioning in two directorates (SSDM and PSD).

Similarly, efforts in capital investment seem diluted by duplicating functions at both the MOH and GHS to perform –what seems- very similar work. No clear role or boundaries have been explained for the MOH/CIMU and thus accountability is diluted. The PPM has not been sufficiently disseminated to all procurement parties at national and district levels which require distribution with immediate effect.

There would be major efficiencies savings if procurement responsibilities were rationalised. Such an exercise might be informed by an application of principles derived from MoH and GHS core functions: policy, monitoring and supervisory activities for MOH and implementation responsibilities at GHS.

Recommendation

Examine and rationalise all units undertaking procurement responsibilities (from MOH: PPME, PSD, CIMU, TMU and from GHS: HASS, SSDM, PU, EMU and TMU) in light of their roles, responsibilities and interrelationships.

5.5 Procurement agent

Health Partners and the MOH reached an agreement, incorporated in the CMA, to contract an agent to undertake administrative procurement so that MoH and GHS could concentrate their attention on their core functions of policy, health service delivery and supervision. As a a procurement agent is the process of being contracted to be responsible for the procurement of the items listed in the procurement plan up to delivery to the MOH at the CMS. The Chief Director of the MOH will be the contract supervisor and his representative, the Director, Procurement and Supply of the MOH, will be responsible for the day to day monitoring and supervision of the selected Procurement Agent.

Terms of reference have been drawn up and are awaiting approval and expressions of interest have been received. A member of the review team has provided comments to improve the document as it currently focuses in the procurement of 'Goods' rather than including the procurement of civil works, goods and services. The TOR will be sent to interested parties and after receiving technical and financial proposals, it is expected that the Procurement Agent will be appointed by July 2003.

Recommendation

Continue with the recruitment of the procurement agent in conjunction with the definition the duties of all other departments with procurement management responsibilities to enable greater accountability and efficient resource allocation.

5.6 Monitoring and evaluation

Thus far the key instrument used for the monitoring and evaluation of procurement performance has been annual audits, both external and internal. The feedback emanating from this process is unhelpful on a day-to-day basis. It is also unclear which MOH department(s) is responsible for monitoring and evaluation functions and as the degree to which it is involved. The SSDP/PSD invites the PPME to consultations related to the tender process. However it is unclear to what extent either unit has responsibility for this process.

It is only recently that the GoG has developed quantifiable indicators of procurement performance. OECD consultants participated in a workshop (CPAR Mission, March 2003) with the view of determining 'key performance indicators for an effective benchmarking and monitoring and evaluation system´ together with the identification of procurement entities that were suitable to start a pilot benchmarking and evaluation survey. The pilot monitoring and evaluation system will track the steps taken to support implementation of the Procurement Bill and the level of compliance by the procurement agencies. However its implementation largely depends on the ability of the Ministry of Finance to allocate the resources to finance transition steps towards the implementation of the Bill. This is a key and important step in the process towards a procurement system that delivers quantifiable results and compliance with procedures.

5.7 Capital procurement

This section discusses performance of the capital plan as it relates to procurement during 2002 as Capital Investment *per se* has been discussed in Section 3 'Financing Health Services'.

Civil works

Implementation of capital procurement

Ghana HSR PoW 2002: Summary of proposed capital projects	\$101,642,000
Procurement Plan for 2002: Summary of projected procurement	\$7,350,946.67
Executed at national level	40%
Executed at region and district levels	20-30%

The difference between the proposed capital projects and the procurement plan lies in the fact that the proposed capital projects are those which the MOH wanted undertaken or initiated during 2002. From the 7.3 million dollar allocation only 40% was spent. The remainder will be reallocated to the 2003 budget. The reasons for delays in execution was attributed to be a lack of financial resources and not to lack of capacity on the part of BMCs.

However, this seems to be only one reason. For example, during 2002 GHS/EMU implemented a third of the plan, another third will be completed by the end 2003 and the remaining third will not be implemented at all. Funds for 2003 have not been released yet, so it is envisaged that only one third of this revised plan will be implemented by the end of the year. Data from the field suggests that implementation rates in regions, districts and sub

districts were also low, at around 20% to 30%. Some facilities (such as Suhum District Hospital) undertook minor maintenance and repairs whilst others such as KATH hospital in Kumasi used their internal generated funds for capital investment projects.

Policy changes have also affected capital investment. According to the final draft of the hospital strategy (p31) there are still numerous problems (aside from capacity) that inhibit the implementation of the Ministry's capital investment programme. Services were provided with minimal involvement of the technical end users and the communities. Added to this is a lack of standard guidelines for planning and development of the country's hospitals. This has resulted in poorly maintained structures or empty shells, which could be used if upgraded instead of building new facilities.

Recommendations

- *Procurement planning, procurement management and finance should work closely together to produce a procurement plan, which is within national priorities, rational budget allocation and within a realistic time span. When projects will be undertaken over a period of time, this should also be specified for clarity and budgeting purposes.*

- *The adoption of a clear hospital strategy, which involves the maximum utilisation of existing infrastructure, reducing redundancy, and releasing resources for upgrades, regular maintenance and repairs.*

Medical equipment

No equipment was procured during 2002 even though it was included in the Procurement Plan. An overly ambitious procurement plan meant the medical equipment budget line had little or no priority. However, it is expected that items in the equipment procurement plan will be purchased and received during 2003. Contracts with international medical equipment manufacturers have usually been awarded for a period longer than a couple of years. As a result, lumpy expenditure may not show up in a single year.

The performance of equipment procurement in 2002

Region	Number of breakdowns	Equipment Performance	Critical areas of impact on equipment performance and comments
Ashanti	71	98%	Electricity and Water
Brong Ahafo	Not available	Not available	18 out of 125 SDPs have a full complement of basic equipment mostly donated by JICA
Central	56	97.8%	Voltage fluctuations and power cuts
Eastern	155	95.5%	No Planned Preventive Maintenance. Power fluctuations
Greater Accra	Not available	Not available	No standby generators
Northern	Not available	Not available	Some health centres in receipt of medical equipment which is not required
Upper East	89	88%	
Upper West	Not available	Not available	Aged and obsolete equipment
Western	85	95%	Responded to 60 out of 68 service calls

According to regional reports (2002 Annual Reviews) the performance of equipment was very high: to up to 98% of the time (see table). A significant hindrance in the performance is the lack of ready availability of spare parts for donated equipment or the technological know-how to maintain and repair equipment properly.

The GHS draws up equipment plans for health facilities due to be upgraded. Medical equipment suppliers are selected, not only on price and quality, but primarily on the quality of the services they can offer in Ghana. As a result, manufacturers of turnkey medical

equipment projects rely on building local capacity to train the equipment users (doctors) and to undertake planned maintenance with MOH trained staff. They maintain a presence of trained local engineers to provide all other maintenance. One supplier mentioned that their equipment was functioning 97% of the time reaching almost the same levels of operation as in Europe. However a challenge is to improve the utilisation of equipment, which often lies idle.

Vehicles

Vehicles featured prominently in the 2002 procurement plan as the fleet was ageing and/or insufficient at regional and district levels. Out of the budget allocation of $9,875,000, $6,000,000 was spent to purchase over 400 vehicles including 6 boats, haulage vehicles, motorcycles; as well as 64 saloon cars to be used as incentives for health workers in deprived areas. The allocation of these vehicles was undertaken at the regional level with approval from the national level. Some vehicles were also allocated to statutory institutions and teaching hospitals. It was disappointing to see pick-ups and motorcycles given to all district administrations and only a few vehicles given to facilities. A recent transport study (M. Healy, 2003) suggested a haulage vehicle distribution plan which was not implemented.

The remaining vehicle budget of $3,875,000 is being used to purchase 300 vehicles for health workers as part of an incentive package during 2003. These cars are going to be offered on a hire purchase scheme on the basis of an ICB price with no tax, duty or interest. Monthly payments will be deducted from salary for a period of seven years. The intention is to assist deprived and remote areas to secure health workers. The effectiveness of this type of incentive is discussed in the HR Section of this report and in its companion report on Private Public Partnerships. Another vehicle allocation, albeit smaller, is envisaged to cover in part the large transport requirement of CHPS.

Fleet statistics for 2002

		Does not include new 2002 vehicle allocation			
Region	**2002[1] Vehicle Allocation**	**Total Number of Vehicles**	**Vehicles over 5 years**	**Serviceable Vehicles (%)**	**Fleet Utilisation (%)**
Ashanti	32	86	22	76	
Brong Ahafo	26	66	46	80	
Central	28	75	42	65	73
Eastern	27	94		78	70
Greater Accra	28	92	68	76	72
Northern	31	324	90	84	
Upper East	23	47	27		
Upper West	21	55	27	87	
Volta[2]	24				
Western	24	62	41	75	50
TOTAL	264				

[1] Received in all regions during April/May 2003 and includes DC Pick Ups, Station Wagon, Saloon Cars, Haulage Vehicles and Buses.
[2]Information unavailable.

The table shows a summary of the vehicle allocation in the 2002 procurement plan together with available statistics (from Regional Annual Reports and Transport Management Report 2001 GHS) on number of vehicles, their age and their utilisation. The fleet has been greatly improved as a result. However, the Transport Management Unit 2001 Annual Report reports that the average driver/vehicle ratio is now one driver per 1.5 vehicles.

Regular maintenance is not programmed in advance, is not part of the ICB vehicle procurement plan and is not linked to the recurrent budget. The hospital strategy suggests the creation of a revolving fund for spare parts at the regional level. Donated new or second hand vehicles, usually given by international Ghanean communities are inefficient as they do not

take into account the availability of after sales service or of spare parts. For the same reason BMCs favour purchases of makes backed by dealers with solid service reputation in Ghana.

During visits to CMS it was found that a fleet of 10 ambulances donated by DFID were awaiting distribution since their arrival in November 2001. It is understood a National Ambulance Service Plan is being drawn up for Parliament approval. However, in the meantime, these vehicles are standing idle and deteriorating when there is a huge demand for ambulances at the facility level.

