REVIEW OF GHANA'S NATIONAL HEALTH FINANCING STRATEGY

Final report

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Acronyms

APOW	Annual Program of Work
BMC	Budget Management Centre
BPEMS	Budget and Public Expenditure Management System
CAGD	Controller and Accountant General's Department
CAPEX	Capital Expenditure
CHAG	Christian Health Association
CHPS	Community-Based Health Planning and Services
CSR	Corporate Social Responsibility
DACF	District Assembly Common Fund
DFID	Department for International Development
DMHIS	District Mutual Health Insurance Schemes
DPs	Development Partners
DRM	Domestic Resource Mobilisation
DiSHOP	District Health Service Operations
EML	Essential Medicines List
GDP	Gross Domestic Product
G-DRGs	Ghana Diagnostic-Related Groups
GFF	Global Financing Facility
GHS	Ghana Health Services
GIFMIS	Ghana Integrated Financial Management Information System
GoG	Government of Ghana
HeFRA	Health Facilities Regulatory Agency
HFG	Health Finance & Governance
HFS	Health Financing Strategy
HFS-IP	Health Financing Strategy Implementation Plan
HRH	Human Resources for Health
HRMIS	Human Resource Management Information System
HSMTDP	Health Sector Medium Term Plan
HSS	Health Systems Strengthening
HTA	Health technology assessment
IGFs	Internally Generated Funds
IP	Implementation Plan
KPIs	Key Performance Indicators
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MMDAs	Metropolitan, Municipal and District Assemblies
MoF	Ministry of Finance

MoGCSP	Ministry of Gender, Children and Social Protection
MoH	Ministry of Health
MP	Member of Parliament
MTEF	Medium Term Expenditure Framework
NDPC	National Development Planning Commission
NHIA	National Health Insurance Authority
NHIL	National Health Insurance Levy
NHIS	National Health Insurance Scheme
NHP	National Health Policy
NIC	National Insurance Commission
NICE	National Institute for Health and Care Excellence
NITA	National Information Technology Agency
P4P	Pay-for-Performance
PFM	Public Financial Management System
PHC	Public Health Care
PHIs	Private Health Insurance System
PoW	Programme of Work
PPME	Policy Planning Monitoring and Evaluation
PPNs	Preferred Provider Networks
PPPNs	Preferred Public Health Care Provider Networks
RBF	Results-Based Financing
RMU	Resource Mobilisation Unit
SDG	Sustainable Development Goal
TWG	Technical Working Group
UHC	Universal Health Coverage
USAID	United States Agency for International Development
VAT	Value Added Tax
WHO	World Health Organisation

Executive Summary

Over the past two decades, Ghana has been committed to the pursuit of Universal Health Coverage (UHC) through targeted health service delivery and financing reforms. Achieving UHC requires commitment to three key objectives:

- mobilise adequate resources to ensure coverage,
- provide quality care by strengthening the health service delivery system and
- ensure that health services are accessible to all, especially poor and vulnerable individuals.

Various reforms have been initiated by governments in that period that aimed at achieving these objectives. These have had varying degrees of success as well as challenges. Without a doubt, however, the principal reform aimed at moving the country forward towards UHC in those two decades has been the introduction of the National Health Insurance Scheme (NHIS Acts 650 and 852). This reform was principally a health financing one but the new institutions and relationships it introduced into the health sector endowed it with the potential to leverage additional, positive, changes in the service delivery sector through judicious use of strategic purchasing. The other policies and initiatives aimed at pushing forward the UHC agenda, especially on the service delivery side, were gradually introduced in the course of time and generally with less fanfare.

It should also be recalled that Ghana has committed to the Sustainable Development Goals (SDGs), which include Goal 3.8 that enjoins it to "achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all". Similarly, the country last year also signed on the Astana Declaration on primary health care (PHC), which renews the Alma Ata goal of striving for universal access to PHC services.

Recognizing the role of health financing as a prime lever for bringing about other needed changes in the sector, and to consolidate the various plans and activities within the health sector to achieve UHC and to coordinate the UHC implementation efforts of different agencies, partners and other actors, a Health Financing Strategy (HFS) document was developed for the period 2014 - 2026, with several phases. The Health Financing Strategy Implementation Plan (HFS-IP) envisions four implementation phases entitled Initiation, Expansion, Deepen, and Solidification.

Phase I Initiation starts HFS-IP critical path activities focused on improving health purchasing and the relationship to service delivery. The intended result is improved expenditure management, efficiency gains enabling movement towards UHC, financial sustainability and improving quality of health care. The core Phase I Initiation activity is the expansion of NHIS PHC capitation payment system and the related key activities of formation of Preferred PHC provider networks (PPPNs), specifying services included in PHC capitation payment contracts, and establishing a population choice payment for going around the covered benefit of accessing PHC through the provider in which you enrol (gatekeeper function). It also initiates improving costing for provider payment system rate-setting. This phase runs from 2014 to 2017.

