# GHANA HEALTH FINANCING FORUM 2019

## FORUM REPORT

DECEMBER 1, 2019

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## 1.0 EXECUTIVE SUMMARY

Over the past two decades, Ghana has committed to increasing both access to health services and financial protection in pursuit of Universal Health Coverage (UHC) through targeted health service delivery and financing reforms. Currently, the principal features of Ghana's health financing system are influenced by the need to underscore the goals of the Sustainable Development Goals (SDGs) backed by the country's development efforts. The Ministry of Health (MOH) organized a health financing forum, held on the 26th and 27th of November 2019. This forum was meant to provide a thorough review of the health financing situation in the country and inject new energy into achieving identified priorities. These discussions were well timed to align the country's health financing strategy with the UHC roadmap currently being developed. Decisions taken at the forum were expected to help shape the new health financing strategy and pave the way for a smooth transition from donor support whilst ensuring financial and programmatic sustainability.

The forum began with opening remarks by the Chief Director of the Ghana Ministry of Health (MOH), who reiterated the need for the forum to reflect and deliberate on the reforms that are required to strengthen the country's health financing system. The Chief Director particularly singled out the fiscal space challenges that the country faced and indicated that the MOH was keen to consider proposals for how fiscal space for health in Ghana could be increased. The acting WHO county representative recognized and thanked the MOH for continued collaboration and thanked the forum organizers. She pledged WHO's commitment to support the health sector on health financing and universal health coverage reforms.

The Honourable Minister of Health indicated that UHC was a key priority for the Government of Ghana and emphasised the need for context appropriate solutions to the country's health sector challenges. He further observed that donor support to the health sector had reduced over the last decade and that domestic resource mobilization was critical. He stressed the importance of finding innovative ways to mobilize additional resources for health. He indicated however that in addition to resource mobilization, it was important for the sector to identify ways to achieve efficiency gains to unlock more resources for the sector.

The forum brought together over a hundred state and non-state health sector stakeholders to take stock of the performance of the country's health financing system. Stakeholders also deliberated on the challenges faced and proposed potential actions that are needed to strengthen the health financing system. The health financing forum was brought to a close with commitments by the MOH, presented by the Chief Director of the Ministry of Health. He took into consideration the forum's recommendations and assured participants of the MOH's commitment to develop plans for implementation. Specifically, the Chief Director made the following commitments along the four thematic areas of the forum.

**MOH Commitments on Resource Mobilization and Donor Transition**

- Revise the health financing strategy to include a resource mobilization strategy that will guide mobilization of additional resources for health
- Advocate for increased allocation from the Ministry of Finance
- Explore the mobilization of additional resources for health from alternative sources that include sin/health taxes, and oil revenue
- Identify and implement measures to enhance the efficiency of the health system and unlock efficiency gains
- Deepen the engagement with the private sector to explore the potential for mobilizing additional resources from the private sector
- Take leadership in the coordination of donor support and transition plans

**MOH Commitments on PFM reforms**

- Harmonize and integrate the budgeting process across MOH and its agencies
- Enhance the adoption and implementation of all GIFMIS modules across MOH, its agencies and levels, as well as for all funding sources including donor funding, statutory funds etc
- Enhance the alignment between the budget and the procurement plan
- Invest in the infrastructure required for GIFMIS implementation (GIFMIS Strategy)- this includes internet access and bandwidth, and hardware

- Invest in capacity development for users of GIFMIS

**MOH Commitments on PHC and sustainable financing**

- Enhance NHIS benefit package to prioritize primary healthcare
- To increase investments in PHC to strengthen their capacity to deliver quality healthcare services – this includes financial, human resource, and infrastructure capacity
- Reform provider payment mechanisms for PHC to incentivize efficiency and quality and ensure financial autonomy (decentralisation)at the district level to facilitate optimal resource allocation
- Enhance the linkage of levels within the district health system (network of practices) to strengthen oversight and care integration

**MOH Commitments on NHIS reforms for UHC**

- Optimize benefit package development by incorporating a systematic, transparent, inclusive, benefit package development process that employs health technology assessment
- Enhance the use of data analytics to inform management decisions
- Re-engineer its systems to enhance the ease of member enrolment and renewal of membership
- Implement measures to improve operational efficiencies that will reduce its administrative costs
- Scale the E-claims system to improve the efficiency of the claims processing
- Enhance the integration of key information systems (financial, claims, membership) within the NHIS to improve efficiency of operations, and across the health system – e.g. with DHIMs

## 2.0 BACKGROUND

The Ghana Ministry of Health (MOH) organized a health financing forum that was held between the 26th and 27th of November 2019. The forum brought together over 100 state and non-state health sector stakeholders to take stock of the performance of the country's health financing system and deliberate on the challenges faced and proposed potential actions that are needed to strengthen the health financing system. Specifically, the forum sought to achieve the following objectives:

- Identify health financing priorities, short, medium and long-term actions, and relevant timelines to achieve sustainable financing for UHC in Ghana
- Agree on a system of coordination and accountability of health financing initiatives by government and development partners

The forum identified 4 thematic areas of focus namely:

- Resource mobilisation and donor transition planning
- Public financial management reforms
- Primary health care sustainable financing
- NHIS reforms for UHC

To facilitate discussions on these thematic areas, sessions briefs that summarized the current state and challenges under each of the thematic areas were prepared and shared with the participants before-hand. The session briefs also outlined discussions questions that would guide the thematic deliberations.

## 2.1 ORGANIZATION OF THE FORUM

The health financing forum was organized in four parts. Part 1 of the forum provided a platform for keynote addresses by senior officials of the ministry of health and development partners. Part 2 was comprised of presentations that aimed to set the stage for forum discussions. Part 3 comprised of 4 roundtable decisions. Each of the thematic areas of focus was discussed in a round table, guided by a set of questions. Participants were asked to identify priority actions that would form the focus of health financing system strengthening for each of the thematic areas. At the end of each round table discussion, a representative of each of the discussion groups presented a summary of their

discussions to all the participants of the health financing forum. Part 4 comprised of a presentation of a summary of the deliberations of the health financing forum and final remarks by the ministry of health. The next section presents a summary of the presentations and deliberations of each of the forum parts.

## 3.0 SUMMARY OF THE PRESENTATIONS AND DELIBERATIONS OF THE HEALTH FINANCING FORUM

### 3.1 PART 1: OPENING REMARKS

The forum began with opening remarks by the Chief Director of the Ghana Ministry of Health (MOH), who thanked participants for taking time to attend, and the WHO for its support to the forum, and other development partners and organizers of the forum. The chief director outlined the forum objectives and reiterated the need for the forum to reflect and deliberate on the reforms that are required to strengthen the country's health financing system. The chief director particularly singled out the fiscal space challenges that the country faced and indicated that the MOH was keen to consider proposals for how fiscal space for health in Ghana could be increased.

The acting WHO county representative recognized and thanked the MOH for continued collaboration and thanked the forum organizers. She pledged WHO's commitment to support the health sector on health financing and universal health coverage reforms.

The Honourable minister of health indicated that UHC was a key priority for the Government of Ghana and emphasised the need for context appropriate solutions to the country's health sector challenges. He reiterated that fiscal space for health remains a key challenge for the government of Ghana and that there is a need to think of innovative ways to mobilize additional resources for health. He further observed that donor support to the health sector had reduced over the last decade and that domestic resource mobilization was critical. He indicated however that in addition to resource mobilization, it was critical for the sector to identify ways to achieve efficiency gains to unlock more resources for the sector. He also highlighted the importance of good governance.

## 3.2 PART 2: SETTING THE STAGE

### 3.2.1 Presentation 1: Roadmap for Universal Health Coverage

This presentation was made by Dr Emmanuel Odame, the director of policy, planning, monitoring, and evaluation (PPME) at the Ghana MOH. The presentation reaffirmed Ghana's commitment to achieve UHC by 2030 and the critical role that primary healthcare (PHC) will play. The objectives of the UHC roadmap are:

- To increase access to better managed essential quality PHC services
- Universal access to interventions aimed at reducing unnecessary maternal, adolescent and child deaths and disabilities
- Universal access to clinical and public health emergencies

The presentation revealed that the UHC roadmap will be financed by:

- Increased domestic resource mobilization aimed at raising US$15 billion excluding wage and commercial loans over 10 years
- Increased proportion of National Health Insurance Funds spent on PHC services from 21% to 50% excluding commodities financing
- Mobilization of additional resources for the NHIS
- Mobilization of at least US$ 3 billion from development partners
- Recapitalization of all PHC facilities to 6 months minimum operating cost using a fundholding approach

### 3.2.2 Presentation 2: Health Financing Strategy Review

This presentation was made by Dr. Ama Pokuaa Fenny from the Institute of Statistics, Social and Economics Research (ISSER) of the University of Ghana. The presentation was based on findings of a review of the implementation of the 2015 Ghana health financing strategy. The review revealed that:

- Most of the planned activities of the Health Financing Strategy were not implemented
- Where implementation was done, it has been ad hoc and limited to activities that have been carried out by individual directorates or units of the MOH and its agencies.