Recommendations

- *Ensure that vehicles are allocated first for facility use and not only for administration purposes.*
- *A fund for spare parts should be established and new vehicle procurement should carry a recurrent budget provision for maintenance and repairs and not only for insurance.*
- *Capacity building should be proactive and include driver training if necessary.*
- *Clarify the policy for an incentive package, which include vehicles at high purchase as it can also act as an un-incentive.*
- *Allocate (and distribute) as of immediate effect: the 10 ambulances, 25 motorcycles, 6 boats and the bicycles in the CMS, which are deteriorating at a rapid rate.*
- *In particular ambulances should be deployed with immediate effect to rapid response projects. It is understood that rapid response obstetric care could be using the ambulances since the preparation work has been undertaken.*

5.8 Drugs and other consumables

There are no performance indicators or deliverables specified on the 2002 PoW for consumable procurement. The only sector-wide performance indicator is the percentage of tracer drug availability. This is reported to be at 90 to 95% of the time at SDPs. However, the indicator is ambiguous as it is unclear whether this high percentage is due to rapid replenishment cycles or to low customer demand.

In 2002, up to 75% of procurement plans for pharmaceuticals were implemented. Drugs are not as sensitive to health fund disbursement as some other expenditure since there is a drug revolving fund, which is replenished by the sale of drugs.

The national level of procurement of RMS' from CMS is 46% (Sarley, D et.al. 2003). However, regions varied in their approach to their own procurement practices, mainly driven by perceptions of availability, quality, price and the customer services offered by the CMS. During field trip visits it was found that in Volta region only 35% of commodities (drug and non-drug consumables) were sourced from CMS. But only four drug items were purchased in local markets. In Eastern region however, 90% of requirements were supplied by the CMS. However, at sub-district level only 39% of consumables were purchased from the RMS and 61% from the private sector. Overall, BMC purchaser preference is to obtain non-drug consumables at CMS as the private sector is able to cater for most drug requirements.

The intention is that facilities, districts and RMS should purchase drugs and non-drug consumables ultimately from CMS. It is only when the CMS/RMS/District is unable to supply that sourcing from the local market is permissible. From research and anecdotal evidence it appears that the CMS often has the commodities but they may not be purchased due to a number of factors.

- Teaching hospitals in particular prefer branded drugs and not generic ones

- There is a prescribing bias, particularly from doctors educated abroad, who prefer drugs with which they are familiar, often outside the Essential Drug List (EDL)
- The quality of CMS' drugs is perceived to be poor due to unsuitable storage conditions
- 'Cheap' prices from CMS make customers suspicious that the commodities are substandard
- CMS' prices of nationally-sourced commodities is higher than on the open market
- Incentives from drug wholesalers and pharmaceutical companies persuade prescribers to use their drugs
- The private sector has a better customer service focus and door-to-door delivery.

This has serious consequences for the customer who is often prescribed drugs unnecessarily and beyond their means. For example, at Suhum District Hospital (Eastern Region) it was found that customers were asked to purchase drugs they could afford irrespective of their efficacy. Exemption decisions were based on subjective evidence: more often than not people were not exempted. In fact, the hospital has stopped exemptions due to lack or delay of reimbursements.

To address some of these inefficiencies, the GHS logistics system has been re-designed to make it more transport intensive and efficient by bypassing the district level. It is argued that mark-up savings will be passed on to the customer.

Recommendations

- *Serious attention needs to be given to prescriber behaviour*
- *CMS price mark ups should be uniform across the country*
- *ICB drugs should have a mark up to bring retail prices below the national market price to drive competitive advantage*
- *All non-value added activities should be avoided to reduce mark ups*
- *Undertake a commodity market analysis*
- *CMS capability to forecast their requirements needs to be strengthened to increase commodities procured under ICB.*

5.9 Central Medical Stores (CMS)

The need to improve the performance of the Central Medical Stores has been well documented (Dukes, 2001). Nordic Fund consultants now lead the technical assistance to upgrade the stores under a carefully drawn plan. This includes a two-year transitional period during which a high-level central management transition team would operate at the MOH to supervise and coordinate:

- Physical development of CMS (renovation and improvement of buildings and stores equipment)
- Computerisation of the CMS stock management
- Improvements in management and performance at CMS within the present structure
- Monitor CMS' performance
- Finalise and introduce a permanent autonomous status conducive to efficient operation and high-quality management'.

Improvements were to start during 2002. However, due to donor funding constraints, the process has been delayed until now (May 2003) although it is expected to begin at present. An MOH person has been identified to become the new CMS head and it is envisaged that he/she will lead the committee managing the upgrade. Other activities include the appointment of a firm of architects to act as consultants to draw up terms of reference for the

physical improvements. Tenders for the store equipment will require further NDF technical inputs. Terms of reference have also been drawn up for the computerisation of stock management.

The justification for these investments has been the preparation of the CMS for eventual autonomy, privatisation, franchising or for operation as a parastatal organisation. It is understood that a final decision, which has been debated for years, has still not been finally taken. It is therefore not what benefits will accrue from these investments or to whom.

5.10 Procurement of consultancy services

The rules governing the procurement of technical assistance and consultancy services of an intellectual and advisory in nature follow the same principles as any other ICB or national procurement as outlined in the Procurement Procedures Manual (PPM). Proposals received are awarded marks for technical merits and value with a maximum 80/20 respectively. The successful bid is the one receiving the highest number of marks.

The donor community have earmarked funds, but now in declining amounts, to procure technical assistance in consultation with the relevant technical area of the Ministry of Health and or Ghana Health Service. Under the rules, the request for consulting services should be triggered by the technical government managers. However, donors sometimes initiate the request given particular concerns or propose consultants with known technical expertise. However, this form of consultancy may cause problems. The donor is the client and the resulting outputs including reports are part of the donor portfolio and not the Ministry's and the MOH does not have ownership of the process and so does not benefit from capacity building.

Recommendation

Careful consideration should be taken to distinguish when the donor is the client and when the MoH or the GHS is the client procedures followed accordingly.

6. LOGISTICS MANAGEMENT

6.1 The logistics system

The drugs and non-drugs consumables procured by the MOH/Procurement Unit (PU) are first stored at the Central Medical Stores at Tema. They are purchased by Regional Medical Stores (RMS) who are expected to pay on collection. CMS can also provide a 30-day credit facility. The 10 RMS in turn receive requisitions from the district level and they from the service delivery points (SDPs).

Reports mention (Brumburgh and Raja 2001) and (van Haperen 2002) that these supply chains were inefficient and cumbersome. They had many non-value adding steps, product shortfalls and stockouts, ineffective and inefficient inventory stocking and control systems, lack of transport, the inability to forecast requirements and communicate timely information. The outcome was a realisation there was an urgent need to re-engineer the supply chain. It was decided that vaccines, contraceptives, drugs and non-drug consumables should be 'integrated' into the same system. However, contraceptives still enjoy 'special arrangements' to maintain vertical control.

Recommendation

Contraceptives should to be integrated to the drug supply chain, administratively and financially. This would make them less attractive for `leakage'. Furthermore, logistics skills and know-how in contraceptive management should be 'shared' with drug supply managers to upgrade their capacity.

6.2 The re-engineered system

A new supply chain was designed in an effort to offer savings to customers. A logistics group with USAID designed the supply chain so that the district level no longer had a distribution role other than supervision and management. The new system envisages a monthly delivery schedule, which will call at all SDPs in the country in a transport intensive, low inventory system approach. The Standard Operating Procedures (SOP) Manual has been a significant deliverable of this process. Technical assistance has been provided to ensure that all aspects of the supply chain requiring attention will be addressed.

As the CMS itself has been the object of substantial technical assistance the consultancy group re-designing the logistics system considered the role of CMS to be the first point of distribution and assumed concurrent upgrades. Unfortunately, during a workshop (October 2002) to develop plans for the reorganisation of RMS', only one participant from CMS was invited to participate. As a result, the performance expectations of Central Medical Stores may or may not be met under the new RMS-SDP delivery system.

Delays in implementation of Regional Training Plans have meant the proposed system will not begin until the summer of 2003 when the upgrade of the CMS is due to start. This will result in a desynchronised system as CMS has not been trained in the objectives of the scheduled delivery system and the change in work practices required to ensure the delivery schedule (Healy, 2003). It is unclear how the new distribution system will be funded but it is understood that logistics costs are be covered by the mark up on commodities.

Recommendations

Performance indictors need to be defined and an operational monitoring and evaluation system designed to identify possible problems and ensure compliance with procedures. Performance indicators might include:

- *Continuous availability of commodities at facility level 95% of the time*
- *Commodity pricing revision given the performance and efficiencies of the new system (reductions expected of at least 10% given the district level is bypassed)*
- *Reporting rate both in terms of timely reporting and receiving accurate data 90% of the time*
- *Monthly scheduled deliveries to 90% of all SDPs*
- *Significant stock reductions at all levels*
- *Increased demand of EDL measured by increased sales*

In addition, the funding of the system needs to be clarified as there is a perception that customers will be paying more for the enhanced service.

6.3 Logistics Management Information Systems (LMIS)

The new logistics system will bring a wealth of instruments to report requirements and consumption. The district HMT has a support function to ensure the smooth transmission and communication of requirements to the RMS. The CMS will replenish its stocks as required.

However the LMIS does not satisfy the requirements of the system. As an example the Procurement Supplier Performance Report contains only partial information and the only conclusion that can be drawn is whether goods have been received at CMS by the report date. There are no mechanisms in place to ensure suppliers adhere to their contractual obligations and, since the report is printed annually, this is of little value for day-to-day management.

Poor communication is causing inefficiencies: double deliveries (after a lengthy wait) and after commodities have been purchased on the open market. Other factors that could be managed better with a more effective LMIS include:

- The unpredictability of RMS' purchases through CMS adding to unstable consumption patterns
- Prescriber's bias due to preference for non EDL drugs
- Poor forecasting based only CMS consumption
- Poor CMS forecasting of annual ICB procurement requirements
- The consequence that commodities are sourced in Ghana at 3 times the international price as CMS supplies do not satisfy annual needs.

Recommendations

- *Use the information from the re-engineered supply chain for re-supply decisions*
- *Seek technical assistance to devise methodologies for annual forecasts that are realistic given improved LMIS at the regional levels.*
- *Incorporate monitoring mechanisms to track logistic system performance and anticipate possible obstacles to the monthly delivery service.*

7. Human resources

7.1 Background

The main issues affecting Human Resources for Health (HRH) in the Ghana health sector include high rates of emigration of trained professionals, with problems of inequitable distribution of staff and great disparities between the urban southern regions and the more rural northern ones. Despite some increases in remuneration and incentives such as the Additional Duty Hours Allowances (ADHA), workforce motivation and productivity remains stagnant. Even under the circumstances mentioned staff salaries have put a lot of pressure on the recurrent health budget consuming about 70% or more of available resources, which reduces the scope for enhanced service delivery.