Phase II Expansion is planned to expand the health purchasing improvement started in Phase I by national roll-out of PHC capitation payment system and PPPN formation including CHPS. In addition, it moves up the levels of service to improve purchasing for outpatient specialty and hospital services by refining Ghana Diagnostic-Related Groups (G-DRGs). Building on the base of strengthened purchasing and provision of

PHC services initiated in Phase I, Phase II improves purchasing and financial incentives to reduce the number of costly hospitalizations and improve service delivery or necessary hospitalizations and outpatient specialty services. Phase II was expected to run from 2018 to 2020. Phase III Deepen will both build on Phase I and II implementation and address major health financing policy issues, finally leading to solidification in Phase IV. The two remaining phases run from 2021 to 2026.

The plan elaborates how health financing will contribute to Ghana's health system goals and objectives and it is based upon the three health financing functions of revenue collection, pooling and purchasing. It also serves as a guiding document to articulate how health financing will contribute to the achievement of universal health coverage. It is through the collective activities of all partners that equitable health financing goals were expected to be achieved.

The Health Financing Strategy (HFS) document is based on a dynamic framework consisting of 15 specific strategies that show the relationships and actions inherent in the overall strategy document to address the key objectives. The objectives of the Ghana Health Financing Strategy (HFS) are to:

- Improve resource mobilization to ensure sufficient and predictable revenue
- Promote equity in the distribution of health resources and use of health services and reduce financial barriers to access to health care
- Efficiently allocate and use health sector resources
- Motivate and stimulate service delivery and quality improvement and increase population satisfaction and involvement in their own health

Purpose and Scope of Work

The assignment of the USAID Health Systems Strengthening Accelerator (HSSA) project is to provide a review of the HFS and its implementation. More specifically, HSSA is to work with the MOH, its agencies, local stakeholders, and development partners to conduct a retrospective analysis of the 2015 Ghana Health Financing Strategy to serve as the baseline evidence ahead of the Health Financing Summit. This includes:

- Taking stock of the 2015 Ghana Health Financing Strategy
- Reviewing ongoing activities and progress on health financing initiatives by the MOH and its agencies and development partners since 2015 to date
- Reviewing available evidence on health financing produced by the MOH and its agencies, development partners and academic/research organizations

To achieve this, the review relied heavily on key informant interviews with main stakeholders and partners as well as relevant document reviews. The MOH and its agencies and the key development partners in the sector were interviewed for this exercise. The 2015 Ghana Health Financing Strategy and accompanying Implementation Plan was reviewed to understand the expectations outlined in the strategy. A document review of published and grey literature on health financing, as well as initiatives implemented in Ghana since 2015 was carried out.

Health Financing Strategy Implementation Plan (HFS-IP)

The Ghana Health Financing Strategy (HFS) is being implemented by the Ghana Health Financing Strategy Implementation Plan (HFS-IP). HFS-IP sections consist of Implementation Phases, Strategy Activities and First Steps for each of the 15 specific strategies, Budgeting and Costing, Institutional Roles and

Relationships, and Implementation. HFS-IP also includes yearly detailed plans of work contained in the Health Sector Medium-Term Development Plan 2014-2017 (HSMTDP) yearly plans of work. The intent of HFS-IP is to provide enough specification or detail to enable implementation but at the same time balancing this with the flexibility required for health financing policy and interventions to best adapt to the continuously evolving environment. By the nature of implementation, content and sequencing of HFS activities will continuously adapt to evolution of the Ghana environment. However, HFS-IP anticipates that the activities will ebb and flow within a broader dynamic or framework consisting of phases that will guide health financing implementation for the next decade and beyond.

Main findings

The main findings from the review are clustered around the broad objectives of the plan. Subsequently, the 15 specific strategies fall within each of the broad activities as shown in Table 1. Strategy 1 falls under the broad activity of Health Financing Policy. Revenue collection is included in Strategies 2-4 and pooling of funds Strategy 5. Health purchasing represents Strategies 6-12, and a health financing policy and monitoring and evaluation (M&E) feedback loop is represented in Strategies 14 and 15 and connected to Strategy 1. Although encompassed in revenue collection, pooling and purchasing functions, the relationship between public and private financing is Strategy 13 to reflect the key nature of this relationship in moving towards universal health coverage.

In reviewing the HFS-IP, there were a number of cross-cutting issues that became very visible from the start. First, one of the core Phase I Initiation activity was the expansion of NHIS PHC capitation payment system and the related key activities of formation of Preferred PHC provider networks (PPPN), specifying services included in PHC capitation payment contracts. This run through several of the strategies, notably Strategies 6, 7, 9, 12 and 13. The government transition following the last elections led to the discontinuation of the capitation program, rendering these activities redundant. Secondly, the M & E plan to accompany the HFS-IP was not initiated as envisaged from the start. This meant that the feedback loop which was expected to run through from Strategies 14 and 15 to Strategy 1, was also missing. As a result, it has been difficult to assess the successes or failures of the plan with the lack of routine evidence on the progress of the plan. This process would have also allowed the activities to be sharpened and put in the relevant context. Table 1 presents a summary of the review and overall progress of activities to be implemented in the Phase I (2014-2017) and part of Phase II (2018-2020).

Table 1: Specific Health Financing Strategies and Level of Progress

Broad Objectives	Strategy	Description	Overall Progress from 2014 to date
Health financing policy	1	Developing health financing policy and legal and regulatory framework.	Not accomplished
Revenue collection and Resource mobilisation	2	Increase GOG revenue allocated to the health sector.	Not accomplished due to the lack of fiscal space and minimum appetite for government to increase taxes. The NHIA is currently focusing efforts on advocating for timely release of 100% of NHIL.