- There has been minimum cohesiveness in implementation, pointing to the lack of a functioning Technical Working Group or steering committee to ensure that the activities were being implemented and tracked
- The health financing strategy did not sit in the broader development space, to allow other stakeholders outside the health sector to participate in its implementation
- Health agencies outside the MOH are insufficiently accounted for and inadequately involved in the monitoring and reporting of their respective areas within the overall HFS

The review made the following recommendations:

- The MOH should broaden the inclusion and involvement of stakeholders in the implementation of the health financing strategy
- The MOH should map and assign accountabilities to its unit and agencies for the implementation of specific aspects of the strategy
- The MOH should reactivate and maintain the functionality of the health financing technical working group to ensure the effective implementation of the plan
- The MOH should strengthen the monitoring and evaluation of the strategy's implementation
- The MOH should mobilize and allocate resources for the implementation of the health financing strategy to ensure that activities are carried out
- Development partners should ensure that strategies and plans are not only formulated but there are funds to support implementation

### 3.2.3: Presentation 3: Health Financing Progress Matrix

This presentation was made by Prof. Justice Nonvignon from the school of public health of the University of Ghana. The presentation discussed findings from an application of WHO's health financing progress matrix tool on the Ghana health financing system. The review found that:

- Several policy documents exist but they are inadequately integrated and harmonized
- The irregular or untimely release of funds is a barrier to effective implementation of equity measures

- Risk pooling is generally well organized as funds flow and risk pooling mechanisms seem to complement each other rather than duplicate
- Nonetheless, the limited coverage of the population under the NHIS (about 40%) may constrain risk pooling efforts
- There are reported cases of informal payments (co-payments) which are illegal
- There is a lack of clearly defined criteria used to determine which services and medicines are to be part of the benefit package
- Public financial management guidelines are being implemented
- Good governance principles and practices are applied in health financing governing bodies and agencies.

The assessment recommended that:

- The MOH should harmonize policies on and related to health financing in Ghana to give a clear and coherent direction to stakeholders
- The Ministry of Finance (MOF) needs to release funds in a timely manner to allow effective implementation of health sector strategies
- Efforts to improve coverage need to be strengthened, especially from the informal sector
- Measures such as the e-claims meant to reduce delays in claims processing, and thus delay in reimbursement need to be improved, in addition to re-examining parameters that inform tariff reviews
- There is a need for clarity in criteria for determining benefits package
- A review of the benefit package to align with universal health coverage reforms is required
- A comprehensive in-depth evaluation is needed to inform measures that will lead to optimum implementation of PFM in the health sector
- Good governance principles need to be strengthened and institutionalized in the health sector

### 3.2.4: Presentation 4: Political Economy Analysis of Health Financing Reforms in Ghana

This presentation was made by Dr. Dominic Abekah-Nkrumah from the School of Business of the University of Ghana. The presentation outlined findings from the application of the

WHO political economy analysis of health financing reforms framework on Ghana. The analysis highlighted the critical role that UHC plays in health financing reforms and found that:

- There was good awareness of UHC among stakeholders and ability to articulate what UHC means within Ghana's context
- Health sector stakeholders were concerned about what is included and excluded from the UHC benefit package and how it compares to the current NHIS benefit package
- Stakeholders raised concerns about the level of inclusion and engagement in the development of the UHC roadmap
- Stakeholders felt that key mechanisms for implementing UHC plans included the NHIS and the primary healthcare system
- It was felt that there was inadequate coordination and harmonization of efforts and policies by the MOH
- Stakeholders felt that fiscal space for health in Ghana was limited and likely to affect Ghana's UHC aspirations
- While the NHIS was the likely vehicle for UHC, concerns were raised about its capacity given well acknowledged weaknesses
- Concerns were raised over the lack of an independent arbitrator of the relationship between the NHIS and healthcare providers
- Stakeholders reported that the capacity of healthcare providers will need to be strengthened to enable them to deliver the UHC benefit package
- The relationship between the MOH and GHS/CHAG needs to be made more functional to ensure that the drivers of the UHC objective (MOH) and the overseers of service provision (GHS) are cohesive and working in consensus
- The MOH, GHS, NHIS, and CHAG are the most critical stakeholders. These stakeholders need to work synergistically for the UHC roadmap to be successful
- The Civil Society is an interested stakeholder who have a significant role at community level
- The relationship between NHIS and MOH (as their regulator/supervisor) needs to be reviewed to ensure it is effective

## 3.3 PART 3: ROUNDTABLE THEMATIC DISCUSSIONS

## 3.3.1 THEMATIC SESSION 1: RESOURCE MOBILIZATION AND DONOR TRANSITION

### 3.3.1.1 Session Brief

**Introduction**

A good health financing system raises adequate funds for health in ways that ensure people can use needed services and are protected from financial catastrophe or impoverishment associated with having to pay for them [1]. International experience shows that sufficient public financing is the cornerstone of the achievement of UHC [2]. Key considerations for revenue raising arrangements of a country's health financing system include [3]:

- The balance between different sources of funds
- Whether adequate resources are mobilized for the health sector
- Whether contribution mechanisms offer financial risk protection
- Whether health financing is equitable
- The efficiency and sustainability of health financing

Ghana's health system is financed by revenues from (1) The government through taxes and donor funding; (2) Premium contributions to the National Health Insurance Scheme (NHIS); (3) Premium contributions to private health insurance companies; (4) Private corporation inhouse insurance schemes; and (5) out of pocket spending by citizens at points of care [4]. The 2015 Ghana Health Financing Strategy acknowledged that the health sector is underfunded, and outlined the increase the budget allocation to the health sector by the government of Ghana as its 2nd strategy [5]. However, according to a review of the implementation of the health financing strategy, this has not been achieved [6]. To compound Ghana's resource mobilization challenges, the country is undergoing a donor transition [7]. This transition will see multiple donors progressively reduce their support to the health sector and eventually completely hand over the funding responsibility to the government of Ghana. Ghana is currently faced with co-financing obligations that will progressively increase as donor funding reduces. To achieve Universal Health Coverage (UHC) Ghana will need to find ways of mobilizing additional revenues for the health sector. This thematic session will focus on ways to achieve this in a sustainable, efficient, and equitable way.

### 1.2.2 Key Revenue Mobilization and Donor Transition Challenges for Ghana

Revenue mobilization for the health sector in Ghana is characterized by:

- Low and declining per capita expenditure on health:
- Low and declining public expenditure on health
- High and increasing dependence on out of pocket expenditure
- Fiscal pressure from donor co-financing requirements
- Inadequate coordination and harmonization of donor support and transition plans
- Cross-cutting health system inefficiencies

**Low and declining per capita expenditure on health:** According to the 2017 national health accounts, per capita healthcare expenditure in Ghana declined from $80.55 in 2015 to $56.57 in 2017 [4]. The WHO estimates that low and middle income countries (LMICs) will need to spend at least USD 86 per capita in order to deliver a set of essential health interventions [8]

**Low and declining public expenditure on health:** The budget prioritization of the health sector by the government is low; Ghana's budget allocation to the health sector as a proportion of the total government budget was estimated to be 7% while public health expenditure as a proportion of the country's GDP was estimated to be 2.5% in 2015 [9]. It is estimated that LMIC public expenditure on health should be a minimum of 5% to achieve meaningful improvements in service coverage, health outcomes, and financial risk protection [10].

**High and increasing dependence on out of pocket expenditure:** The health sector has a high dependence on out of pocket expenditures, which accounted for 42% of total health expenditure in 2017[4]. User fees are charged at all levels of the public healthcare delivery system.

**Fiscal pressure from donor transition co-financing requirements**: Revenue mobilization is adversely affected by co-financing obligations from the donor transition processes in the health sector. It is projected that Ghana's health sector will face an external financing **reduction of USD 104 million** in 2025 as compared to 2018 [11]. Further, government of

Ghana will need to budget **for co-financing requirements of USD 2 billion from 2019 to 2025** [11]**.** Co-financing obligations has put fiscal pressure on the health sector, resulting in reduced or low allocations to other priorities [12].