> ### *Health PRSP/HR targets*
>
> Activity: Launch and implement CHPS – emphasizing basic primary services.
>
> HR target is The % of total number of doctors located in 4 regions increases from 7% to x% in 2005
>
> The Health Sector Strategies for Poverty reduction HR Indicators:
>
> - Ratio of population per nurse in Northern: GAR 4:1 (2000) 3:1 (2004)
> - Ratio of population per doctor in Northern: GAR 5:1 (2000) 4:1 (2004)

Table 1: Distribution of GHS health professionals[16] (from GHS – HRD HRIS)

PROFESSION	TOTAL	HQ	GAR	VR	ER	CR[11]	WR	AR	BAR[1]	NR[1]	UER[1]	UWR[1]
Anaesthetist Assistant	73		5	15	14	4	3	8	8	8	4	4
%	**100%**		**6.85%**	**20.5%**	**19%**	**5.5%**	**4%**	**11%**	**11%**	**11%**	**5.5%**	**5.5%**
Auxiliary nurse	4924	4	1073	517	969	443	419	357	398	394	210	140
%		**.08%**	**21.8%**	**10.5%**	**19.7%**	**8.9%**	**8.5%**	**7.25%**	**8.1%**	**8.0%**	**4.3%**	**2.8%**
Dentist	29	2	8		5	3	4	3	3			1
%		**6.9%**	**27.6%**	**0%**	**17.2%**	**10.3%**	**13.8%**	**10.3%**	**10.3%**	**0%**	**0%**	**3.4%**
Doctor	664	35	179	55	85	41	58	79	64	28	30	10
%	**100%**	**5.3%**	**27%**	**8.3%**	**12.8%**	**6.2%**	**8.7%**	**11.9%**	**9.6%**	**4.2%**	**4.5%**	**1.5%**
Medical Assistant	442	2	86	34	43	38	42	71	38	42	28	18
%	**100%**	**0.5%**	**19.5%**	**7.7%**	**9.7%**	**8.6%**	**9.5%**	**16.1%**	**8.6%**	**9.5%**	**6.3%**	**4.1%**
Pharmacist	162	10	26	21	18	10	15	30	12	9	6	5
%	**100%**	**6.2%**	**16%**	**12.9%**	**11.1%**	**10.6%**	**9.3%**	**18.5%**	**7.4%**	**5.6%**	**3.7%**	**3.1%**
Professional Nurse	4320	28	1333	305	647	345	353	410	221	287	202	189
%	**100%**	**0.6%**	**30.9%**	**7.1%**	**14.9%**	**8.0%**	**8.2%**	**9.5%**	**5.1%**	**6.6%**	**4.6%**	**4.4%**
Regional Populations	18.4m		2.9m	1.6m	2.1m	1.6m	1.8m	3.2m	1.8m	1.85	.92m	.58m
%	**100%**		**15.8%**	**8.7%**	**11.4%**	**8.7%**	**9.8%**	**17.4%**	**9.8%**	**10.1%**	**5%**	**3.2%**
Total staff (ALL STAFF)	26,193	544	4,835	2,999	4,130	2,382	2,322	2,832	2,199	1,851	869	1,230
%	**100%**	**2%**	**18.5%**	**11.4%**	**15.7%**	**9.1%**	**8.9%**	**10.8%**	**8.4%**	**7.0%**	**3.3%**	**4.7%**

Note: *Teaching Hospitals staff not included based in GAR & AR. CHAG staff (total 5969) not included*

16. Note that: 5280 additional CHPS officers required for 110 districts

1 Deprived Regions. Data not available for CHAG & KBTH, private Sector

Table 2: Population per GHS doctor ratios by Regions

Regions	GHS doctors	Population per GHS doctor
Greater Accra	179	1:16201 *Excludes TH & large Private Sector*
Eastern	85	1:24705
Volta	55	1:29090
Central	41	1:39024
Western	58	1:31034
Ashanti	79	1:40506 *Excludes TH & large private sector*
Brong Ahafo	64	1:28125
Northern	28	1:66071
UER	30	1:30660
UWR	10	1:58000

Note: *This table uses GHS distribution figures only which may well reflect for doctors in all region except Greater Accra and Ashanti with Teaching Hospitals and large private sector services in the capitals*

7.2 Key strategies and actions in 2002

The main HRH objectives in the POW 2002 were as follows.

1. To develop Incentives to attract and retain health professionals,
2. To ensure the appropriate distribution of personnel and to ensure career development opportunities.

Specifically …

- to assess existing HR Plans and Policies
- to define the gaps in HRH Policy Development and develop plan of action to deal with the situation
- to recommend a comprehensive HRH policy
- to develop a costed HRH Policy/Plan to focus on the regional priorities & CHPS.

The progress made against each of these objectives is tabulated at the end of this section. Major achievements included the completion of HR strategy documents prepared by MoH (`Human Resource for Health Development Plans 2002-06') and costed HR plans prepared by the GHS. The extent to which these strategies are able to address the major HR issues facing the sector in and provide a durable basis for improving workforce productivity within a realistic budget are key issues which are discussed below. A number of important training activities were initiated during 2002, not the least the launching of training for CHPS workers.

7.3 Current HRH strategies

Civil service reform and HR management

The civil service reforms are parallel to Health Sector reforms and concentrate on the so-called "Central Management Agencies" of government (MOF, OHCS, SEC etc). There are synergies in the objectives of both reforms in terms of improving efficiency and evolving a client focus, but the CSPIP emphasis is on improved policy analysis, development and monitoring by key government agencies. Aspects of the proposed reforms that aid HR management in the health sector relate to public sector HR and salary decentralization. Recruitment and promotion interviews and approvals are now authorized at the respective councils/boards instead of being at the Civil Service Council. Negotiating this with

advantages of accountability and control of expenditure may motivate the MOF and OHCS to accept local salary management by health sector executive agencies.

Retention of health professionals and links to GPRS targets[17]

The ADHA (additional duty hours allowance) has, it appears, helped to improve the retention of doctors and slow their emigration. It appears ADHA is beginning to attract some staff from CHAG and the private sector back into the public sector, In 2002, of 22 doctors (not house-officers) recruited into the GHS, 13 (59%)[18] were from Mission hospitals and private for profit institutions. It may have become a de-motivating factor for nurses and para-medicals due to huge differentials in take-home pay (Table 3).

Table 3: Remuneration & ADHA comparisons in government health sector[19].

Cadre & pay-scale	Basic annual starting level salary	Estimated monthly Additional Duty Hours Allowance
Medical Officer – L16 **Dep. Dir. Nursing S – L16**	23,082,919.00	C2,219,511.00 (200Hrs fixed) C1,109,700.00 (100hrs max)[20]
Senior Nursing Officer- L11	11,435,144.00	C549,766.00 (100hrs max)
Pharmacist – L14	17,343,510.00	C833822.00 (100hrs max)
Principal Enrolled Nurse – L10	9,910,866.00	C476,483.00 (100hrs max)
Senior Community Health Nurse – L9	8,590,822.00	C415,020.00 (100hrs max)

Table 4: 2002 ADHA distribution by regions/agencies

Regions	Total	%	Regions	Total	%
Headquarters	6,992,347,875	3	UER	8,666,243,000	3.8
Greater Accra	25,980,752,000	11	UWR	7,517,390,000	3.2
Eastern	21,713,399,000	9.4	KBTH	34,712,395,000	15.1
Volta	14,328,807,000	6.23	KATH	19,702,074,000	8.6
Central	9,354,836,000	4.1	TTH	2,532,882,000	1.1
Western	13,593,314,000	5.9	Accra Psych	3,967,830,000	1.72
Ashanti	30,065,623,000	13.06	Pantang Psych	2,062,463,000	0.89
Brong Ahafo	18,804,377,000	8.2	Ankaful	1,773,169,000	0.77
Northern	8,386,551,000	3.6	**Total**	**230,154,452,875**	

The national rural/hardship incentive systems have not been implemented and thus no distribution incentives are in place. Regions and districts have innovated incentives of their own and the danger is that well–endowed districts may proffer more incentives than deprived ones. Specific incentives should be developed for the three northern regions and selected

17. The Health Sector Strategies for Poverty reduction HR Indicators:
Ratio of population per Nurse in Northern: GAR 4:1 (2000) 3:1 (2004)
Ratio of population per doctor in Northern: GAR 5:1 (2000) 4:1 (2004)

18. Obiri-Yeboah, HRD recruitment of Medical Officers Jan-Dec 2002. unpublished from HRD database.

19. CHAG staff members are paid on same rates though additional local incentives may be provided by individual institutions.

20. Staff other than doctors get ADHA up to a maximum of 100 hours.

deprived districts in addition to enforcing staffing norms with salaries. This will be the foundation for improved distribution of staff and meeting the GPRS targets on shifting professionals: population ratio disparity between the various regions.

In addition to monetary incentives, good governance of staff, leadership, respect, recognition and valuing of their efforts (non-financial incentives) are equally, if not more important to higher productivity of the workforce.

Performance management in the sector

Performance Management can be assessed at two levels: (i) individual performance assessments required for promotion (which remains quite centralized); (ii) performance assessments of an agency, service units and indeed the managers of such units and organizations. This second type is dependent on specific objectives and targets being set, utilising tools such as performance agreements.

In the health sector, the duration of managerial appointments is not clear; nor do clear performance agreements exist between the MOH and its agencies. Implementing performance agreements with senior managers would build the confidence of staff in the reforms and enhance their productivity.

Progress on the decentralisation of HR management

Decentralization of the health sector has generally followed two paths. De-concentration involving the delegation of authority to regions and districts under the umbrella of the Ghana Health Service. Delegation has taken place in terms of the shifting of service execution responsibilities from the Ministry of Health to the GHS, THBs and to the CHAG Institutions etc.,. The appointment of HR managers to all regions and teaching hospitals was expected to facilitate decentralized HR management. Some HR managers appear to have been constrained by their limited experience and capacity but also the lack of incentives for local managers to be effective such as further decentralization of staff budget and payroll management.