	3	Continually refine NHIS premium specification and improve means-testing to better target NHIS exemptions to poor and vulnerable populations.	Not accomplished, since efforts to increase the premiums have not received approval by parliament. The NHIA will rely on the means-testing by the MOGCSP to complete this exercise.
	4	Innovative resource mobilization and coordination of health revenues.	The MOH is developing a corporate sector engagement strategy towards leveraging and harmonizing Corporate Social Responsibility and private sector support for health development. MOH has implemented structural reforms for increased efficiency which included the formation of the Resource Mobilization Units (Multilateral, Bilateral and Domestic) to coordinate the engagement with the donor platform and support
Pooling of funds	5	Improve pooling of funds.	Not accomplished as none of the initial activities were undertaken.
Health purchasing	6	Improve breadth, scope and depth of services and benefits	Not accomplished as progress hinged on the scale up of the capitation programme. NHIA has undertaken an actuarial study to provide evidence on what benefit package is affordable within the available resources.
	7	Coordination of MOH services and benefits including prioritization of preventive and primary health care services.	Not accomplished as first steps included coordination of MOH services and NHIS benefits arising from the PHC capitation payment system. MOH plans to develop this further in the UHC roadmap.
	8	Improving health worker motivation and performance.	Progress has been made with the completion of the staffing norms to streamline staff retention and distribution.
	9	Improving and harmonizing provider payment systems for variable costs of direct patient care.	Not accomplished as majority of the activities depended on the capitation being scaled up. However, progress made with drug supply chain management.
	10	Improving capital purchasing.	Progress has been made with the finalisation of the Capital Investment plan (2016 -2019). Infrastructure strategy is being developed to address inherent problems with low maintenance culture.
	11	Strengthening public finance management (PFM) and information systems supporting health purchasing.	Progress has been made with the introduction of GIFMIS across all institutions. Electronic claims management system is used in all major hospitals. MOH is developing a 3-year plan to connect all health facilities to a central data portal within the country.
	12	Ensuring that health purchasing stimulates desired service delivery and quality improvements.	Some progress made although capitation process was suspended. The MOH conducted a comprehensive CHPS verification exercise to reposition the CHPS program.

Coordination between public and private	13	Improving relationships and coordination between public and private financing.	Not accomplished since activities hinged on the capitation being expanded. However, the NHIA engages with the private sector to improve service delivery through its credentialing system and also has oversight responsibilities on private health insurance systems.
Monitoring & evaluation	14	Strengthening monitoring and evaluation (M&E) and monitoring Health Financing Strategy implementation.	Not accomplished as M & E plan was not included in the HFS-IP.
	15	Develop and implement a communications strategy.	Not accomplished

1. **Health Financing Policy**

   The plan seeks to provide mechanisms for health financing policy dialogue and processes to ensure open, transparent and participatory dialogue to take decisions and refine major policy issues. This strategy also includes amending and implementing the legal and regulatory framework to codify health financing policy decisions and finally incorporate feedback from M&E into evidence-based policy dialogue. These activities are included in Strategies 1 and 14 but also cut across some of the other strategies. The specific objectives of policy development and legal and regulatory framework are improved policy, increased stakeholder participation, clear and executed laws and regulations, and public accountability. As part of the first step activities, a functioning health financing implementation committee was supposed to drive the process. Unfortunately, funding to support this process did not materialize and therefore the committee met occasionally and eventually the activities ceased. Major decisions that have emanated from policy dialogue among stakeholders directly related to health financing have not taken place.

2. **Revenue Collection and Resource Mobilisation**

   All the three revenue collection and resource mobilisation strategies (2, 3, 4) are intended to ensure sustainable financing in moving towards UHC. Strategy 2 activities include developing options and analyses to engage in dialogue with Parliament, Government and MOF on the level and source of GOG revenue allocated to health as well as advocacy and systems strengthening to help ensure timely and complete collection and transfer of GOG revenue. Some of the activities initiated in 2015 as part of Strategy 2 first steps, were: the process of engaging in dialogue with Government and MOF, to meet the 15% Abuja target (health share of GOG total expenditure); the drive to increase the National Health Insurance Levy (NHIL) or VAT tax from its current 2.5% to 3% and also advocacy for the introduction of 'sin taxes'.

   Innovative resource mobilisation activities are included in Strategy 4. Private sector funding as a potential source for financing the health sector is noted. Currently, the MOH is developing a corporate sector engagement strategy towards leveraging and harmonizing Corporate Social Responsibility and private sector support for health development. Another broad activity under Strategy 4 is to improve coordination between the country and development partners to maximize impact and increase sustainability. Currently, the MOH has implemented structural reforms for increased efficiency which included the formation of the Resource Mobilization Units (Multilateral, Bilateral and Domestic) to

coordinate the engagement with the donor platform and support. However, evidence gathered from interviews with the RMU show that there are still challenges with coordinating or pooling donor funds.