**Inadequate coordination and harmonization of donor support and transition plans:** Donor support and transition is uncoordinated with individual donors developing their own transition plans without reference to other donor transition plans. As a result, Ghana MOH is faced with uncoordinated donor support and transition plans.

**Health system inefficiencies:** Several inefficiencies are apparent in the challenges highlighted above. In addition, a cross-programmatic efficiency analysis revealed inefficiencies arising from the existence of multiple MOH agencies with overlapping or unclear roles as a reason for inefficiencies in the health sector [13]. Highlighted examples include: The distinctive roles of the Ministry of Health, and the Ghana Health Service were not clear. It was felt that while on paper the MOH's role was policy and regulation, and the GHS role was implementation, in practice the MOH carried out some implementation functions, and the GHS carried out some policy making functions. The roles of the Health Facilities Regulatory Agency (HEFRA), the Ghana Health Services, and the National Health Insurance Agency regarding health facility accreditation was not clear

### 1.2.3 Discussion Questions

1. How might we increase fiscal space for health in Ghana?
2. how can we achieve efficiency gains to enhance fiscal space for health in the Ghana health sector?
3. How might we mobilize private financing for health?
4. How might we structure Government policies and institutional arrangements for sustainable financing including Donor coordination?
5. How might we best communicate and advocate for increased Government allocation for health?
6. How might we ensure the necessary capacity to mobilize resources?
7. How do we optimize & harmonize all financial resources?

### 3.3.1.2 Participant Recommendations

**QUESTION 1: How might we increase fiscal space for health in Ghana?**

**Facilitator:** Dr. Aboagye **(Ghana Health Service)**

Round table participants recommended the following actions

- The MOF and MOH should explore mobilizing additional resources from the health sector from sin taxes. This should however be guided by an assessment of the feasibility and acceptability of proposed strategies. Proposed strategies include
  - The introduction of new taxes earmarked for the health sector
  - Increasing the level of taxation of existing taxes
  - Reallocation of existing taxes such as alcohol, and tobacco taxes
- The introduction of sanctions for environmental pollution or degradation. These sanctions could then be earmarked for the health sector
- Explore raising additional funds from the health sector from oil revenues that were reported to be increasing
- The MOH should enhance measures to advocate for additional resource allocation to the health sector
- The MOH and other relevant ministries should consider the allocation of a proportion of funds generated by agencies whose actions impact the health sector such as the Driving and Vehicle Licensing Agency (DVLA)
- Explore the mobilization of resources from non-state actors such as churches, and philanthropic individuals.

**QUESTION 2: How can we achieve efficiency gains to enhance fiscal space for health in the Ghana health sector?**

**Facilitator: Prof. Felix Ankomah Asante (ISSER, University of Ghana)**

Round table participants recommended the following actions

- Improve the timeliness of funds disbursement to facilitate budget execution
- Digitization of business processes in the health sector. This will reduce turn-around times for business processes and minimize fraud
- Capacity building and skill improvement for personnel to improve the productivity of the health workforce

- The service delivery model should be strengthened to enforce the gatekeeper system and make PHC attractive at the community level through competition and choice
- Coordination and harmonization of donor support funds and partnerships. This will lead to avoidance of duplication
- Improved and better procurement practices – enforcement of procurement act and practices in addition to strategic purchasing

**QUESTION 3: How might we mobilize private financing (corporate funds/investment) for health?**

**Facilitator: Mohit Pramanik**

Round table participants recommended the following actions:

- Build capacity of the respective agencies within the health sector to advocate engage and mobilize the private sector as a health partner
- Invest in developing optimal relationships with the private sector
- There is need to develop a legal framework to guide the meaningful engagement of the private sector

**QUESTION 4: How might we structure government policies and institutional arrangements for sustainable financing including donor coordination?**

**Facilitator: Dr. Emmanuel Odame (MOH)**

Round table participants recommended the following actions:

- Expand the use of GIFMIS to ensure increase in confidence in the donor community
- Implement service charters to improve the efficiency of the health system
- Build the capacity of the resource mobilization unit (RMU) to enhance the mobilization of funds
- MoH should strengthen the implementation of guidelines for the use of internally generated funds (IGF) to cut down waste and misappropriation of funds
- Enforcement of the Common Management Arrangement (CMA) to ensure harmonization and effective coordination and usage of government and donor plans and funds
- Implement institutional arrangements for proper targeting of the private sector

- Leverage on academia as a vital resource for capacity building, skills transfers and service delivery

**QUESTION 5: How might we best communicate and advocate for increased government allocation for health?**

**Facilitator: Mr. Bright Amissah Nyarko (Coalition of NGOs in Health)**

Round table participants recommended the following actions:

- There is a need to demonstrate that spending on health is not an expenditure but a key investment and consider the health sector as key for human capital development
- The MOH should leverage development partners that have strong links with ministry of finance to lobby for additional resources for the health sector
- Active inter-ministerial meetings must be encouraged
- Need for advocacy on the point that education and health should be considered together
- The MOH should leverage civil society organizations to lobby and advocate for additional revenues for the health sector
- The MOH should sensitize and create awareness among citizens on health as a human right that should be demanded and that they should hold their leaders accountable for providing

**QUESTION 6: How might we ensure the necessary capacity to mobilize resources?**

**Facilitator:** Dr. Joe Kutzin (WHO)

Round table participants recommended the following actions:

- The MOH should establish a health financing unit that will lead and coordinate the development and implementation of health financing policies and strategies
- The MOH should leverage the newly established Health Technology Assessment (HTA) committee to support capacity building for resource mobilization
- Need for M&E plan to monitor implementation of resource mobilization activities
- Employ operations research to generate evidence

**QUESTION 7: How do we optimize & harmonize all financial resources?**

**Facilitator:** Dr Asamoah Baah (UGMC)

Round table participants recommended the following actions:

- Donors should be encouraged to shift from unbudgeted support to budget specific support
- There should be institutional collaboration to avoid duplication of activities
- There must be political will power to resist donor imposition
- There should a bottom up flow in communication to be able to identify needed projects at the local level

## 3.3.2: THEMATIC SESSION 2: PUBIC FINANCE MANAGEMENT REFORMS

### 3.3.2.1 Session Brief

**Introduction**

Public finance management (PFM) refers to the institutional arrangements, systems and processes used by the public sector to mobilise revenue, allocate public funds, undertake public spending, account for funds and audit results [14]. PFM systems aim to maintain fiscal discipline, enhance allocative and operational efficiency, and promote accountability and transparency [14]. PFM systems affect the level and allocation of public funds to the health sector (budget formulation), how effective these funds are spent (budget execution), and the flexibility of the utilization of these funds (pooling, and purchasing) [15]. An effective PFM system enhances the predictability of budget allocations and reduces the fragmentation of funding flows [15]. It also improves the timeliness of budget execution and enhances the transparency and accountability of financial management in the public sector [15]. PFM hence influences the extent to which public health spending promotes health system goals [15].

Ghana's 1992 constitution provides the legal basis for PFM, while the Public Finance Management Act (PFM) was enacted in 2016 as a specific law that guides PFM in the country [16]. Several PFM reforms have been undertaken in the last three decades. Key among them include 1) the introduction of Ghana's Medium-Term Expenditure Framework (MTEF), 2) the transition from activity-based budgeting to program-based budgeting (PBB), and 3) the introduction of the Ghana Integrated Financial Management Information

System (GIFMIS) [17]. While these reforms are intended to improve PFM systems in Ghana, sector wide challenges have been documented [16]. In the health sector, strategy 11 of the 2015 Ghana Health Financing Strategy aims to strengthen PFM [5]. This thematic session considered PFM challenges and deliberated on potential strategies to strengthen PFM in the Ghana health sector.

**Key PFM Challenges in The Ghana Health Sector**

**PFM Policy**

While the PFM Act 2016 provides a legal framework for PFM in Ghana, an up-to-date national level PFM Strategy is not in place and the Health Sector PFM Strategy is yet to be finalized [18]. There is a need to establish a formal arrangement for strategic direction and oversight of PFM reforms in the health sector [18].

**Budget Formulation Challenges**

**Fragmentation of budgeting development process:** The budget formulation process in the health sector is not integrated. This occurs because of the complexity of institutional arrangements and actors in the sector. While the Ministry of Health leads health sector policy, it has several subordinate agencies with varying degrees of autonomy and hence non-integrated budgeting processes [19]. These include the Ghana Health Service (GHS), and the National Health Insurance Authority (NHIA). For instance, major disease programs of the GHS have separate budgets that are not harmonized across the agency [12]. This presents challenges for monitoring and implementation of efficiency measures.

**Lack of a resource allocation formula:** Several assessments have concluded that the health sector appears not to have an explicit resource allocation formula[12], [17]. A resource allocation formula provides a lever that can be used to advance health system resource allocation goals such as efficiency and equity.