Training programmes for the health professions

Courses leading to Registered Nurse qualification have been upgraded to Diploma level. However, certificate courses continue for auxiliaries converting to professional status. This dual mode of basic nurse training may raise issues of comparative status and conditions of services. Enhancing basic qualifications may simply increase emigration. The proposed separation of educational certification from professional registration has evoked debate between MOH and the NMC about establishing an examination board.

The Ghana Postgraduate Medical College has been launched, although the final course design, intake and the running of programmes are still under discussion.

The proposal to establish new examination boards will probably be more feasible and require less capacity for those MOH run programmes that do not currently have examination boards. The effort can then be gradually extended to include current nursing systems. However, in the interim, the MOH should have more representation and say in nursing examinations including fee-setting.

The role of professionals training needs to be strategically linked to access and equity and should include curricula that provides for referral- receiving skills in support of CHPS.

In-service training and skills development

In-service training has progressed significantly. The logbook has been widely distributed; 59% of staff now possesses the In-service training logbooks. In 2002, 36.7% of courses were

as `structured courses' whilst 67.3% were `remedial.'[21] Remedial courses should be recognised and accredited and logged. However there are wide variations in the number of courses run in the regions (Central Region - 3 courses; Ashanti Region - 74) Logbook distribution to staff ranges from 10.1% in Volta Region (a pilot region) to 84.6% in Eastern Region[22]. Problems include the definition of recognized training courses and the coordination between training by national programme managers and regional training coordinators.

There is strong incentive among staff to use the logbooks, as they are being used as indicators for promotion and the renewal of nurses' professional registration. Some 185 training coordinators from regional and district level have been trained by the JICA/HIST project in 2002.

In-service training influences the quality of services. To assure this, it is important to have assessments of training impact and regular reviews of skills utilization to inform training needs prioritisation.

7.4 Discussion, conclusions and recommendations

The key to quality and productivity in health service delivery lies in having well-motivated health workers. The HR plans so far developed need to be thoroughly debated and evidence adduced as to their likely impact on these overriding objectives: service quality and efficiency and the equitable distribution of services. A thorough `appraisal' of the HRH systems will provide the basis for a national forum to build consensus and agreement on these difficult issues.

Ghana's health services are constrained by the high international marketability of its health professionals, the economy's inability to support competitive wages for health workers, and inefficient management and utilization of the available professionals. Five areas of strategic interest bear influence on the sector's utilization of human resources.

Equity of access

This is a core premise of the 2nd 5 year strategic plan, in practice meaning providing qualified professionals and hence services to the deprived northern regions and other pockets in the south. A starting point is having adequate numbers of staff and then their retention and a second is the type and skills of staff are appropriate for the tasks. The main strategy to address equity and access is the CHPS strategy which envisages quite rapid expansion in numbers of certain categories CHNs (5280 needed). Reaching this CHPS employment target will strain the training capacity as well as the support, supervisory and referral systems and severely expand the wage component of the budget.

Access and referral systems for CHPS requires to be strengthened with reinforced surgical, emergency care and obstetric skills at district hospital level, supported through in-service training.

Recommendation

The HR strategy needs to address these anticipated constraints more clearly, which may include a need to re-prioritise and target the most deprived areas for CHPS coverage within the limits imposed by budget constraints.

Brain drain, incentives and motivation

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21. Draft Annual Report 2002 JICA HRDD Health In-Service Training project.
22. Draft Annual Report 2002 JICA *ibid*

Managing the brain drain is a priority in order to secure the health objectives of the 5-Year POW. A number of options have been considered – including increasing intake/production of certain cadres (exception: doctors), improving the take home wages (via ADHA), and managing some "push" factors such as creating local training and career development opportunities (eg; National PG medical College, Specialized Nursing programmes). Recognition of the dynamics of the international labour market may mean formal policy to train for the benefits of export. This means the capacity for expanded training and sustained quality should exist, and international recruitment is managed and remittances facilitated to the benefit of the country (and its health services). The interplay between exports and retained resources will need to be thoroughly investigated and the security of internal health care services should remain paramount.

Retention incentives must be addressed at the two levels: (i) retention from international migration and from loss to the health sector (or public health sector) and (ii) Retention/attraction to specific work locations that may be geographically or professionally unpopular. The ADHA attempts to address the first with mixed results (for non-doctors at least), the second is yet to be tackled but an estimated US$3.0m is expected to be the cost of rural incentives.[23]

The fact that ADHA is not performance based means that it is unlikely to improve staff productivity. It is also critical to acknowledge and out into practice steps to improve managerial leadership and supervision with a good organisational ambience, which will ensure that non-financial incentives compliment the financial ones.

Recommendations

To sustain health services and retain health workers, Ghana may need to develop "non-tradable" cadres such as Medical Assistants and increase their scope of practice. The HRH plans do not currently include any strategy in this area. Given the lag time in HR production, any such change needs to be expressed in the current HRH plans.

A thorough review of ADHA and distributional incentives is needed along with analysis of resources available to assess and redress the constraint and gaps.

Quality of care

The POW addresses this area through improved structured in-service training systems, better and localized post basic training and reorientation of cadres curricula (and scopes of practice). The In-service training programme has achieved significant improvement (59% of staff have IST Logbooks) though there is a need to investigate the impact of training and the way new skills gained impact on the clients. The current scopes of practice of CHNs (basic to CHPS)and Medical Assistants especially with regard to clinical care seems so limited as to reduce the effect of client satisfaction from meeting our equal access targets and avoiding duplication of client visits to 2^0 levels of care.

Recommendations

The emigration of health professionals means that local cadres with wider scopes of practice will need to be developed to sustain the quality of services.

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23. Dr. SA Akor, Dir. PPME - MOH

Private/Public Mix

How can the private sector be best integrated into the POW? Substantial links with CHAG, the main non-profit provider seem to be developing well despite the lack, as yet, of a signed agreement or performance contract between them and MOH/GHS. A clear policy may need to be articulated on the methods of sharing staff (eg; secondments and appointments) and the coordination of incentives. A phenomenon observed has been the absorption of CHAG and private sector staff into the public sector with the advent of ADHA. It was not possible to compare previous years' recruitment but this may well be a trend to be observed carefully. A second area of HRH private sector involvement is in the area of ceding off certain specific services – eg; laundry; security; catering. This must be integrated with local management of salaries with internal incentives to save on the payroll.

Recommendation

It is essential that the MOH's HRH strategic plans estimate the impact of the private sector as a consumer of health workers and also estimate the wastage and anticipated expansion of that sub-sector.

HR planning

Competent HR policy and planning profoundly affects the short and long term ramifications of strategies to improve services. Continuous monitoring, evaluation and revision of strategies and targets is also important. The lag time of HRH training and production means long time frames are required to correct misaligned HRH.

HRH Strategic plans have been produced for the Ministry and the GHS. The Teaching Hospitals with some 25% of total public sector health workforce have not produced plans. Both available plans have detailed cost implications but have not been linked with the available resources. These strategic plans should also provide alternative scenarios for meeting funding projections.

Recommendation

The HR plans of various MOH agencies need to be better coordinated with the overall MOH strategic objectives. This needs to be a joint effort by all the agencies and the MOH. A critical analysis is required of the qualitative issues in the strategic plans and SWOT analysis and risks assessments conducted on various strategies and cost implications.

Performance, accountability and HRH management in the MOH agencies

Effective use of human resources requires good performance management and accountability systems as well as adequate rewards and motivation. Good management requires some form of performance contracts especially at managerial levels. The GHS and MOH have prepared guidelines performance appraisals involving all staff. Such a system demands significant staff time and effort, often without producing effective change in productivity. However, setting out performance agreements with BMC managers with clear performance criteria is feasible and should assist in creating a management environment for effective HRH utilization.

The decentralisation of salary management has not been implemented as expected. The risks of losing assured payment of salaries and weak local management capacity have been used as arguments to delay it. However, this current situation removes any incentive for managers to use their staff resources more efficiently and to utilize budget savings made. It also has impact

on staff distribution, by not allowing saving to be applied to staff incentives in deprived areas, and by permitting staff to receive salaries at posts other than where they actually practice.

Recommendations

There is need for a national HR forum based on prior expert analysis of the HRH strategies proposed. This forum should determine a programme for achieving crucial HRH decisions with clear ***milestones and timelines*** *and* ***with specific monitoring mechanisms****.*

Management of the salary budget should be decentralized and expenditure balances available for the managers to utilize for other staffing/HRH issues. This does not need to be in cash form (as items 2&3) but each manager needs a clear notion of the salary budget and expenditure. Positive balances on salary accounts should be utilized only by the particular BMC. Such a system should enhance staff distribution as well as create efficient HR management.

The compilation of each BMC's Staff database should be an assigned "project" for each Regional & THB HR Manager to accomplish as entry point into understanding their roles. Regular support and supervision of HR managers is critical in the early phase and regular reviews should be held to share experiences and learning opportunities. The compilation of staff databases should form the basis for an "HR audit" of the health sector.

It may be useful for the MoH to invest in producing an HR manual including all major personnel administration processes, procedures, and forms as well as staff benefits to assist local HR managers and staff understand better their responsibilities.