3. Pooling of funds

The specific objectives or aims of pooling of funds under Strategy 5 are to increase redistributive capacity of prepaid funds and align different revenue sources for complementarity. The HFS agrees that risk pooling (or a large proportion of the population together in one pool in order to share health risk) is necessary to insure people against the risk of catastrophic health expenditures. Therefore, to be consistent with both GOG policy and international health financing best practice, the HFS-IP perspective is to separate health finance and management functions with a functional specification of centralize finance and decentralize management in the health sector. The first step is to develop a health sector functional specification assigning appropriate functions including financing and management to each administrative level based on both Ghana's context and international experience. This functional specification will allow proactive development of health sector pooling of funds and decentralization options, analyses, conclusions and proposal to prepare for engaging in policy dialogue consistent with the Government process. It also includes the assessment of geographic disparities in resource allocation and efforts to address these disparities by mechanisms such as further pooling of funds or geographic equalization formula. However, both of these steps were not undertaken.

4. Health purchasing

According to the HFS, the overarching health purchasing priority is optimizing relationships between the two funding streams (general revenue health budget and the NHIS funding) to enable good expenditure management and efficiency gains. It does so under six broad areas; Benefit package and coverage (Strategies 6 & 7), Human Resource (Strategy 8), Improving and harmonizing provider payment systems for variable costs of direct patient care (Strategy 9), Improving capital purchasing (Strategy 10), Strengthening PFM at all levels (Strategy 11) and Establish preferred provider networks (PPNs) (Strategy 12).

Benefit package and coverage

Fiscal space considerations combined with rapidly increasing utilization and costs means that Ghana will have to make policy choices and face trade-offs regarding the breadth, scope and depth of services and benefits. HFS encourages dialogue on improving specification or even reducing MOH services and NHIS benefit package. Strategy 6 hinged on the scale up of the capitation program which was suspended. On the benefit package, the NHIA is relying on the current actuarial model which is being developed to determine what constitutes a feasible package. Strategy 7 is coordination of MOH services and NHIS benefits including prioritization of preventive and primary health care services. On coordinating NHIA and GOG funds, the development of the UHC roadmap is expected to focus on how these goals will be achieved.

Human Resource

Strategy 8 is improving health worker motivation and performance. Health worker salaries are a high proportion of total health costs and key to both efficiency gains and the relationship between health financing and service delivery. Better personnel management at all levels will improve management, productivity and efficiency. Currently, a number of Phase I activities have been initiated. Staffing norms have been conducted by the MOH to give policy direction for the recruitment and retention of health workers. A human resource forecasting was conducted as part of the staffing norms and

projected the human resource requirement up to 2030 and identified the skills gaps anticipated for achieving UHC.

Improving and harmonizing provider payment systems for variable costs of direct patient care

Strategy 9 is improving and harmonizing provider payment systems for variable costs of direct patient care. Expected activities included refining provider payment systems for PHC; refining provider payment systems for outpatient specialty and inpatient or hospital care; improving drug payment in concert with addressing major policy issue of drug supply management and improving payment systems for other health-related programs such as population based public health and medical education. The HFS expected that the expansion of PHC capitation payment in Phase I will inevitably lead to the refinement of provider payment systems for outpatient specialty and hospital care which will also lead to the need for refinements in G-DRGs in Phase II and then result in even greater need to improve payment for drugs in Phase III. Since the capitation system was not expanded, the subsequent activities were impeded.

However, traction has been achieved with the efforts to improve drug payment in concert with addressing major policy issues of drug supply management. These include the institutionalization of the health technology assessment as an essential tool within the medicines policy MOH plans to reform drug supply chain through the implementation of a Drug Supply Chain Master plan. The Logistics Management Information System is expected to be rolled out by the end of 2019, or by first quarter of 2020, as part of the E-health project. A pilot of framework contracting arrangements (for procurement) that considered the cost drivers of medicines reimbursements was implemented in 2017/2018. Fifty-four (54) medicines were contracted in the first instalment of the framework contracts pilot in 2017/2018. The second instalment has been launched, incorporating the lessons learnt from the pilot and applying the lessons learnt to improve the process. The medicines have also been increased to 64. Once the LMIS is fully operational, we expect to see a reduction in the costs and length of procurement for the hospitals. A warehousing optimization study was conducted to determine the possibility of establishing three strategic hubs to augment the existing RMS as part of the supply chain management improvement process.

Improving Capital Purchasing

Strategy 10 is improving capital purchasing as planning of capital investment is an important aspect of both cost containment and service delivery improvement. HFS-IP envisions capital planning and investment including facility infrastructure and major equipment purchases to be kept separate under MOH. A key activity expected under this strategy was the development of a comprehensive and step-by-step capital investment planning and regulation framework. Progress has been made with the finalisation of the Capital Investment plan (2016-2019). Currently, the World Bank is supporting the development of a 4-year Infrastructure Strategy that will address some of the inherent problems such as financing capital investments and maintenance. Central to this new plan, will be finding new strategies of changing the attitudes of institutions towards a better maintenance culture to cut down the waste in the health system and the total reliance on GoG and DPs to provide resources to fund recurrent and capital costs.