**Challenges with program-based budgeting (PBB):** The implementation of program-based budgeting in the health sector is characterized by several weaknesses. First, *inputs continue to drive budgetary allocations*, rather than programmatic targets and needs [17]. Second, *PBB has not been universally adopted* in the health sector [17]. Further, the PBB

structure excludes the NHIA, and disease programs [17]. Third, *PBB has not improved resource allocation* [17]. Allocation of budget to salaries takes prominence to the other economic classifications during resource allocation and in budget implementation. Compensation for personnel is budgeted first and other inputs are adjusted accordingly should compensation increase [17]. Fourth, there is therefore *no flexibility to reallocate across inputs*, only to substitute the amount of input in one program with another [17].

**Budget Execution Challenges**

**Low budget execution:** According to the MTEF program-based budget estimates for the health sector, the budget execution rate in 2017 for Government of Ghana allocation was 51%, internally generated funds was 38%, donor funds 26%, annual budget funding amount 17%, while the overall sector execution rate was 43% [12].

**Funds flow challenges:** Disbursement of funds in the sector is characterized by delays. This includes disbursement of budget allocation to agencies such as the NHIA and to sub-national units [12], [17]. A review of funding flows for Global Fund grants revealed delays in the disbursement of funds from national level to the regional level [20]. For instance, it was reported that funds disbursed to the TB program took about 50 working days to reach the regional level [20]. Second, there are reported delays in submission of quarterly forecasts to the Global Fund [20]. This compounded delays in disbursements.

**Budget Monitoring and Accounting and Systems**

**Low adoption of GIFMIS:** The implementation of GIFMIS is characterized by low usage [12]. For instance, the Ghana Health Service, which is the implementing agency of the health sector and hence controls the bulk of health sector resources does not use GIFMIS but rather uses a parallel system. Further, not all transactions are currently captured in the GIFMIS system at the local government offices [20]. Where GIFMIS is used, it is characterized by vulnerabilities that provide opportunities for fraud [12]. For instance, the system has multiple dummy accounts that have clearance levels that could facilitate high value financial transactions.

**Inadequate record keeping and reporting:** A review of funding flows for Global Fund grants found poor record keeping by regional and district health authorities [20]. There was also late and non-submission of statements of expenditures by district health authorities to regional health authorities [20]. This delayed the reporting process and distorted the expenditures on the various programs in their statutory reports to the Global Fund [20].

**Inadequate enforcement of budget accountability:** While the PBB introduced performance monitoring, enforcement of accountability for meeting targets our outcomes is weak [17]. In 2017 government had over US$5 million declared ineligible by various development partners.

**Discussion Questions**

1. How might we improve the budget formulation process?
2. How might we improve the budget execution process?
3. How might we improve the budget monitoring and evaluation process
4. How might we best support the roll out of GIFMIS?
5. How might we ensure the necessary capacity for budget execution

### 3.3.2.2: Participant Recommendations

**QUESTION 1: How to improve the budget formulation process?**

**Facilitator:** Sally Lake (World Bank)

Round table participants recommended the following actions:

**Recommended actions**

- Enhance the alignment between budgets and plans – budget formulation should be based and guided by the short and medium-term development plan (SMTDP)
- MOH should explore alternative revenue sources for the health sector
- MOH budgets should be better aligned with resource availability to ensure that budgets are realistic
- Enhance the integration of the budgeting process between the ministry and its agencies. The role of the budget committee is critical in ensuring this

- The procurement plan of the ministry of health should be based on the approved budget. There should be provision for revisions of the procurement plan to align with the approved revised budget
- The MOH should use the data available to it (and use simulations) to inform the setting of priorities

**QUESTION 2: How might we improve the budget execution process?**

**Facilitator: Daniel** Ayindingo (MOH)

Round table participants recommended the following actions:

- Integration of budgets. Budgets should integrate all sources of funds, rather having budgets based on funding sources
- The MOH should advocate for the early release of funds from the ministry of finance
- The MOH should liaise with the Ministry of Finance to ensure that funds released from the health sector are based on available funds.
- The adoption and use of GIFMIS should be enhanced to ensure that all funds are managed through GIFMIS. This will enhance accountability and transparency
- Enforcement of guidelines for the management of internally generated funds (IGF)
- Need for flexibility of capital expenditure allocation
- Need for alignment of procurement plans with the budget

**QUESTION 3: How might we improve the budget monitoring and evaluation process?**

**Facilitator:** Mr. Daniel Osei (Korle Bu Teaching Hospital)

Round table participants recommended the following actions:

- GIFMIS should be decentralized so the users can also have administrative rights to set people up and handle some of the minor challenges that come up at the user level.
- Need for system adaptations of GIFMIS to align with the operational needs of different users – e.g. the NHIS
- Need peer-to-peer learning with other countries that have implemented IFMIS
- Improved supervision for GIFMIS implementation

- There is the need to integrate GIFMIS, HYPERONE and other systems

**QUESTION 4: How might we best support the roll out of GIFMIS?**

**Facilitator: Mr. Jacob Yeboah (GIFMIS)**

Round table participants recommended the following actions:

- Need to map infrastructure needs for GIFMIS and Invest in the infrastructure required to support GIFMIS implementation. This includes hardware and internet connectivity.
- Mobilize political support across government at all levels and departments for the implementation of GIFMIS
- Align the administrative and finance process of MOH agencies with GIFMIS
- The MOH and MOF should enhance the sensitization of GIFMIS
- Implement training programs for GIFMIS on users of the system
- Need to mobilize resources (Including from donors) for the implementation of GIFMIS
- Introduce sanctions and incentives for the use of GIFMIS. Incentives could include for instance a district league table for GIFMIS implementation
- Need to implement the health desk and the GIFMIS Academy at the district levels to enhance adequate information dissemination and support services

**QUESTION 5: How might we ensure the necessary capacity for budget execution?**

Facilitator: Nana Kwabena Adjei Mensah (Chief Director, MOH)

Round table participants recommended the following actions:

- All public officers, junior and senior should be involved in all the budgeting process. This will enhance buy in and ownership
- There should be consolidation sector budgets
- There should be training of all key staff involved in the preparation and the final execution of the budget
- The budgeting process requires sufficient time to ensure quality

- Enhance the monitoring of budget execution to ensure that expenditures are aligned with budgets
- There should be timely releases of allocations to the respective sectors
- Enhance social accountability for the budget formulation and execution process

### 3.3.3: THEMATIC SESSION 3: PHC AND SUSTAINABLE FINANCING

#### 3.3.3.1: Session Brief

**Introduction**

Primary healthcare (PHC) is considered the foundation of achieving universal health coverage (UHC) [21]. In most countries, primary health care (PHC) providers are the first point of contact that people have with the health care system [22]. PHC is the most used part of the health system and hence has the potential to have the greatest impact on health. Further, PHC has the greatest potential for enhancing greater equity and access to healthcare services, patient satisfaction, and efficiency [22]. Against this background, financing for PHC is key in enhancing health system performance and promoting UHC [23]. To achieve UHC countries should ensure that PHC is prioritized, adequately funded, characterized by effective pooling and purchasing arrangements[21], [23].

PHC in Ghana is funded from public, private and donor funds [4], [5]. Public funds are derived from budget allocations by the Government of Ghana (the consolidated fund) and the National Health Insurance Scheme (NHIS) reimbursements [4]. Donor funds are derived from, among others, multilateral and bilateral agencies, and Non-governmental organizations (NGOs) [23]. Private funds comprise of out of pocket payments (OOP) from households and private employers' health expenditure on their workforce [3]. Funds from NHIS claims, private insurance schemes, and OOP are considered as health facility internally generated funds (IGF) [3]. Figure 1 outlines the flow of funds in the Ghana health system