Table 5: Health training intakes analysis of some key cadres 2000-2002 (From GHS-HRD)

CADRES	2002		2001		2000	
	Intake	Output	*Intake*	*Output*	*Intake*	*Output*
MOH State Reg. Nurse (*est. requirement 712)*	**570**	272	**473**	395	**489**	309
CHAG State Reg Nurses	**89**	85	**46**	91	**-**	77
MOH Psychiatric Nurses *(est. requirement 35)*	**12**	-	**45**	-	**14**	5
MOH Community Health Nurses[24] Total	***391***	***275***	***360***	***230***	***260***	***223***
SRN Midwife Total	**87**	-	**106**	102	**112**	100
Medical Assistants (*est. requirement 200*)	**30**	30	**31**	27	**27**	41
Community Technical Officer	**86**	33	**65**	37	**32**	42
Field Technician	**40**			32	**32**	
Laboratory Technicians- Korle Bu	**35**	36	**35**	26	**70**	34
X-Ray Technician - Korle Bu	**22**	20	**8**	30	**20**	18
Public Health Nurse (est. *requirement* 292)	**42**	35	**37**	37	**38**	37
Peri - Operative Nurses (est. *requirement* 494)	**14**	-	**-**	13	**21**	21
Critical Care Nursing (est. *requirement* 289)	**18**	-	**-**	12	**29**	29
CHN/EN Midwifery*(est. requirement 1010)*	**195**	22	**198**	121	**181**	87
Doctors – *(est. requirement 150)*	**193**	63	**238**	116	**223**	116
Dental Surgeon (*est. requirement 10)*	**10**	6	**14**	6	**13**	5
Pharmacist (UST) (Basic) *est. requirement 70*	**175**	96	**106**	106	**111**	99
Pharmacist (UST) (Postgraduate)	**31**	6	**18**	4	**8**	5
Degree Medical Lab. Technologist (UST)	**35**	17	**60**		**40**	

Total GHS Staff shortfall/requirements estimated at 9857(From GHS – Strategic Plan p24-28, 31-32)

24. Note that 5280 CHPS officers required for target coverage by 2006

Summary of MoH progress against overall PoW HRH objectives

Objectives	Specific actions observed	Achievements	Comment
To develop incentives to attract and retain health professionals	Additional Duty Hours Allowance(ADHA) still being implemented.	Possible increased doctor retention countrywide.	Other professional groups dissatisfied. ADHA does not have distribution component.
To ensure the appropriate distribution of personnel	Some control on salary payments of people who have been posted to new locations effective.	Not yet clear whether distribution gap has shifted – data not routinely collected.	Within regions and districts some local innovations on incentives for posting have been applied. However, national re-distribution not affected.
To ensure career development opportunities	Both THBs and GHS have been considering "Draft" conditions of service/schemes of service.	Largely at discussion stage and not much action taken on finalizing.	There is need for MoH coordination to ensure they complement each other. Who is in charge
Specific "Objectives"			
Assess existing HR Plans and Policies	Draft MoH HRHD Plan and GHS Strategic HRH Plan available	Fairly detailed plans produced for MOH and GHS Agency. No HR Plans for THBs and CHAG	Both plans will require further expert review (eg; pop^n ratio norms instead of projected sector plan requirements.
Define the gaps in HRH Policy Development and develop plan of action to deal with the situation	Draft MoH HRHD Plan and GHS Strategic HRH Plan available ? based on reviews conducted.	2 (MOH & GHS) Plans	A gap still exists between the MOH plan and the GHS one and there is no clear plan of steps to deal clearly with the HRH issues.
Recommend a comprehensive HRH policy	No particular activity in this area.	The HRH Strategic Plans for both MOH & GHS are a step forward	The Strategic Plans are different from Policy and the policy direction needs to be clearly articulated.
Develop a costed HRH Policy/Plan to focus on the regional priorities & CHPS.			The plans are costed but these costs are not compared with the resource envelope and available resources.

Summary of MoH progress against HRH 2002 PoW objectives

General activities with HR Implications

Activities	Achievements	Comment
Establish Act 525 Implementation Committee	Committee established and draft LI's presented to Minister 2002	Not much movement with Legislative Instruments to allow proper management of agencies.
Issue Appointment Letters and schemes of service to staff	Draft Schemes –ready no appointment letters issued.	The appointments are important to a] Define the executive status of each agency to their staff b] Establish exact staffing level of each agency. c] make management appointments & performance contracts make an impact on productivity.

Specific HRH activities

Activities	Achievements	Comment
Training and staff development activities		
Pre-Service Training, Standards review & synchronization with National Education System.	Diploma programmes started for some registered Nurse programmes. However, University accreditation not completed. Standards review?	New schools require investments eg: 1. Training qualified and experienced tutors, 2. Supporting logistics & Infrastructure eg; teaching equipment & HLM,, 3. Pupil/tutor ratios& supervision of course content & standards.
Accreditation and certification Board for all post SSS programmes/ Converting post SSS into Diploma programmes.	Examination Board for Nurses proposed for discussion. Nursing SSS programmes converted to "diploma"	Currently MOH certified programmes not covered by proposed board.
Rationalization of Training Institutions – efficiency,	No evidence of new "rationalization". Expansions in intake of current schools.	The new CHNT schools for each region were not 'rationalized' in terms of reducing overheads & consolidating infrastructure and tutors needs.
Public/Private In-Service Training Opportunities.	IST Log Book in use within CHAG institutions. Good involvement of CHAG staff in regular IST.	It is not stated clearly as to what the policy is with "private for profit" providers links to training.
Human Resources Planning & Management Activities		
Separate MOH and agencies payrolls with separate IPPD.	This item has not been initiated.	Salary management and IPPD/HR databases were not decentralized in agencies. Local staff lists were available.
Incentives Mechanisms & Brain Drain:	Continued ADHA payments. Draft report on rural hardship incentives ready with proposals.	Policy decisions needed on Distribution incentives especially for most deprived regions.

Summary of GHS progress against HRH 2002 PoW objectives

Activities	Achievements	Comment
Training and Staff Development:		
Retraining Staff – scope expansion and Quality Control, Curricula development, HLMs etc.,	Extensive IST taking place. Several curricula for SIST completed in Draft form.	HLM covers more pre-service trg than IST. Improved coordination is needed with national tech^n training programmes. Closer attention needs to be paid to linking IST to national priority services.
Operationalize SIST – resource Persons, TIS, Log Book monitoring systems	SIST has been in operation in all regions in terms of utilizing logbooks & recording courses. New Course Curricula drafted. All training coordinators trained in Trg. Mgmt. 2002	Coverage of Log Books average 59% of staff, still weak in some pilot regions. Use by CHAG, & GHS/THBs extensive. Information systems in non-project regions need to be developed further
"TRG INSTITUTIONS": *a] New Auxiliary 'nursing' Cadre* *b] Analysis and review of intakes*	a] Training has taken place in GHS regions and THs. b] Schools Intake increases at all levels	Health Aides training decentralized hence need for quality monitoring & evaluation of products. Not clear if school intake changes reflect priorities, resources limitations etc.,,.
CHPS	Pilot placement of staff in Communities in all regions. 2 New CHNT Schools started?	Are target communities/ districts prioritised given high wage implications? Rapid expansion of CHNTS means new overheads, quality control problems etc., which should be addressed in plans. CHPS may need to prioritise and target the most deprived areas in 2nd POW.
Monitoring of Quality of Training	NMC doing regular visits/ supervision of nursing schools.	Not much being done for non-nursing schools. Quality of In-Service training also needs monitoring. It is important that regular skill audits are conducted to identify training needs of cadres.
Human Resources Planning & Management:		
Up to date HRIS developed	IST info system set up & may gradually cover more regions. National HRIS is dependent on IPPD(which has own problems & constrained by payroll needs	For mgmt purposes each BMC should have secure staff Admin database for comparison with IPPD.
Enforcing Staffing Norms	Some enforcing of salary payment only at post of service helps norms.	Do the norms still reflect the real needs? Are all emerging service types covered by the norms? Do norms reflect cost-effective skill mixes and HR utilisation?
Equitable Distribution of staff & Decentralization.	Enforcing staff norms may assist with this. Not much done.	A coordinated strategy for HR retention & distribution is needed. Salary decentralization is essential to decentralized HR mgmt. However, constraints of doing this should be modified with innovative strategies.

8. Organisational issues

8.1 Introduction

The review of the health sector at the end of first 5-year POW in 2001 concluded that there had been significant progress in developing district level management and in decentralising the management of the health budget but that significant further improvements (efficiency gains) in the entire health sector could be generated by improving organisational arrangements to achieve health sector goals. Such improvements were to be achieved through four main institutional reforms:

- Separation of the Ministry of Health from the Ghana Health Services and Teaching Hospitals as autonomous agencies of service provision, thus leaving the Ministry to focus on the purchasing, regulation and coordination of service delivery.
- Improvements in management systems by creating a decentralised planning, and budgeting system, strengthening the financial management and performance monitoring systems and investing in overall management development and capacity building within the sector.
- Improving the regulatory environment by strengthening existing regulatory bodies and establishing new ones where appropriate, as well as reviewing existing laws and enacting new ones.
- Improving the coordination of development partners and ensuring coherence of their activities through the establishment of the SWAP.

In addition to these strategic roles directed towards its agencies and the public (external responsibilities), MOH also has administrative responsibilities towards itself.

These proposed improvements were incorporated into the second POW (2002-2006) as strategic objectives to be achieved by 2006. This section of the review report looks at what was achieved in 2002, that is in Year 1 of the second POW, discusses shortcomings that exist and offers suggestions for accelerating the pace of implementation. Wherever possible, the analysis examines trends from 1997 up to and including 2002.

8.2 Organisational performance in 2002

The overall intention for 2002 was to set up structures and procedures to manage the implementation of Act 525. More specifically this involved:

- Setting up six committees to manage implementation of Act 525 and ensure the MOH objective are carried out
- Developing a phased approach for taking over functions performed on behalf of MOH by other agencies.
- Completing the separation of the staff of MOH from GHS by compiling MOH-specific staff and payroll management systems and establishing an integrated personnel and payroll database
- Developing and initiating a sector wide framework for commissioning and contracting all agencies
- Preparing manuals and guidelines on registry practice, capital project planning, management and supervision and completing and disseminating policy and guidelines on management of civil works.
- Developing policies for an effective procurement, storage and distribution systems for the public sector health services
- Enhancing the current process of engagement between government and its development partners through the regular health summit

Achievements

During 2002, MOH made clear attempts to position itself as the lead agency for the health sector. Cabinet approved a proposal for re-structuring the MOH. Six directorates and several positions were created to handle what the Ministry regarded to be its main functions: these were for Finance, Administration, Procurement and Supplies, PPME, HRMD, Research, Statistics & information Management (RSIM), and Traditional & Alternative Medicine (TAM).

Directors were appointed for the directorates and were given job descriptions

The Minister initiated a forum for regular meetings with its agencies. This is judged to be useful by members of the forum. He also set up a task force to resolve the poor interpersonal relations between MOH and GHS.

Shortcomings

Several shortcomings offset these achievements. Working relations between MOH and several of its agencies were judged to be poor and definitely worse than in previous years. Tensions have arisen between a centralising tendency of MOH and a demand from agencies for more decentralisation of function. There were tensions and disagreements with the GHS over which agency should have responsibility for procurement, capital planning and human resource development. There was confusion about what MOH expects of CHAG. The external partners complained of being alienated from the procedures that the CMA clearly prescribes for both sides of the partnership. Overall ambiguities in existing laws and guidelines have been exploited by individual agencies to lay claim on territory that would go to others if efficiency, effectiveness and equity criteria were to be applied.