Strengthening PFM and information systems supporting purchasing

Strategy 11 is strengthening public finance management (PFM) and information systems supporting health purchasing. Since these underlie all program operations, improvements of these systems will

create efficiency gains and reduce administrative costs. The HFS-IP envisions improvements in PFM will include the implementation of GIFMIS across all functions and at all levels including budgeting, payment, funds flow, accounting, financial reporting, internal controls, and audit to strengthen the operating foundation of health purchasing. GIFMIS replaced Budget and Public Expenditure Management System (BPEMS) project, which began operation from 1999 and ended in the year 2009. GIFMIS started as a pilot in 2009 and was fully rolled out in 2012. Within the health sector, GIFMIS is currently being implemented in all cost centres (health sector institutions) for GoG funding. GIFMIS is implemented in a few facilities for managing IGFs. Donor funds are yet to be managed via the system and currently their expenditures are inputted into the system ex-post. The use of GIFMIS for public financing management is authorized by ACT 921. A GIFMIS roadmap is being developed to ensure that it is implemented at all institutions for all the three main sources of revenue (GoG, IGF and Donor funding). A financial management improvement plan has also been developed since 2015 and it is expected to be added to the roadmap to roll out the GFMIS across all sectors.

On improving, standardising, and unifying health information and other supporting systems, the HFS–IP includes activities that increase efficiency and ensuring effective operations. First steps included strengthening NHIS claims verification and management and accelerate e-claims scale-up. This activity is ongoing, all teaching hospitals are on e-claims. The eHealth project led by the MOH, provides an interface with other data platforms in the health sector. The interfacing the eHealth platform with other data platforms (DHIMS2, LMIS, Ghana Integrated Financial Management Information System (GIFMIS), DHL) started in 2017. It is expected to be completed by 2019. In 2018, the teaching hospitals continued the process of developing key performance indicators which will be uploaded on the DHIMs to improve data capture in the sector. The unified Key Performance Indicators (KPIs) will help to harmonize reporting of data to aid peer review performance among TH, and aid in standardized reporting to the MOH for its monitoring and performance review activities and holistic assessment reporting. The MOH is also developing a 3-year plan to connect all health facilities within the country.

Ensuring that health purchasing stimulates desired service delivery and quality improvements.

Strategy 12 is ensuring that health purchasing stimulates desired service delivery and quality improvements. Health purchasing can contribute to broader health delivery system restructuring including shifting from a hospital-based to PHC-based system, and strengthening PHC and the periphery of the health system especially in rural areas. One of the broad activities was to establish preferred provider networks (PPNs) including CHPS to enable contracting for comprehensive PHC services as part of scaling up the capitation payment system. Although the capitation process was suspended, the MOH conducted a comprehensive CHPS verification exercise. The objective of the study is to reposition the CHPS program by ascertaining the functionality, challenges, map up the location of all CHPS infrastructure and help to redefine the zone concept towards the UHC drive (APOW, 2019).

5. Coordination between public and private

Strategy 13 contributes to improving relationships and coordination between public and private financing. Ensuring that private financing can fund health services in public providers and public financing can fund health services in private providers helps to level the playing field between public and private provision of health services. The first step is an assessment on whether there are any regulatory barriers for PHC capitation payment contracting with PPPNs including private providers.

This process was not initiated with the suspension of the capitation payment mechanism. Another step is to develop plans and activities consistent with Ghana's private sector strategies but specific to the health sector. On the financing side, some efforts have been made by the NHIA to engage with the private sector. This arises from the role assigned by law to the NHIA as regulator of private health insurance schemes (PHIs). Similarly, the National Insurance Commission (NIC) is also having a re-look at the insurance industry, to ensure that the PHIs have enough funds to cover payouts should they become insolvent.

6. Monitoring and Evaluation

Improving M&E for all aspects of the Ghana HFS is critical to guide continuous refinement of interventions, institutionalization and increased ownership at all levels of the health system.

addition, it is expected that HFS implementation will create demand for M&E particularly related to further health purchasing improvements (e.g. costing for provider payment system, rate-setting, operations research studies). The first step was to develop performance framework and monitoring indicator package for routine HFS monitoring. However, this step was not done as funding was not available to put together a team to produce it. The purpose of the communications strategy was to inform and educate stakeholders, promote health sector results and advocate for resource mobilization, financial risk protection, efficiency gains and quality improvement. The communication strategy was also not initiated due to lack of funds to engage a team to roll this out.

Conclusion

The review covered all 15 strategies identified in the HFS. A number of gaps were discovered and the report draws a number of conclusions and makes recommendations that could improve future health financing strategies. Overall, majority of the activities planned for Phases I and II were not achieved due to process and implementation challenges. Implementation has been adhoc and limited to activities that have been carried out by individual directorates or units of the MOH. There has been very minimum cohesiveness in implementation, pointing to the lack of a functioning TWG or steering committee to ensure that the activities were being implemented and tracked. The results suggest that the plan did not sit in the broader development space, to allow other stakeholders outside the health sector to participate in its implementation. Indeed, even health agencies outside the MOH do not appear to be sufficiently accounted for, or adequately involved in the monitoring and reporting of their respective areas within the overall HFS.

Recommendations

The review clearly showed that to improve scale-up of many of the pilot health financing activities, incentives across the service delivery interface need to be properly aligned to goals of the HFS. Process and implementation recommendations are presented below.