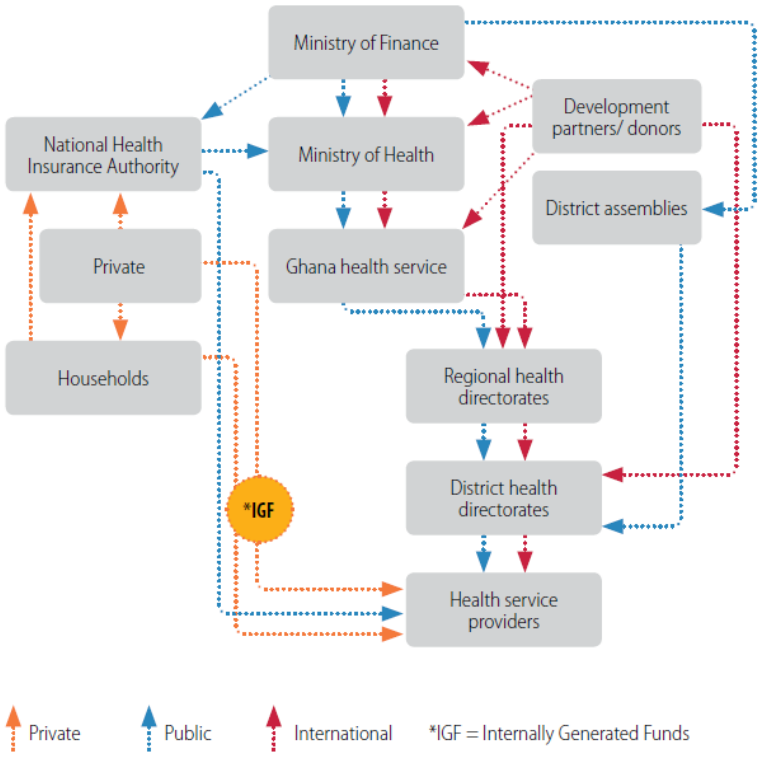


Figure 1: Flow of PHC funds in Ghana health system[23]

This thematic session will discuss the state of PHC financing in Ghana and deliberate on options for strengthening PHC through adequate, sustainable, effective, efficient and equitable financing.

**Key Primary Healthcare Financing Challenges for Ghana**

**Inadequate PHC financing:** The PHC system is inadequately funded. Budgetary allocations to PHC facilities from the Government of Ghana has drastically reduced in the last 3 years. As a result, PHC facilities are increasingly relying on internally generated funds (IGF) from the NHIS, OOP, and funds from vertical programs and projects (EPI, malaria, HIV/AIDS and tuberculosis control programs, the World Bank Maternal and Child Health and Nutrition Improvement Project). These sources finance operations and logistics as well as some health system strengthening activities but are inadequate.

The decrease in donor funding due to donor transition plans has compounded the funding challenges that PHC facilities face and has increased the reliance of PHC facilities on OOP

and NHIS reimbursements. NHIS spending on health centers, maternity homes and community-based health planning (CHPS) zones services constitute about 20% of total NHIS claims payment expenditure.

NHIS financing of PHC is however compromised by unreliable funding of the NHIS by the Government of Ghana. Funding disbursement to the NHIS has perennially fallen below expected disbursements. For instance, the NHIS expected a disbursement of GH₵845.34 million for January to June 2019 and received none. As a result, OOP remains stubbornly high and currently contributes 42% of total healthcare expenditure [4]. In an analysis of GLSS7 data those spending more than 5 percent of total expenditure on health care, on average spent 22 percent of household income. Those spending more than 25 percent of the household budget on health care, on average spent 51.2 percent.

Chronic underfunding of PHC facilities has also resulted in pushing them into insolvency. Table 1 presents the national outlook.

**Table 1** State of Solvency of PHC Service delivery facilities as of end December 2018

| **Current Assets** | **Item** | **All revenue GH₵** | **Minus Payment of Claims GH₵** |
|---|---|---|---|
| | Cash In Bank Service - IGF | 22,082,065.35 | 22,082,065.35 |
| | Cash In Bank Drugs - IGF | 16,152,814.53 | 16,152,814.53 |
| | Cash Undeposited- IGF Service | 125,219.08 | 125,219.08 |
| | Cash Undeposited - IGF Medicines | 165,298.49 | 165,298.49 |
| | Corporate Debtors - IGF | 163,931,804.79 | - |
| | Petty Cash - IGF | 719.00 | 719.00 |
| | Advances - IGF | 252,302.52 | 252,302.52 |
| | **Total Assets (Operating capital)** | **202,710,223.76** | **38,778,418.97** |
| **Liabilities** | | | |
| | Taxes Withheld - IGF | 39,546.79 | 39,546.79 |
| | Trust Funds - IGF (Program Funds) | 281,363.87 | 281,363.87 |
| | Creditors - RMS | 96,327,231.09 | 96,327,231.09 |
| | Creditors - Open Market | - | - |
| | **Total Liabilities** | 96,648,141.75 | 96,648,141.75 |
| | **Net Assets** | **106,062,082.01** | **(57,869,722.78)** |

**Fragmented PHC financing and funding flows:** PHC facilities in Ghana receive funding from multiple sources that are channeled through multiple financing agents that include Ministry of Finance, Ministry of Health, Ghana Health Service (GHS), NHIS, donors, Metropolitan and Municipal District Assemblies (MMDAs), the private sector, NGOs and households. Some of these agents have separate planning and budget implementation and reporting systems. This leads to fragmentation to introduces inefficiencies in the system.

**Weak provider payment mechanisms:** The NHIF pays primary healthcare facilities using fee for service provider payment mechanism which does not incentivize efficiency. Other funding sources use an input financing approach that offer little opportunity for incentivizing quality, efficiency, or equity. However, some projects have implemented, on a limited basis, results-based mechanisms, which are yet to yield useful lessons. There have been several experimentations and pilots on how best to organize and finance primary health care services led by government and different partners. From these emerge several lessons and opportunities that could be adopted and scaled up. These have not been emphasized and adequately interrogated in the context of health financing.

**Unpredictable and unreliable disbursements:** PHC financing in Ghana is characterized by unpredictable and unreliable funding disbursements from both the NHIS and other sources. The variability and unpredictability of funding flows, and the different conditions for managing the funds, distort the implementation of plans, and do not yield the synergies essential for optimal results.

**Reduced facility autonomy:** PHC financing is characterized by rigid expenditure conditions that limit PHC facility managers ability to plan and implement of programs. Facilities have limited control over their investment and compensation planning and the associated budgets.

**Discussion Questions**

1. How might we prioritize PHC within government spending?
2. How might we use financing lever to improve PHC service delivery model to improve efficiency and quality?

3. How might we include PHC in the NHIS benefits package?
4. How might we innovate for cost effective PHC provision?
5. How might we ensure strong public financial management at community-based health planning (CHPS) level?
6. How can we ensure performance and quality in primary healthcare?

### 3.3.3.2: Participant Recommendations

**QUESTION 1: How might we prioritize PHC within government spending?**

**Facilitator: Dr. George Amofa (Private Consultant)**

Round table participants recommended the following actions:

- Need to package the evidence on health outcomes and cost-effectiveness of PHC interventions
- Need to match human and financial resources with the function of PHC
- Strengthen the capacity of PHC to respond to emergencies
- Strengthen the collaboration with community CSOs NGOs, and FBOs
- Need for collaboration between administrative decentralization process and decentralization in the health sector
- The need for increase the resources for PHC
- Provide more career paths for community health workers
- Revise political priorities away from expensive regional hospitals to PHC
- Revise PHC financing to incentivize prevention and promotion activities

**QUESTION 2: How might we use financing levers to improve PHC service delivery model to improve efficiency and quality?**

**Facilitator: Dr. Nana Enyimayew (Ghana College of Physicians and Surgeons)**

Round table participants recommended the following actions:

- Assure donors and update them on the currently robust GIFMIS
- Need for effective communication and well-defined criteria for payment of co-funded programmes
- Need for bank accounts and fiscal autonomy for all healthcare facilities even at the lowest level

- Implementation of capitation as a payment method for PHC against a backdrop of strong gatekeeper system.