While some of these tensions existed in previous years, they have worsened with the appointment of new people into the MOH and the definitive separation of MOH from GHS. Good working relations depended more on personal relationships and less on developing binding or enforceable procedures and guidelines. Other reasons include the perception that new MOH staff are inexperienced in matters of health sector reforms and SWAP, younger in employment and wont to play the boss over the GHS. The MOH team on the other hand came into their jobs with a desire to ensure that business is conducted in way that will lead to real change and that may necessitate a change in interpersonal relations. It was evident in our discussion that on both sides there was inadequate understanding and interpretation of the provisions and implications of Act 525 and the management arrangements guiding the reforms.

In the absence of regular and effective forums this inevitably led to poor interpersonal relationships. However, in the first part of 2003, officials from both sides report some thawing due to a determination to accommodate each others differences.

Appointments and assignments remain incomplete half-way through 2003. Several vacancies exist below the directors level remain vacant because there are no bodies to employ. Though the top managers have come with experience from working at various levels of the health services, few of them have received specific orientation in the key functions of policy analysis, formulation and translation into practice. This may be necessary to give the entire MOH a corporate vision shaped around these core functions

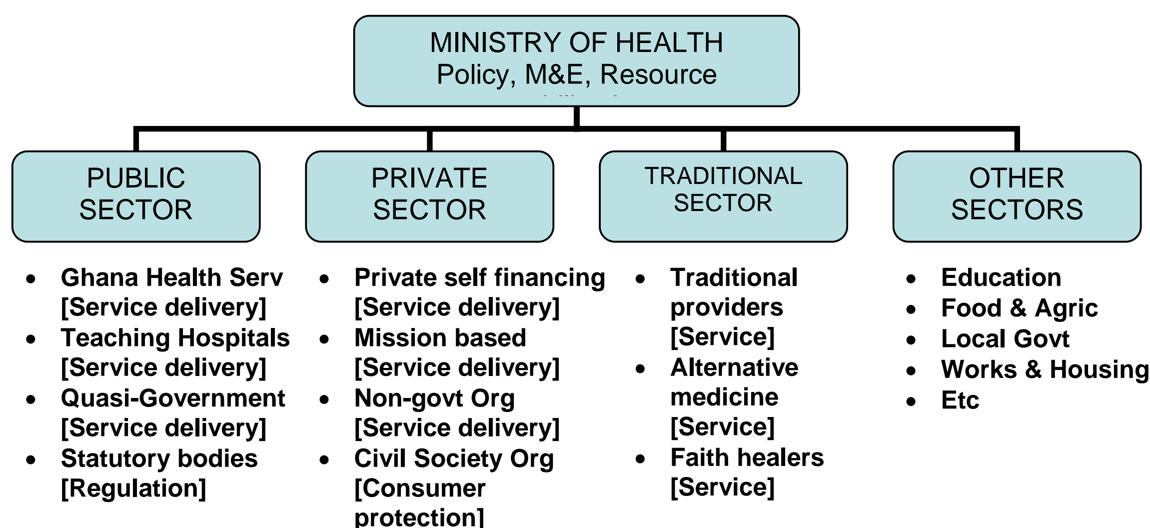
The large size of establishment proposed and the functions of some top positions is at variance with the expectation of the Office of the Civil Service. The issue at stake is whether MOH

and its agencies are set up to perform their core functions efficiently and effectively. The same question has been raised in the on-going functional review of Ministries, Departments and Agencies[25].

The assignment of the National Health Insurance programme to the Director of PPME in 2001 has become a pre-occupation at the expense of the core business of that directorate. Health insurance in important in addressing some of the inequalities and gaps to be addressed in POWII and should be given as much priority is it deserves but it is important to establish the proper status and home for such an important programme.

8.3 The sector's organisational structure and functions

Figure 1: Structural relationship and key functions in the health sector in 2002



Functions

The vision for the health sector is one of multiple partners and agencies with the MOH retaining a stewardship role to ensure maximum efficiency and to strive for more equity and optimal health gains. MOH's key roles are to:

- provide overall policy direction for all stakeholders in health delivery system;
- mobilise and allocate resources to all providers;
- provide relevant and adequate information for coordination and management of health service;
- provide regulatory framework for all providers;
- monitor and evaluate health services in Ghana;
- be a strong and effective advocate for multi-sectoral action in health services;
- procure services and goods for the health sector.[26]

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25. A Functional review has been commissioned under the National Institutions Reform Programme (NIRP).

26. Responsibility for Human Resource Management & Development and to a lesser extent Procurement and Capital planning have remained a contentious issue between MOH and GHS and will be discussed separately.

If properly managed these reforms would create a purchaser/provider split with MOH as the purchaser and regulator of service provision while the other agencies would become service providers and statutory bodies enforce the rules. Whether overall regulation of the health sector should be a function of the central MOH or should be carried out by a new independent body is the subject of discussion in the on going audit reviews commissioned by the National Institutional Renewal Programme (NIRP).

Policy function

There is consensus that the MOH should take the lead in developing and reviewing national health policies and in translating government policy into implementation objectives for agencies. To ensure the process of formulating and interpreting policy is well informed by agencies that generate information and implement these policies it is essential to use forums and procedures that involve them at all stages. While these already exist they were not used optimally in 2002.

Leadership function

MOH currently lacks the full capacity and orientation to provide leadership to other health sector agencies. Some of the agencies like the GHS and THS have more experience and better-qualified staff to play this role than the MOH.

Within the MOH itself, leadership and coordinating roles are vested in the Chief Director but this does not seem obvious in the operations of the ministry. For example, the function of leading the ministry in defining and implementing a strategic vision is exercised by other sectors of the ministry. Coordination and liaison with partners is done by PPME, while the administrative functions are handled under the Chief Director's office. Thus technical and administrative axes, both reporting to the Minister, replace the integration that would make MOH function as a single organisation. This adds to the confusion of functions and inefficiency.

While the CMA recognises the civil service character of MOH, it does not give due attention to the role of a coordinating office for all its directorates.

The existing arrangement fails to address concerns of some agencies like CHAG that wants signed/binding agreements in their relationship with MOH (through a Memorandum of Understanding).

The National Institutional Renewal Programme (NIRP) has contracted a private consultancy firm to assist the public health sector agencies streamline their functions to minimise duplication and confusion of purpose and health is one of the sector's receiving this assistance.

Monitoring, evaluation and contract management functions

In addition to the technical monitoring of the health sector, for which a minimum number of indicators have been agreed, it is suggested that the central level takes on the new responsibility of managing contracts and SLAs, which will become a very important function in the re-structured health sector.

Planning and management functions

There has been a reversal in gains made in decentralised management, budgeting and financial system. The successful BMC accreditation criteria offer guide to what can be done when clear objectives and standards, adequate funding and effective monitoring is put in place. Unfortunately this process has not been reinforced nor extended to other institutions.

Service functions

If the service agencies are to provide services to an agreed standard, agreements are required between them and MoH that would be binding on both parties for the MoH to provide appropriate inputs and for the agencies to deliver agreed services. This is line with Act 525, which provides for such contracting arrangements to ensure more compliance on both sides and this is discussed further in the next section. Improving management skills within the civil service system has not yet yielded these results.

Recommendations

The on-going functional review offers a good opportunity to clarify and resolve the confusion over roles and functions. It should receive the fullest support and priority from senior directors and from the Minister.

The key functions of the MoH are policy, agency contract management (including M&E) and financial management. The simplified organisational structure implied is in line with NIRP thinking. The sector's regulation is probably best contracted out to an independent agency with a mandate to protect consumers' interests.

If a restructuring of the clinical workforce is required, staff should be given choices. These might include: continuing under civil service employment conditions, applying competitively for positions with a restructured GHS under fixed term contracts or receiving one-off payments to set up in private practice. Such choices should be seen to be evenly balanced in terms of their risks and rewards.

The monthly forum with the minister could be used more effectively to deal with all aspects of relationships. Use task forces with clear time-bound assignment resource matters that require more intensive engagement.

Important design and technical work related to the NHIP is overburdening PPME at the expense of other duties. However, it is vital that MoH direct the design phase of the work before designated agencies take over its implementation. Once implementation begins important maintenance and stewardship functions will need to be continued by MoH but at a lower level of intensity. Possible alternatives for managing the present temporary high workload include:

- *creating a dedicated team of experts on short term contracts under the management of the Director, PPME*
- *creating a temporary independent body with strong public sector representation under contract to the Minister.*

BMC accreditation should be revived and extended to staff and staff budget management and also to providers in the private sector under contract to MoH.

Similar accreditation arrangements should be put in place for District Assembly and health insurers' management performance.

8.4 The implementation of arrangements that mediate relationships between organisations

Contracting and service level agreements

Contracting and service level arrangements are two of several mechanisms that the health sector reforms have proposed to use to improve accountabilities, define responsibilities and generate efficiency gains. There will be clear separation of functions. MOH will contract with the GHS, which, in turn, will contract out services to other agencies, including sub-BMCs, with comparative advantage in the delivery of health services. Contracting can also be regarded as a mechanism for achieving the broader government objective of greater private sector involvement in national development. The target for the health sector is to shift the balance of service provision from public/private ratio of 60/40 to 40/60 (see companion report on private public partnerships).

No progress has been made in putting in place new contracts and SLAs. The GHS does not yet contract health services to other service providers[27]. The largest provider after GHS is CHAG. CHAG is yet to conclude an MOU with MOH that will pave the way for contracting by the GHS. Since the public sector health agencies have no experience in contracting or other forms of service agreements, a major exercise is required to build up capacity in MOH and its agencies to manage contracts.

The Common Management Arrangements

Formal relationships, designed as part of the health sector reforms, have been well captured in the Common Management Arrangement and its accompanying Memorandum of Understanding. However these arrangements operate on the basis of trust and are not binding.

Recommendations

Revise the CMA to incorporate more specific responsibilities of each participating agency or partner.

Build in incentives and sanctions for use of guidelines

There should structured on-going sessions (weekly to monthly) where all directors and staff at central level learn/discuss the provisions and implication of the key documents that guide operations of the health sector (Act 525, CMAII, the Civil Service Act and related document). All new entrants into the system must have an orientation on these laws and guidelines.

District Assemblies and decentralised district health services

The existing structure of district assembly defines clear roles in relation to district health services. Health is one of the decentralised services expected to become part of the administration/secretariat of the DA's responsibilities. DAs are now in receipt of funds for health, from HIPC, and are likely to receive much more in the future both as a result of debt relief and the GPRS. These funds will allow DAs to become health service purchasers.