	Institutions	Recommendations
Process lessons		
	MOH/ Other agencies	• Clearly mapped out activities that show the involvement of other key stakeholders. • The parameters should be widened to draw in more stakeholders and make units accountable for specific responsibilities. • The strategy should be all encompassing and must prioritize appropriately, particularly around reducing waste and improving efficiency.
	DPs	• DPs should ensure that strategies and plans are not only formulated but there are funds to support implementation.
Implementation Lessons		
	MOH/Other agencies	• Sustain a technical working group to ensure the effective implementation of the plan. • Strengthening mechanisms for active feedback of M&E information and evidence into next generation policy dialogue. • The M&E Strategy must include broad activities that include the design and completion of periodic policy analysis, operational research studies or evaluations to generate evidence for policy dialogue and review. • Policy makers in ministries of health and other institutions to see the usefulness of interpreting multiyear trends in health financing data
	DPs	• Sustainable financing of projects to ensure activities are carried out and not end up in plans and policy papers. • Helping to ensure transparency and accountability, beefing up reporting systems, supporting transition planning etc.
General lessons	All	• UHC roadmap can become a rallying point for the public, advocates and politicians. • Depoliticise health programs to ensure continuity. • Continuous dialogue between partners about how to improve resource mobilisation, financial management, reduce waste and inefficiencies

1 Introduction

Ghana, like many countries in Africa has recognized the need for greater financing in health. Since, the 2001 Abuja Declaration when African leaders pledged to increase health spending to 15 percent of their government's budgets, a number of reforms have taken place within the health sector. The ability to raise enough revenue to meet the demands of health sector has been severely constrained by macroeconomic upheavals in the past decade. The external funding landscape has also changed in recent years, with several debates about the effectiveness and sustainability of aid amidst the rising costs of scaling up health and other systems to meet the Sustainable Development Goals (SDGs). Yet, additional funding alone does not guarantee strengthening of health systems especially in the long run. The World Health Organisation (WHO) has encouraged low- and middle-income countries to engage in structured policy processes to develop health financing strategies (HFSs). HFS should be based on a diagnosis of a health system's current challenges to achieving its goals, focus on the entire population rather than a subset, identify detailed objectives and actions to overcome current challenges, and include an evaluation strategy (WHO, 2017). An effective HFS should increase people's ability to use health care based on need, protect the population from financial ruin, and improve the quality of health care (WHO, 2017).

Due to pressing health financing challenges in Ghana, it became apparent that there was the need for establishing a Health Financing Strategy (HFS). The process began in 2015 and the plan elaborates how health financing will contribute to Ghana's health system goals and objectives and it is based upon the three health financing functions of revenue collection, pooling and purchasing. It also serves as a guiding document to articulate how health financing will contribute to the achievement of universal health coverage.

This HFS review comes at a critical time when efforts are being made to address some of the challenges in attaining (Universal Health Coverage (UHC) in Ghana. The current situation in public revenue for health is driven by Ghana's relatively low fiscal capacity combined with its slightly greater than average health prioritization reflecting GOG commitment to health. On the average, allocation to the health sector as a proportion of the total government budget is 14.0%; a percentage less the Abuja target of 15% (APOW, 2019). The situation supports the general conclusion that there will not be much scope for large increases in overall public spending in the foreseeable future, although gradual increases in GOG revenues are envisioned. The challenge is determining how best to increase health revenue through maintaining and gradually increasing GOG revenue for MOH including general revenue health budget and NHI levies; better NHIS premium specification and exemption targeting; innovative resource mobilization; efficiency, improving relationships between public and private financing; and mitigating the impact of declining donor funding. In summary, this review will assess how many of these challenges have been addressed, ascertain some of the gaps in implementation and make recommendations for the future.

Successful HFS require a number of processes to ensure successful implementation. A review of eight countries with HFS conducted by Cali et al. (2018), shows that to ensure sustainability, HFS are explicitly linked to broader sector/national strategies and are not stand-alone efforts. Although none of the eight HFSs meets the ideal of being embedded within a national health policy, they are linked to other strategic health sector document, or national development plan (e.g. Cambodia's health financing strategy is part of an overall national social protection strategy). Also, all of the HFS processes examined in other countries were guided by a multisectoral steering committee or technical working group, with the exception of Haiti

(Cali et al., 2018). With the support of development partners, countries employed several creative mechanisms for benefiting from international experience in the development of their HFSs.

The eight countries reviewed by Cali et al. (2018) sought to build inclusive coalitions for HFS development in order to foster a broad sense of ownership for the strategy and prevent resistance from stakeholder groups to the strategy's approval. For its HFS strategy formulation, Senegal divided stakeholders into thematic working groups focusing on revenue collection, pooling, purchasing, governance, monitoring and evaluation, and social determinants. In Botswana, private insurers were asked to present on health insurance operations; In Cambodia, development assistance partners were only invited to comment on drafts of the document. Despite their differences, all of these approaches resulted in HFS documents that were aligned with health sector objectives.

Many of the countries with HFS, have found it necessary to conduct additional analysis to inform the development of their HFS. Tanzania commissioned working papers in multiple thematic areas, although the papers took approximately one year to complete; Haiti and Botswana supplemented their situational analyses with stakeholder discussions and interviews, and the Health Finance & Governance (HFG) project assisted Botswana to conduct a financial gap analysis and produce reports on options for improving health sector efficiency and potential national health insurance design (Cali et al. 2018). None of the HFSs reviewed by Cali et al., (2018) included a specific evaluation plan, and only four of the eight had any guidance or monitoring the strategy. Senegal's HFS was the closest to including a monitoring strategy but still lacked important details such as a final list of monitoring indicators.