**QUESTION 3: How might we include PHC in the NHIS benefits package?**

**Facilitator: Michael Borowitz (Global Fund)**

Round table participants recommended the following actions:

1. PHC is part of UHC and so a commitment for UHC should ensure the expansion of the NHIS benefit package to include PHC services. This includes preventive, promotive, palliative, rehabilitative services, as well as NCD screening
2. There is also a need to include mental health curative services
3. Need to consider the inclusion of services currently paid for by programs – e.g. HIV/AIDS, TB

**QUESTION 4: How might we innovate for cost effective PHC provision?**

**Facilitator: Dr. Toomas Palu**

Round table participants recommended the following actions:

- Clearly define the PHC benefit with a clear focus on prevention and promotion. Clearly communicated and clearly linked with gate keeping mechanism
- There is a need to structure provider payment mechanisms to generate positive incentives to healthcare providers (efficiency, equity, quality)
- Leverage on digital health to nudge patients to adopt health lifestyles and seek screening services for early detection of diseases
- Strengthen the community health system by incentivizing community health volunteers
- Need to provide financial autonomy at the district level to facilitate redistribution of resources to match with health needs
- Facilitate technical autonomy for the NHIA so that they can innovate on their policies that drive the PHC package

**QUESTION 5: How might we ensure strong public financial management at community-based health planning (CHPS) level?**

**Facilitator: Mrs. Vicky Okine (Alliance for Reproductive Health)**

- Strengthen the integration of the CHPS with the rest of the district health system
- The need to strengthen community accountability by strengthening the engagement mechanisms with the community
- The community should have a role in contributing the management of funds for the CHPS
- There is a need to harmonize and de-fragment funding for CHPS
- Needs to be an agreement of the effective package to be provided by CHPS
- The MOH should develop ascertain the resource requirement for the delivery of services by the CHPS
- The MOH and MOF should move away from input-based budgets towards more accounting for outcomes at the PHC level
- It is important to keep financial management for PHC facilities simple

**QUESTION 6: How can we ensure performance and quality in primary healthcare?**

**Facilitator: Peter Yeboah (CHAG)**

Round table participants recommended the following actions:

- The MOH should invest in human resources to ensure that the PHC level has adequate numbers and skill mix
- Enhance the use of data generated at the PHC level for decision making and policy formulation
- Build a culture of quality as a continuous process through supervision
- Train traditional health practitioners and enforce regulation

### 3.3.4: THEMATIC SESSION 4: NHIS AND UHC REFORMS

#### 3.3.4.1: Session Brief

**Introduction**

The government of Ghana established the National Health Insurance Scheme (NHIS) through an Act of Parliament in 2003 and fully implemented it in 2005 [1]. The NHIS objective is to ensure access to basic healthcare services by mobilizing and pooling resources, and purchasing healthcare services on behalf of all Ghanaians irrespective of their socio-economic background [2]. The NHIS is largely financed through taxes; it draws its funding from 6 sources namely:

- A 2.5 percent sales tax
- A 2.5 percent social security deductions from formal sector workers managed by the Social Security and National Insurance Trust (SSNIT)
- Government of Ghana annual budgetary allocations
- Accruals from investments of surplus funds held in the NHIS
- Grants, gifts and donations made to the NHIS
- Premium contributions from members

Every Ghanaian resident is eligible to enrol with the NHIS. Both formal and informal sector members are required to re-enrol annually, with formal and informal sector employees required to pay an annual renewal fee of Ghana cedes 5 and 25 respectively [3]. The poor are exempt from making re-enrolment fees. The NHIS benefit package promises to carter for 95% of the healthcare needs of enrolled members. The benefit package consists of basic health care services, including outpatient consultations, essential drugs, inpatient care, maternity care, eye care, dental care and emergency care, and excludes certain services that include, cosmetic surgery, assisted reproduction, and drugs not listed on the NHIS drug list [2]. The NHIS contracts and purchases healthcare services from public and private healthcare providers and pays for these services using two provider payment mechanisms: diagnostic related groups for the payment of inpatient and outpatient healthcare services, and fee for service for the payment of medicines. The NHIS covers approximately 35% of the Ghanaian population [2].

Since its inception, the NHIS has made considerable gains in improving health care access for millions of poor and vulnerable people in the country. The NHIS is predominantly tax funded and operates a single, unified pool, and a single benefit package in keeping with best practice. Despite these remarkable design features, the NHIS faces several implementation challenges. This thematic session will deliberate on the challenges of the NHIS and policy reforms need to enhance enrolment (population coverage), financial sustainability, and strategic purchasing.

**Key Challenges Faced by The Ghana NHIS**

The NHIS is characterized by the following key challenges

- Enrollment and pooling challenges
- Threats to financial sustainability
- Purchasing challenges
- Operational inefficiencies

**Enrolment and Pooling Challenges**

**Low population coverage of the NHIS:** the proportion of the population covered by the NHIS is estimated to be about 37% [2]. This low population coverage is partly explained by the poor retention of enrolled individuals which is in turn partly explained by the fact that both formal and informal sector members are required to re-enrol annually with the NHIS. Both informal and formal sector members find this process inconvenient, characterized by long queues and waiting times. Further, formal sector individuals, who automatically make payments through an earmarked 2.5% social security deduction are further inconvenienced by a requirement to personally reconcile their payment records between the Social Security and National Insurance Trust (SSNIT) and the NHIA. This is because the SSNIT and NHIA databases are not synched.

**Adverse selection:** NHIS members are more likely to be in high-risk age groups [4]. Compared to national census data, the NHIS membership has a greater concentration of children under the age of five and individuals over the age of 55 [4]. Further there is a high attrition rate of NHIS members. Out of all active members in January 2014, only 42 percent

remained in the scheme in January 2015 [4]. This suggest that members may enroll during periods when they anticipate needing medical care, then leave the system once they have received that care.

**Threats to financial sustainability:** There are concerns about the financial sustainability of the NHIS [3]. A World Bank review reported that growth in NHIS claims outpaced growth in revenues between 2009 and 2014 leading to a deficit [4]. By 2014, this deficit had widened to GH¢300 million. Rising NHIS claims expenditures were driven by an increase in utilization, expansion of population coverage, and rising unit costs [4].

**Purchasing Challenges**

**Challenges with the NHIS benefit package**: The benefit package is biased towards curative care, and gives little priority to preventive and promotive care [4]. Further, the benefit package development process is not guided by evidence-based criteria.

**Service utilization is biased towards higher level facilities:** The benefit package's bias towards curative services also biases service availability towards higher levels of care. This in turn drives utilization of curative, high-cost and low-impact services with limited focus on high impact, cost-effective primary healthcare (PHC) services that include preventive and promotive components.

**Weak referral systems:** Ghana's referral policy is poorly adhered to. There is no effective gate keeping mechanism and hence citizens often bypass lower level healthcare facilities to seek care in higher level healthcare facilities without appropriate referrals resulting in inefficiency [5].

**Challenges with NHIS provider payment mechanisms:** The NHIS uses two provider payment mechanisms: diagnostic related groups (DRGs) for the payment of inpatient and outpatient healthcare services, and fee for service for the payment of medicines. The NHIS provider payment mechanisms are characterized by several challenges. First, the fee for service payment of medicines has experienced escalating value of claims for medicines [4]. Medicine claims now constitute approximately 50% of total NHIS claims. Further, there is significant variation in medicine prices, with average medicine prices in Ghana reported to

be seven-fold that of international reference medicine prices. Second, Ghana's DRG system has design weaknesses. These include narrow bundling of services, and inadequate controls. The DRG system is hence characterized by miscoding which further escalates costs.

**Payment delays by NHIS to healthcare facilities:** Claims payment by the NHIS to healthcare facilities can take up to 6 months or more to get paid. These delays partly contribute to health facilities charging unauthorized user fees. These delays are due to operational inefficiencies that are outlined in the next section.

**Inadequate accountability to users and the public:** There are concerns about the accountability of the NHIS to the government, enrolled members and the public. Oversight mechanisms appear weak and/or ineffective.

**Operational Inefficiencies**

**Manual claims processes:** Healthcare facilities manually compile and submit their claims. Once claims have been submitted by healthcare facilities, the NHIS processes claims manually. While the NHIS is in the process of implementing an e-claims system, currently only 20% of claims are processed using the e-claims system. Claims processing is hence labor intensive and inefficient.

**Inadequate system integration:** The NHIS claims management, membership management, and financial management systems are not integrated. This results in significant inefficiencies since linkages across these systems are done manually. Further, the information system used for NHIS claims is not integrated with that of the wider health system, resulting in different systems for the insured and uninsured populations. This reflects a more general health system governance failure that has led to insufficient coordination between the main funding flows in the health system.

**Discussion Questions**

1. How might we strategically purchase services to enhance efficiency, equity and quality

2. How might we use evidence for decision making to ensure an affordable, comprehensive benefits package?
3. How might we increase NHIS membership?
4. How might we strengthen governance and efficiency in the administration of the NHIS?
5. How might we increase accountability and member voice in the administration of the NHIS?

How might we ensure the necessary capacity at NHIS for intelligent analytics?