As a result, there should be a composite district plan with clear health sector component. The district health administration will need to work increasingly toward the District Assembly

[27]. Although contracting out civil works and vehicle maintenance is a well established practice that can serve as example for managers

rather than the Regional Health Administration. This way the health sector is expected to be more responsive to needs of the communities they serve and would achieve greater efficiency through a composite service and development programme.

The review revealed that District Health Administration (DHA) links with DA is very weak. Composite plans are not routinely available except in some donor sponsored project districts and even these are largely unused. Participation in DA activities tends to depend on personalities rather than on the statutory obligation to do so partly because there are no sanctions attached to non-compliance. In contrast DHAs have very strong links with GHS to which they are bound by financial ties, current management processes, the provisions of Act 525 and by history.

Management capacity in DA is very weak relative to the District Health Service. District Health Management team members tend to have better academic and professional qualifications than their District Council counterparts. Furthermore the health sector has a long history of continuous management training and strengthening processes dating back to the 1980s.

An important development in 2002 was the decision to increase DA funding through direct allocation of HIPC funds. One billion cedis has been allocated per district in 2003. Health services have a claim to these funds but it is too early to assess to what extent health services will access these funds. The release of HIPC funds depends on submission and approval of a district-wide development plan that should include health, education and water and sanitation components. This process could serve as an incentive for more composite planning and programmes at district level.

Agreement was reached recently between the World Bank and the Ministry of Finance that HIPC funds would be used to exempt obstetric services from fees in the four northern regions. However, the mechanisms for transferring these funds to BMCs and the conditions under which they would be transferred have not been agreed.

It is clearly important to provide capacity for both planning and fund management in DAs and all other sectors. With the lessons of SWAP in mind how should the process be managed such that the expected gains in efficiency and equity will be realised? One possibility is to use the experience of health budget management decentralisation to BMCs by setting accreditation standards that need to be met before funds are released. Another is to use SLAs or contracts as the instrument by which DAs purchase health services. This would strengthen performance incentives by converting what might be loose input-based subsidies into output-specified agreements.

The managerial weakness of DAs also needs to be addressed by training in health service purchasing and budget management.

Recommendations

Decentralising budget fund management to District Assemblies is clearly in line with health sector objectives of decentralised planning and management and should be supported. However, sustained investment in capability development will be required.

Seek parliament/cabinet, MoF and Local Government support for earmarking some district level HIPC funds to use for equity and access objectives eg exemptions to purchase services for defined sub-population groups, community insurance schemes, CHPS compounds. This would ring-fence some HIPC funds to meet health sector objectives, which also contribute to GPRS goals

8.5 Making things happen

What emerges from analysis of the shortcoming of the health sector during 2002 is the lack of clarity about roles and functions and the incentive mechanisms to encourage people work diligently towards the sector's goals and objectives. Hence the recommendations in this report to focus on people and their work. The two aspects of such attention are the managerial and the legal.

Recommendations

Managerial

Provide clear job descriptions for defined functions and positions

Focus on outputs and deadlines This requires a change in focus from inputs (for example how long a person sits the office) to outputs (what product an employee has delivered at the end of the day)

Support people's work Provide supportive supervision for all workers at all levels; provide them with tools and skills needed for their work. Assessing performance and measuring improvements in performance are critical activities in this support.

These managerial interventions apply to the individual worker as well as to a unit, division or agency of the health sector.

Legal

Act 525 and other legislation provides much of the legal basis for the operation of the Ghana Health Service and other agencies. But these need to be reviewed and revised to eliminate ambiguities over roles and functions and structure.

A Road Map towards an efficient and effective health sector

- Organise a series of senior management retreats, possibly facilitated by one of the consultants working with MoH on the functional review. It should have a clear agenda to resolve differences in the interpretations of Act 525, and to define a feasible, time-bound work plan for moving towards its full implementation.
- Review and learn from the experiences of other countries, similar to Ghana, in implementing such organisational reforms, possibly informed by a bench-marking visit to establish long term supportive relationships between senior managers.
- Re-establish monthly-quarterly meetings as a key forum for dialogue and information sharing between MOH, its agencies and partners
- Clarify jobs, responsibilities and outputs
- Develop service level agreements and contractual arrangements and build capacity for managing them
- Use a minimum set of indicators to monitor performance of each BMC and each category of staff
- Review Act 525 to identify and resolve ambiguities
- Prepare LI that help to clarify some of the ambiguities

9. Government-partner relations

Under current SWAP arrangements PPME/MOH is responsible for overall co-ordination of development partner inputs into the POW. Its specific responsibilities include:

- ensuring ongoing policy dialogue and joint planning with development partners
- coordinating planning and the use of earmarked funds
- taking oversight of all project implementation arrangements
- liasing with local partner offices and visiting delegations and health summit organisations.

These fit with the job description of PPME recently approved for MOH.

9.1 Planning and monitoring roles

This is prescribed in the CMA. Donors have complained of being excluded from planning and policy discussions in 2002 and MOH itself admits it wants some space to itself to determine its focus and priorities. This is considered to be contrary to the spirit and letter of CMA and to the pattern of relations that had previously existed.

9.2 Trends in pooled funding

Since funding is one of the main ingredients shaping the government partner relationship the following table identifies trends in donor-pooled funding over the past few years and discuss how this could affect future relationship:

Year	% of donor funds managed by GOG	No. of donors contributing to pooled funds
1999	61	5
2001	63	5
2002	N/A	4
2003	→ Central budget support	(4)

The data for the whole of 2002 are not available and it would be worth updating this table when they are. However, the withholding donor pooled funds for part of the year suggests a decrease in funds under MOH control. Moreover, discussions with donors indicate a clear intention to shift from sector to budget support over the coming years.

9.3 Formal relations

The formal structures governing relations between MoH and the health Partners are still in place and in use but perceived by donors to yield lower benefits than before. They quote, for example, that decisions are not followed up with the same dispatch. However, relations are not uniform across the spectrum of donors, with some partners interpreting the changes as inevitable and necessary developments in a maturing and growing system. Nevertheless, the progress made in specific areas of the partnership in first five years of SWAP increased government control over donor resources, increased mobilisation of donor resources and spending and improved donor transparency. Current arrangements have focused on government-donor management systems and have to a very large extent become a successful model for other countries.

However, donor influence over national health policy development had been significant but largely shaped by individual donor preferences. On the whole the new MoH team perceives the SWAP to have been largely donor driven with support of some MOH (former) officials who also believed in its benefits.

Donors have also had a significant influence over the allocation of government resources: overall towards more spending on primary care, but within-years at the expense of cashflow stability in spending units. Sanctions in the form of withholding funds are permitted under the CMA. However, the benefits of the recent experience of holding back of donor fund releases in the face of accounting delays needs to be assessed against the costs imposed on BMC managers and on the level of trust between MoH and its health partners.

Important strategic considerations relate to the proposed shift in donor funding to the central budget. This will require different relations between MoF and MoH and between MoH and its agencies. It will also require health partners to engage across a wider spectrum of public sector activity in Ghana. This will impose new challenges for competency and time management. It may also require formal revisions to the CMA. Whether central budget support will lead to efficiency gains is much debated.

9.4 Informal relations

Informal relations between MOH and partners have cooled considerably compared to 2001. The CMA arrangements are good on procedure but make no provisions for sanctions for non-performance. The resolution of difficulties in the past has depended much on interpersonal relationships.

MOH officials report that they require space to develop its own thinking and position on key issues. Some partners have interpreted this as a snub. As a result, there has been a loss of good will, which is an important ingredient in effective team working.

On whole MOH and donors both want to improve the efficiency and effectiveness of the health services. However, tensions have arisen because of different expectations of implementation pace and the extent to which donors were involved in defining policy and core MOH functions.

At a personal level, relations between health partners and GHS headquarters' staff have remained good as most of the `old guard' are to be found there. This has aggravated tensions between MoH and GHS as some senior MoH staff perceive this to be against the grain of formal management structures which assign responsibility for managing partner relations to the MoH.

Recommendations

It may be time to take another look at what should be formalised to ensure that responsibility for action depends on statutory requirements and not just on the basis of friendship.

Review the CMA to take account of new budget support trend and the attendant shift of control towards the Ministry of Finance

MOH should ensure that regular meetings are held with the health partners, with mutually agreed agendas and clear steps on carrying out agreements reached.

The Minister of Health should identify and charge key representatives of MOH and partners be personally responsible for identifying and promoting other informal means of enhancing relationship between the two key stakeholders.

Partners need to recognise the need for a reconstituted MoH to position itself for leadership and policy-making roles and to respond constructively to the request for space.

10. Of measurement and management

A common management aphorism is: `if you measure it, it tends to get better.' Indeed measurement is at the heart of decentralised performance management systems. The important theoretical reason for this is that managers who delegate responsibility need to ensure that management agreements are fulfilled. This is particularly important in the public sector where management agreements are `incomplete contracts,' only partially specifying the services to be delivered.[28] The sector-wide performance indicators agreed under the CMA are examples of measurements that reassure health partners that their funds are well spent..

Ghana has accumulated extensive experience of measurement as an aid to management in the health sector. The sector-wide indicators specified in the First Five Year Programme of Work have been refined until they now more manageable and robust that for many health sectors in other countries.[29] However, looking across the whole annual cycle of management and budget agreements, reporting and reviews, as for example outlined in an annex to the Ministry of Health Annual Report 2002, including the external reviews, the system seems to be overly cumbersome, costly and not very effective. In fact, it is unlikely that the full cycle of activities, built on district and facility plans, could be completed properly within a year. The results can be seen in incomplete and inaccurate reports from districts and regions as managers save their time for tasks that have a more direct bearing on the resources they manage.

There are a number of points to keep in mind. One clear lesson that seems to emerge from international experience is that managers only have strong incentives to collect accurate information when it helps them to manage better. As many information systems are not designed with local managers' needs in mind, this incentive is often diluted. It is important to ask managers what information would help them and then make it easy for them to analyse data to give them this information.

Internal reporting is useful but does not provide verifiable performance information. Managers have strong incentives to report inaccurately if that is in their best interests.

Accumulating international experience of performance measurement emphasises the hazards of perverse incentives for providers. For example, an emphasis on bed occupancy rates will induce a tendency to keep patients in hospital for longer; or an emphasis on waiting lists will result in `cream-skimming' (treating simple cases first irrespective of clinical urgency); or an emphasis on cost savings will induce a tendency to minimise treatments and in-patient days at the expense of service quality and clinical effectiveness.