2 Objectives

The assignment of the USAID Health Systems Strengthening (HSS) Accelerator project is to provide a review the HFS by doing the following:

- Work with the MOH, its agencies, local stakeholders, and development partners to conduct a retrospective analysis of the 2015 Ghana Health Financing Strategy to serve as the baseline evidence ahead of the Health Financing Summit. This includes:
    a. Taking stock of the 2015 Ghana Health Financing Strategy.
    b. Reviewing ongoing activities and progress on health financing initiatives by the MOH and its agencies and development partners since 2015 to date.
    c. Reviewing available evidence on health financing produced by the MOH and its agencies, development partners and academic/research organizations.

3 Methodology

To take stock of this strategy, the HSS Accelerator developed a framework to evaluate the HFS based on the following questions:

- How was the 2015 Ghana Health Financing Strategy conceived and what process was taken to develop the strategy? Was the HFS explicitly linked to broader sector/national strategies and are not stand-alone efforts? Was there a broad sense of ownership for the strategy or resistance from

stakeholder groups? Was the process guided by a multisectoral steering committee? Are there any process lessons Ghana should consider for the next phase of this strategy?

- Was the 2015 Ghana Health Financing Strategy successfully implemented or not? If not, why? Are there any implementation lessons Ghana should consider for the next phase of this strategy?
- How were the costs of the strategy determined – through use of a standard costing tool to cost the defined activities, or through the budget-constrained approach of identifying the potentially available resources during the strategy period, and then prioritizing the activities that could be afforded as a consequence of those limited resources?[1]
- Was the expected implementation budget or cost plan followed? What budgetary considerations should Ghana keep in mind for the next phase of this strategy?
- Did the strategy include a guidance or monitoring the strategy?

To address these questions, the HSS Accelerator first reviewed the 2015 Ghana Health Financing Strategy and accompanying Implementation Plan to understand the expectations outlined in this strategy. There was a need for more information to be gathered from a number of key informant interviews since up to date information was lacking in any of the documents reviewed (see the Annex for the list of key informants and documents reviewed). The HSS Accelerator worked with the MOH, key agencies, local stakeholders and development partners to compile a list of documents, initiatives, and key informants to be included in this analytical phase of the work.

In addition to the Key Informant Interviews conducted, the team reviewed some key government documents and published literature as part of the exercise. However, most program specific documents that could corroborate implementation of activities were not available to the review team and we relied heavily on the annual reviews conducted by the MOH (Holistic Assessment Review reports) and the summary of key achievements included in the annual programme of work documents. Key government agencies had not published annual reports on their website to be reviewed by the team; The NHIA had not published an annual report since 2013 and the most recent annual report on the GHS website was from 2016.

4 Overview: 2015 Ghana Health Financing Strategy

The aim of the Health Financing Strategy is moving towards universal health coverage. The vision is comprehensive including all types of public and private financing. It balances revenue increases and improved expenditure management including efficiency gains to extend coverage and increase sustainability together with direct links to desired service delivery and quality improvements.

The objectives of the Ghana Health Financing Strategy are:

- Improve resource mobilization to ensure sufficient and predictable revenue
- Promote equity in the distribution of health resources and use of health services and reduce financial barriers to access to health care

[1] The advantages of the latter approach include the necessity of engaging with stakeholders, partners and, importantly, the Ministry of Finance. It also helps clarify true priorities and avoids a simple wish list that might never be realistically achieved.

- Efficient allocation and use of health sector resources
- Motivate and stimulate service delivery and quality improvement and increase population satisfaction and involvement in their own health

4.1 Key features of the strategy

The critical path envisaged in the HFS is increasing health revenue; better service and benefit specification and coordination; provider payment systems with incentives for cost containment and efficiency gains; and strengthening the relationship between health financing and desired service delivery improvements and population involvement in their own health. Even though the above elements in the critical path are laudable, the HFS failed to outline a clear strategy on 'how' the MOH intended to achieve the above mentioned.

The HFS is based on a dynamic framework consisting of 15 strategies that show the relationships and actions inherent in the Health Financing Strategy to address the key objectives. It is based on the three health financing functions and includes all sources of funding as well as all institutions and stakeholders involved in health financing. Revenue collection is included in Strategies 2-4 and pooling of funds Strategy 5. Health purchasing represents Strategies 6-12, and a health financing policy and monitoring and evaluation (M&E) feedback loop is represented in Strategies 1, 14 and 15. Although encompassed in revenue collection, pooling and purchasing functions, the relationship between public and private financing is Strategy 13 to reflect the key nature of this relationship in moving towards universal health coverage. The strategies under the major themes are described briefly in Table 2.

Table 2: Specific Health Financing Strategies

Broad Objectives	Strategy	Description
Health financing policy	1	Developing health financing policy and legal and regulatory framework.
Revenue collection and Resource mobilisation	2	Increase GOG revenue allocated to the health sector.
	3	Continually refine NHIS premium specification and improve means-testing to better target NHIS exemptions to poor and vulnerable populations.
	4	Innovative resource mobilization and coordination of health revenues.
Pooling of funds	5	Improve pooling of funds.
Health purchasing	6	Improve breadth, scope and depth of services and benefits
	7	Coordination of MOH services and benefits including prioritization of preventive and primary health care services.
	8	Improving health worker motivation and performance.
	9	Improving and harmonizing provider payment systems for variable costs of direct patient care.
	10	Improving capital purchasing.