### 3.3.4.2: Participant Recommendations

**QUESTION 1: How might we strategically purchase services to enhance efficiency, equity and quality?**

**Facilitator: Dr. Joe Kutzin (WHO)**

Round table participants recommended the following actions:

- Use data/evidence to inform decisions about benefit package design, and provider payment rates
- There is there need develop a common information system platform that links develop integration and inter-operability between key information systems. Specifically, the district health information system (DHIMS) should be linked to the NHIS information system
- There is need to enhance equity in geographical access and availability of healthcare services
- There is the need to leverage on technology to enhance efficiency hence reducing cost of health services
- Enhance the implementation of framework contracting to reduce the cost of medicines
- There is need to enhance the autonomy of public healthcare provider to facilitate managerial actions that promote efficiency
- Entrench the use of health technology assessment to promote efficient resource allocation in the development of the benefit package

**QUESTION 2: How might we use evidence for decision making to ensure an affordable, comprehensive benefits package?**

**Facilitator: Dr. Chris Atim (R4D/HSSA)**

Round table participants recommended the following actions:

- Research and evidence generation should be embedded and institutionalized in the NHIS
- There is need to package and communicate research evidence in ways that are accessible and understandable by decision makers
- There is need to put in place incentives to create demand for use of evidence
- There is need for strong public education based on evidence

**QUESTION 3: How might we increase NHIS membership?**

**Facilitator: Mr. Peter Yeboah (CHAG)**

Round table participants recommended the following actions:

- Need to enhance intersectoral collaboration to enforce NHIS enrollment. For instance, active NHIS membership could be made a pre-requisite to access to services across all government agencies
- Need to enhance client satisfaction
- Need for flexibility in premium collections
- Need to re-engineer the registration and membership renewal process to make them easier and more convenient. Potential actions include:
    - Further automation of processes
    - Decentralize card renewals at the local level by the community merchants

**QUESTION 4: How might we strengthen governance and efficiency in the administration of the NHIS?**

**Facilitator: Dan Degbetse (MOH)**

Round table participants recommended the following actions:

Population coverage

- Continue to partner with state institutions (GES, LEAP, DVLA) and other private institutions/associations to make the NHIS card a requirement for accessing certain services
- Need for a cap on administrative expenditure and to ensure efficiency

Transparency

- Periodic publication of annual reports (income and expenditure)
- Review allocation of funds to parliamentarians to reduce sustainability threat

Purchasing of care

- Synchronise and scale up electronic claims management system (e-claims and Claim-it applications) to reduce claims processing and payment time
- Services at the lower of care should be free, funded by the tax (NHIF) and other sources of funding

**QUESTION 5: How might we increase accountability and member voice in the administration of the NHIS?**

**Facilitator: Dr. Isaac Morrison (SPMDP)**

Round table participants recommended the following actions:

- There should be systematized feedback between NHIS and DHMT on issues of NHIS and coordinate and communicate issues of NHIS at the District Council and Assembly level.
- Use data from call centers to formulate engagement questions and track feedback.
- Use NHIS data to improve quality assurance e.g. in enrollment and Health facility.
- Publish NHIS annual report and other relevant information
    - Response and action on issues of NHIA should be published, positive or negative
- There is need for more transparency on the usage of the 10% allocation from the NHIS to district directors for their health care activities
- Feedback on from the call centers should be published

**QUESTION 6: How might we ensure the necessary capacity at NHIS for intelligent analytics?**

**Facilitator: Dr. Lydia Dsane Selby (Director, NHIA)**

Component of 10% goes to the district directors for their health care activities

- There is need to build the capacity of existing staff by training the right staff
- There is need to recruit new personnel with required qualifications
- There is need to link the NHIS Research unit with research and academic institutions
- There is need to develop research recommendation policy for NHIS to guide the research functions of NHIS
- The NHIS should use the recommendations made after the 2016 NHIA review.

## 4.0: CONCLUSION

The health financing forum was brought to a close with commitments by the MOH, made by the Chief Director take consider the forums recommendation and develop plans for implementation. Specifically, the Chief Director made the following commitments along the four thematic areas of the forum.

### 4.1: MOH Commitments on Resource Mobilization and Donor Transition

- Revise the health financing strategy to include a resource mobilization strategy that will guide mobilization of additional resources for health
- Advocate for increased allocation from the Ministry of Finance
- Explore the mobilization of additional resources for health from alternative sources that include sin/health taxes, and oil revenue
- Identify and implement measures to enhance the efficiency of the health system and unlock efficiency gains
- Deepen the engagement with the private sector to explore the potential for mobilizing additional resources from the private sector
- Take leadership in the coordination of donor support and transition plans

### 4.2: MOH Commitments on PFM reforms

- Harmonize and integrate the budgeting process across MOH and its agencies
- Enhance the adoption and implementation of all GIFMIS modules across MOH, its agencies and levels, as well as for all funding sources including donor funding, statutory funds etc
- Enhance the alignment between the budget and the procurement plan
- Invest in the infrastructure required for GIFMIS implementation (GIFMIS Strategy)- this includes internet access and bandwidth, and hardware
- Invest in capacity development for users of GIFMIS

### 4.3: MOH Commitments on PHC and sustainable financing

- Enhance NHIS benefit package to prioritize primary healthcare
- To increase investments in PHC to strengthen their capacity to deliver quality healthcare services – this includes financial, human resource, and infrastructure capacity
- Reform provider payment mechanisms for PHC to incentivize efficiency and quality and ensure financial autonomy (decentralisation)at the district level to facilitate optimal resource allocation
- Enhance the linkage of levels within the district health system (network of practices) to strengthen oversight and care integration

### 4.4: MOH Commitments on NHIS reforms for UHC

- Optimize benefit package development by incorporating a systematic, transparent, inclusive, benefit package development process that employs health technology assessment
- Enhance the use of data analytics to inform management decisions
- Re-engineer its systems to enhance the ease of member enrolment and renewal of membership
- Implement measures to improve operational efficiencies that will reduce its administrative costs
- Scale the e-claims system to improve the efficiency of the claims processing

- Enhance the integration of key information systems (financial, claims, membership) within the NHIS to improve efficiency of operations, and across the health system – e.g. with DHIMs

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## 6.0: APPENDIX

### 6.1: APPENDIX 1: HEALTH FINANCING FORUM AGENDA

| | **DAY 1** |
|---|---|
| 8:00 – 8:30 | Breakfast and Registration |
| 8:30 - 9:00 | **Welcome, opening remarks and program overview**<br>*Welcome remarks -Chief Director*<br>*Chairman's Remarks – Hon Minister for Finance/Deputy Minister*<br>*Keynote speech -Hon Minister of Health*<br>*Contributory statement – DP Lead*<br>*Program Overview* |
| 9:00 - 10:45<br><br>15 minutes per presentation | **Setting the stage: A new era of health financing and Making the case for reforms**<br>• Revised National Health Policy for UHC<br>• UHC Roadmap – where are we?<br>• Health Financing Progress Matrix – **Validating the stock-taking report**<br>• Political Economy of Health Financing Reforms in Ghana – **Key messages**<br>• National Health Financing Strategy – **Stock-taking report**<br>Questions/Clarifications |
| 10:45-11:00 | **Coffee/tea break** |
| 11:00 - 13:30<br><br>5 minutes<br>25 minutes<br>60 minutes<br>60 minutes | **Round-Table Discussions 1: Resource Mobilisation and Donor Transition Planning**<br>Full Group Presentation: Introduction to session format<br>Full Group Presentation: Background and Local/Global Evidence<br>Round Table Discussions on Topics/Questions<br>All tables report back in plenary (10 mins per table) |
| 13:30 – 14:30 | Buffet lunch |
| 14:30 - 17:00<br><br>30 minutes<br>60 minutes<br>60 minutes | **Round-Table Discussions 2: Public Financial Management Reforms**<br><br>Full Group Presentation: Background and Local/Global Evidence<br>Round Table Discussions on Topics/Questions<br>All tables report back in plenary (10 mins per table) |
| 17:00 – 17:30 | **Quick Summary, Next day layout and closing** |
| | **DAY 2** |
| 8:00 – 8:30 | Breakfast |
| 8:30 – 11:00<br><br>30 minutes<br>60 minutes<br>60 minutes | **Round-Table Discussions 3: Primary Health Care Sustainable Financing**<br><br>Full Group Presentation: Background and Local/Global Evidence<br>Round Table Discussions on Topics/Questions |

| | |
|---|---|
| | All tables report back in plenary (10 mins per table) |
| 11:00 – 11:15 | Break |
| 11:15 – 13:45<br><br>30 minutes<br>60 minutes<br>60 minutes | **Round-Table Discussions 4: NHIS Reforms for UHC**<br><br>Full Group Presentation: Background and Local/Global Evidence<br>Round Table Discussions on Topics/Questions<br>All tables report back in plenary (10 mins per table) |
| 13:45 – 15:00 | **Lunch** |
| 15:00 – 17:00 | Summary – All themes |
| 17:00 -17:30 | Final Remarks and Closing |