The team has not been able to formulate comprehensive suggestions, and this is probably not its role, but it flags these issues for further attention. The following suggestions emerged during team discussions, some of which may be worth consideration.

- Invest in district and facility business plan preparation with an extended planning horizon (three to five years) and make these the basis for medium term budget and expenditure plans
  (In return, MoF, MoH and donor partners need to devise more effective ways of stabilising the flow of funds to BMCs)

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[28]. In contrast, contracts with private sector providers to supply a specific set of services can and should be better specified (see companion report on Private Public Partnerships).

[29]. Nonetheless, the review team believes that additional indictors of provider efficiency would be helpful.

- Concentrate annual plans only on major policy initiatives or changes managers want to make and make these the basis for incremental budget allocations
- Equally restrict annual reporting to measures of success in relation to the changes sought in service delivery volume or quality
- Introduce independent information to verify compliance with management agreements and include consumer information[30] (these might be based on data collected by a few, small, highly skilled and well equipped mobile teams)
- Make this information available publicly, in ways that health service consumers can understand it, in the press and on the internet.
- Supplement and deepen this information with a performance database from studies (for example, the hospital costing study and the 20 district study) and from international surveys in which Ghana participates (for example, DHS and LSMS).
- Make this information available publicly, in ways that health service consumers can understand it, for example, through the Health Bulletin and similar publications and on the internet.
- Make annual performance hearings less routine and more related to performance and include consumers. Initially these might pick a limited number of BMCs at random. The findings of the performance hearings might determine when that BMC is visited next: the next visit might not be specified if the findings were good but it might be in six months if the findings were to the contrary.
- Focus external reviews more precisely on topics where international experience would be informative, as in the in-depth studies proposed fro the 2002 external Review.

[30]. This should go beyond consumer satisfaction surveys and make enquiries from patients about treatment protocols. Women attending antenatal clinics can tell if their blood pressure and been taken or their urine examined.

11. Conclusions

11.1 Some common themes

The review team has taken note of a number of positive developments in the sector:

- its inherent robustness and the commitment of its staff;
- the government's continued commitment to health as evidenced by the increase in budget share going to the sector;
- the emphasis it has given to improving equity by proposing to phase out `cash and carry' and by moving the CHPS programme ahead rapidly
- the progress made in rebuilding the formerly depleted MoH team.

Perhaps most important of all, the team has been impressed by the talent and dedication of key staff in MoH and GHS and their determination to see outstanding issues resolved so that the sector can move forward.

However, there have also been some less positive developments:

- the inevitable effects of the costs of changes and the legacy of unfinished structural reforms in the sector;
- the failure (as yet) to turn new money into improved service volumes and quality;
- the costs of continued misallocation of financial and human resources in terms of the sector's equity objectives;
- the decline in budget efficiency as staff costs continue to rise relative to total recurrent expenditure;
- the increasing instabilities in funding flows to spending units;
- the uneven but generally low levels of productivity in the sector;
- the failure to capture the full efficiency gains from new innovations (such as CHPS) by adding repeated layers of new services to old without adjusting the service delivery structure as a whole;
- the continued inefficiencies and distortions in the hospital sector;
- the continued failure to take private sector activities fully into account in planning government services and, despite substantial progress in preparation during 2002, the slow progress in realising the Minister's vision of a coherent, well-regulated, pluralistic sector;
- the lack of a clear policy and appropriate services for the rapidly increasing numbers of urban poor.

The resolution these problems would pose formidable challenges even without those associated with the government's new policy initiatives. However, their solution is the more important in view of imminent changes in the sector. The reduction in debt-servicing obligations under HIPC will release more budgetary funds over which the government has discretion and, together with GPRS resources, will make more funds available for health. It would be the greatest possible tragedy for the people of Ghana if this new money were not converted into better and more health services, particularly for the poor. Yet Ghana's experience, along with many other countries', is that this does not happen automatically.

The second important change facing the sector is the emergence of two new important purchasers of healthcare: health insurers and District Assemblies. This will make the management of funding flows by health service providers more complex and the overall stewardship functions of MoH more demanding. The team believes that the investments

required in human and organisational capacities to implement new initiatives, as well as to prepare BMCs for their introduction, have been seriously under-estimated.

Meantime cashflow instabilities have eroded budget managers incentives to attend to public priorities. If they continue to receive most public money in the second half of the year, they will pursue IGF-funded activities in the first half, which may have little to do with the sector's targets and defer pro-poor and public health activities, possibly for a long time. It will be even more vital that the flows of funds from GoG and pooled funds are predictable as the competition for provider attention from other health service purchasers' increases.

11.2 Three headline issues

This analysis leads the team to conclude that three major sets of issues require attention.

Improving the demand for important health services

So far health policy in Ghana has been largely driven by innovations to improve access, both geographical and financial. The emphasis on lowering the cost of access to health services for poor people remains important. Indeed, this report emphasises the need to make exemptions more precisely `pro-poor'. However, experience all over the world suggests that people, even poor people, will bypass free services of a poor quality to find services that they deem to be better even if they have to pay for them.

This has at least three practical implications. First, the public needs to be educated much more aggressively about the value of better health behaviour and better health-care seeking behaviour. They need to know how to look after their own health better. They need to know where to find good quality services and they need to be taught how to use health services more efficiently. These are major challenges for public information strategies. More money needs to be spent on them and professionals need to be engaged to design and implement them. On the other hand, health workers also need to continue to focus on their educational functions and need to understand that the way they receive patients establishes the service's reputation. Health services need to be convenient for clients more than staff.

Second, the supply of publicly financed services needs to be adjusted to demand. Government services need to compete actively for clients with private services suppliers, on quality and price. However, the money Ghana spends on maintaining staffing norms in clinics and hospitals where the caseload is low, could be spent better elsewhere. Unless adjustments are made to match supply with demand, it is probable that the benefits of new funds in the sector will be low.

Third, health services need to be planned creatively to deliver the most for the least money and holistically, taking into account all purchasers and all providers. This needs to be done district- by-district taking into account epidemiology, demography, population density and poverty incidence to create service delivery strategies that are tailor-made to specific clients' needs. District-level planning has a long history in Ghana. However, much of it has assumed that the government is the only health service purchaser and has ignored the contribution made by private sector providers or the contribution they could make if commissioned to do so. This has all changed. District teams need to create `business plans' showing how they plan to address the major health needs by creating demand for the right services, what services they intend to commission, what services need to be financed from the health budget, given the presence of insurers and District Assemblies as alternative purchasers, and what services they can justifiably provide on the grounds of comparative advantage. Similarly, District Assemblies and insurers need to learn how to become good health service purchasers.

This should not be done all at once but initially concentrated in `focus districts' where methodologies can be developed and refined with support from the regional and national levels. These `focus districts' might then become the sites for introducing improved planning, budget management, contracting and purchasing arrangements.

Balancing greater freedoms with greater accountability

It is probable that, if the sector's resources could be rearranged optimally, in some magical way, and if all staff were motivated to give of their best, much more could be done for health in Ghana without increasing the budget. Act 525 had this objective in mind. It was based on a greater reliance on local managers' knowledge and greater managerial discretion in applying resources to priorities. At the same time it proposed to replace administrative controls with arms-length, but no less powerful, agreements with managers to deliver on service targets for which they would be held accountable.

Increase managerial freedoms have occupied the minds of many, more than the necessary counterpoint of increased managerial accountability. Enforceable management agreements have not been developed between the Minister and agency CEOs; nor between Teaching Hospital CEOs and their department heads, nor yet between the GHS Director General and BMC managers. In fact, by 2002, the performance management cycle had become significantly eroded compared with earlier years. As a result, there has been a weakening of administrative controls without anything to replace them. This has reduced the sector's efficiency and there are understandable concerns that further controls will be lost of Act 525 is fully implemented.

This need not be so.

However, much greater attention will need to be given to at least three areas before the managerial freedoms incorporated into the Act can be `made safe' by more powerful accountability systems. In the first place Service Level Agreements specifying the outputs required need to be hammered out between the Minister and agency heads. These need to be simple, clear, feasible, not over-specified but enforceable. They need to be supported by similar Service Level Agreements between agency heads and their BMC managers. Second, they should be backed by sanctions and systems to administer them fairly and sensibly. The sanction for poor performance should not be a reduction in budget allocation. This taxes the consumer rather than the manager. More appropriate responses are management support, retraining, a move to a less demanding role or, in the case of serious under-performance, dismissal. Third, management agreements need to be supported by independently verifiable information from the consumer perspective that allows the `principals' offering management agreements to `observe' the actions of their agents. Internal reporting does part of the job, but not all. The organisational implications of this statement have been explored to an extent in the last two sections of this report but much more work is required.

Doing the hard things first

It is self-evidently easy to do easy things and hard to do hard things. It is more than passing tempting to do easy things first in order to demonstrate progress. However, many of the difficulties being encountered now in the health sector are due to hard decisions related to accountabilities that have been deferred:

- the full implementation of Act 525 by giving GHS and THS autonomy under contract with the minister;
- the implementation of its associated employment policies;
- the further implementation of budget decentralisation;

- the implementation of the Hospital Strategy;
- bringing the capital budget management into line with the recurrent budget;
- the future of the Central Medical Stores.

They are harder to implement now that interest groups have focussed their attention on the benefits they stand to gain, without giving equal attention to their compliance with agreed rules and procedures. New deals will need to be struck if progress is to be made.

It is hard to develop accountability systems ahead of increased managerial discretion. Yet this needs to happen. Importantly, Ghana already has the experience of giving managers incentives to comply with accountability regimes by setting out criteria for BMCs to manage their own budgets provided they met agreed standards. This experience provides a good model that can be developed to focus more on performance standards and applied widely in the sector to develop capabilities in advance of new funding flows: centrally, at the level of regional and district BMCs and in District Assemblies.

The central focus of this report has been on accountability systems and compliance. The backlog of related but unresolved issues from the past needs to be cleared up, so that the sector can move on. Implementing the big decisions will require outstanding and committed leadership. New competencies will not be built quickly or all at once. Sustained investments over a number of years will be required. Health Partners can support this process, but they cannot supplant, the sector's leadership. This report concludes by placing these challenges before the Ministry of Health and its Partners.