## 6.2: APPENDIX 2: List of participants -Day 1 & 2

| NO. | NAME | ORGANIZATION | CONTACT |
|---|---|---|---|
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| 2 | RICHMOND OWUSU | SPH | 243126896 |
| 3 | BENJAMIN GODET | GLOBAL FUND | 41786148206 |
| 4 | CHRIS ATIM | R4D/HSSA | 265241662 |
| 5 | JUSTICE NONVIGWOA | SPH | 507407935 |
| 6 | ALEX WRACH | GLOBAL FUND | |
| 7 | PROF. K. OHENE BUABENG | KNUST | 200742911 |
| 8 | PETER YEBOAH | CHAG | 244136207 |
| 9 | BEN A. NKANSAH | MOH | 242383921 |
| 10 | JACOB YEBOAH | MOF/PFM | 200428696 |
| 11 | DR. ISAAC MORRISON | PRIVATE | 243162284 |
| 12 | DR. FRED ADOMAKO BOATENG | GHS | 244674020 |
| 13 | ALEX MOFFATT | MOH | 242223294 |
| 14 | ENOCH OTI AGYEKUM | JICA | 553033969 |
| 15 | EDITH A ANNAN | WHO | 208139612 |
| 16 | JANEAN DAVIS | USAID | |
| 17 | DR. AMOFAH GEORGE | CONSULTANT | 244322843 |
| 18 | AYINDIGO DANIEL | MOH | 244519594 |
| 19 | DIAH AYO SEKYI | KOFIA | 207385477 |
| 20 | MOHIT PRAMANIK | GHS | 269535677 |
| 21 | MERCY ACKAH | ISSER | 244724962 |
| 22 | KWESI ASANTE | UNICEF | 244654193 |
| 23 | NIYI OJUOCAPE | UNFPA | 243852114 |
| 24 | AHMED IMORO | NHIA | 243820621 |
| 25 | KYEREMEH ATUAHENE | GH. AIDS COMMISSION | 244526899 |
| 26 | ANTHONY SEDDOH | WORLD BANK | 244341835 |
| 27 | REUBIN BIDZOAH | GHS | 246711814 |
| 28 | TOOMAS PALU | WORLD BANK | |
| 29 | FELIX A. ASANTE | ISSER | |
| 30 | DR. ERIC K. NGYENU | CCTH | 249918545 |
| 31 | KINGSLEY FRIMPONG | WHO | 243448350 |
| 32 | DR. JOAN YAMPONG | MOH-HTH | 205161310 |
| 33 | EMMANUEL S.K. DONEUR | SPH | 243388856 |
| 34 | DOREEN A. ODAME | ISSER | 506616251 |
| 35 | HYEJIN JUNG | KOFIH | 209652889 |
| 36 | FRANCIS ASENSIO-BOADI | NHIA | 243613635 |
| 37 | ADWOA TWUM | R4D/HSSA | 244260694 |
| 38 | SOFONIAS GELACHEW | WHO | |
| 39 | JOE KUTZIN | WHO | 41795175861 |

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|---|---|---|---|
| 40 | EDWIN | WHO | |
| 41 | AMA POKUAA FENNY | ISSER | 243343855 |
| 42 | FRANCIS XAVIER ANDOH ADYEI | NHIA | 244613747 |
| 43 | ANGELA TRENTON-NBONDE | UNAIDS | 501608828 |
| 44 | SALLY LAKE | WORLD BANK | 4.47901E+11 |
| 45 | JOHN AZAARE | SPH | 243404217 |
| 46 | KAZUNORI MIYASAKA | JICA | 202639982 |
| 47 | MIAKO HASHIMOTO | JICA | 244871042 |
| 48 | JKUO TAKIZANA | JICA | 81352268304 |
| 49 | AYA YAYI | JICA | 81332268360 |
| 50 | FRANCIS OTI FREMPONG | NHIA | 244778180 |
| 51 | MARY ADDO-MENSAH | USAID | 244772546 |
| 52 | NANA ENYIMAYEW | FPA/GCPS | 548605957 |
| 53 | DR. LYDIA DSANE-SELBY | NHIA | 242689232 |
| 54 | FLORIANE BOUEARD | FRENCH EMBASSY | |
| 55 | DR. ANOTHONY OFOSU | GHS | 208180111 |
| 56 | MICHAEL BARIK | GLOBAL FUND | 41792944301 |
| 57 | ALI SUBANDORO | GFF | 12023446693 |
| 58 | UZO GILPIN | DFID | 540122995 |
| 59 | SANTIAGO CORUEZO | GZUI | 41792518550 |
| 60 | CHARLLOTTE KANSTRAGO | UNFPA | 556198815 |
| 61 | MAX SENYO HLORDZE | AHPC | 243140180 |
| 62 | ISADORA QUICK | WHO | |
| 63 | MICHELLE THULKANAM | WHO | |
| 64 | DR. PATRICK ABOAGYE | GHS | 243283322 |
| 65 | ELLEN VAN OU POU | GFF | 12025178398 |
| 66 | DR. MRUNAL SHETYE | UNICEF | 244331043 |
| 67 | F. MCASEY | UNICEF | 552558218 |
| 68 | DANIEL DUDGETSE | MOH | 203667453 |
| 69 | JAMES EBO SEY | FSS/GAC | 207002655 |
| 70 | FREDA AGYEI ASARE | MOH | 244865945 |
| 71 | ALEX OFORI MENSAH | CHAG | 201150609 |
| 72 | REV. DR. ATTIPOE ROBERT | MOH | 248147695 |
| 73 | DR. MAUREEN MARTEY | MOH | 244369807 |
| 74 | ABEKAH-NKRUMAH G. | UGBS | 553122132 |
| 75 | ERIC NSIAH BOATENG | SPH | 546955122 |
| 76 | YOSHUN NYIHUO | UNICEF | 245352911 |
| 77 | ROBERT K. MENSAH | UNFPA | 244380158 |
| 78 | JEAN-PHILIP LAWSON | UNFPA | 570245319 |
| 79 | GEORGE KUMI KORANTENG | UNFPA | 245640024 |
| 80 | DR. MARTHA GYANSA-LUTHERODT | MOH | 244328787 |

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|---|---|---|---|
| 81 | DR. ANGELA ACKAN | MOH | 244677324 |
| 82 | VIOTON COFIE | NATIONAL AMBULANCE SERVICE | 208157622 |
| 83 | VICKY OKINE | ARHR | 244324464 |
| 84 | ERICK DIXON | MOH | 244250710 |
| 85 | BOATENG AGYEI SOLOMON | MOH | 546852928 |
| 86 | PETER KORTO | MOH | 206393479 |
| 87 | FLORENCE ANIABOR | MOH | 244221130 |
| 88 | YVAN HALSENA | UNICEF | |
| 89 | BRIAN ASARE | MOH | 244529867 |
| 90 | SALLY TETTEH | MOH | 266150510 |
| 91 | NII SARPEI | ARHR | 244746567 |
| 92 | BAFFOUR AWUAH | MOH | 208138035 |
| 93 | KWABENA G. KWAKYE | WBG | 244830964 |
| 94 | IRENE A AGYEPONG | GHS | 244862665 |
| 95 | ALEXANDER K.K. ABBAN | MOH | 244988818 |
| 96 | A. ASAMOA BAAH | UGMC | 55818152 |
| 97 | NANA K. ADJEI MENSAH | MOH | 244310534 |
| 98 | NEEMA RUSIBAMYILA KIMANBO | WHO | |
| 99 | BRIGHT AMUSAH NYARKO | HEALTH COALITION | 201156511 |
| 100 | DR. KOFI SUTHSLAD | GHS | 209261873 |
| 101 | GYABMAH | MOH | 242215645 |
| 102 | DR. EMMANUEL ODAME | MOH | |
| 103 | HON. KWAKU AGYEMANG MANU | MOH | |
| 104 | DR. MAXWELL ANTWI | PHARM ACCESS | 555000275 |
| 105 | THOMAS APPIAGYEI | MOF | 208301034 |
| 106 | ERNEST SEKYERE | MOF | 246557410 |
| 107 | THELMA J. JAKALIA | MOH | 204611611 |
| 108 | ERIC OBENG APPIAH | OHLGS | 244993101 |
| 109 | MAYESO ZENEGEYA | IUNICEF | 543170403 |
| 110 | DANIEL OSEI | KBTH | 244364221 |
| 111 | BRIAN SAMPRAM | MOH | 246579392 |
| 112 | HAMIDU ADAKURUGU | MOH | 244688558 |
| 113 | SFEIR ANTHONITA | MOH | 501544227 |
| 114 | FIAWOYIFE MAKAFUI | MOH | 242736638 |
| 115 | BLANKSON FRANCIS | MOH | 200724002 |
| 116 | MICHELLE SCHAAN | USAID | 244311936 |
| 117 | JULIET ONYAME | MOH | 547615144 |
| 118 | PEARL A. OPOKU-YOUNGMANN | GFF | 275469184 |