	11	Strengthening public finance management (PFM) and information systems supporting health purchasing.
	12	Ensuring that health purchasing stimulates desired service delivery and quality improvements.
Coordination between public and private	13	Improving relationships and coordination between public and private financing.
Monitoring & evaluation	*14*	Strengthening monitoring and evaluation (M&E) and monitoring Health Financing Strategy implementation.
	15	Develop and implement a communications strategy.

Some of the challenges that were predicted at the conception of the strategy included the following:

- How institutional structure, roles and relationships should evolve?
- How to build institutional and human capacity?
- What implementation sequencing is most likely to accomplish objectives?
- How to improve health sector coordination?
- How to improve monitoring and evaluation and feed information back into policy dialogue?

4.2 Process of developing the HFS - stakeholders engaged

The HFS was developed though a participatory approach using meetings and comments from key stakeholders on the strategy. A steering committee was formed as well as a Technical Working Group (TWG). A final validation workshop with all stakeholders was conducted to ensure the buy-in and involvement of the relevant sectors. Stakeholders included the MOH and its agencies including the Ghana Health Services, National Health Insurance Authority, Christian Health Association (CHAG) and Regulatory Agencies as well as representatives from the private Sector. Comments and suggestions were incorporated into the final document. The development of the strategy was funded by DFID.

4.3 How was the strategy costed and financing plan developed?

From the implementation plan, the budget for this was supposed to be implemented in line with the budget for the MTEF (2016 -2020). From 2014-2017, the HFS was expected to be implemented within the fiscal space analysis of the health sector medium term expenditure framework (MTEF) projections contained in the HSMTDP and was based on the assumption that revenues projected for public health funding would not exceed the fiscal space projections in the HSMTDP due to fiscal constraints. Additionally, it was envisaged that the projections or budget estimates for implementing the HFS activities would be included in the subsequent annual plans of work (APoW).

In that vein, the development and implementation of the Health Financing strategy was defined under objective 2 of the 2014-2017 Health Sector Medium Term Development Plan. (**Objective 2: Ensure sustainable financing for health care delivery and financial protection for the poor**), and the dissemination and implementation of the Health Financing Strategic Plan was included in the 2015 PoW, which indicated that the resource allocation review had been reviewed and implemented and the health expenditure review had been initiated.

A budget of **GHC 3,925,066.61** was estimated for implementation of objective 2 in the HSMTDP but did not include a detailed breakdown on funds for the specific activities envisaged under the objective. However, a review of the 2015 POW showed that some activities under the NHIS, such as expansion of capitation, had been included in the PoW which indicated that it had been expanded beyond the Ashanti Region to the Upper West, Volta and Upper East Regions.

5 Overview of the implementation plan

The Ghana Health Financing Strategy (HFS) is to be implemented by the Ghana Health Financing Strategy Implementation Plan (HFS-IP). HFS-IP sections consist of Implementation Phases, Strategy Activities and First Steps for each of the 15 specific strategies, Budgeting and Costing, Institutional Roles and Relationships, and Implementation. HFS-IP will also include yearly detailed plans of work contained in the Health Sector Medium-Term Development Plan 2014-2017 (HSMTDP) yearly plans of work. The intent of HFS-IP is balancing providing enough specification or detail to enable implementation with the flexibility required for health financing policy and interventions to best adapt to the continuously evolving environment. By the nature of implementation, content and sequencing of HFS activities will continuously adapt to evolution of the Ghana environment. However, HFS-IP anticipates that the activities will ebb and flow within a broader dynamic or framework consisting of phases that will guide health financing implementation for the next decade and beyond.

5.1 Development and financing of the implementation plan

The Health Financing Strategy Implementation Plan (HFS-IP) was developed by the Ministry of Health (MOH) and was supervised by the Director MOH Policy, Planning, and Monitoring and Evaluation (PPME). The development of the HFS-IP was supported by a number of key stakeholders led by the MOH Policy, Planning, and Monitoring and Evaluation (PPME) team. Stakeholders included the MOH and its Agencies, including Ghana Health Services, National Health Insurance Authority, Christian Health Association (CHAG) and Regulatory Agencies. The HFS-IP was funded by DFID with technical support from WHO Geneva and WHO Country Office Accra.

The HFS-IP appears to have been costed through the budget-constrained approach by situating it within the HSMTDP Program Based Budgets that had estimated budgets for key activities identified by and included in the HFS. These activities were prioritized in the HFS implementation plan, which defined the sequencing of activities from Phase I through Phase IV and set the basis for building of the achievements of each phase. What was missing were the specific budgets for widespread dissemination of the strategy and its accompanying implementation plan, to explain the proposed sequencing of activities to build off the gains of improving health financing. Secondly, the key monitoring and evaluation indicators and an accompanying plan for measuring the outcomes of the implementation were never developed. The resultant effect was that activities were implemented outside the framework of the strategy and any reforms of policies and activities happening within the Phase 1, failed to be captured and reported on in the annual reviews.

5.2 Phases of the implementation plan

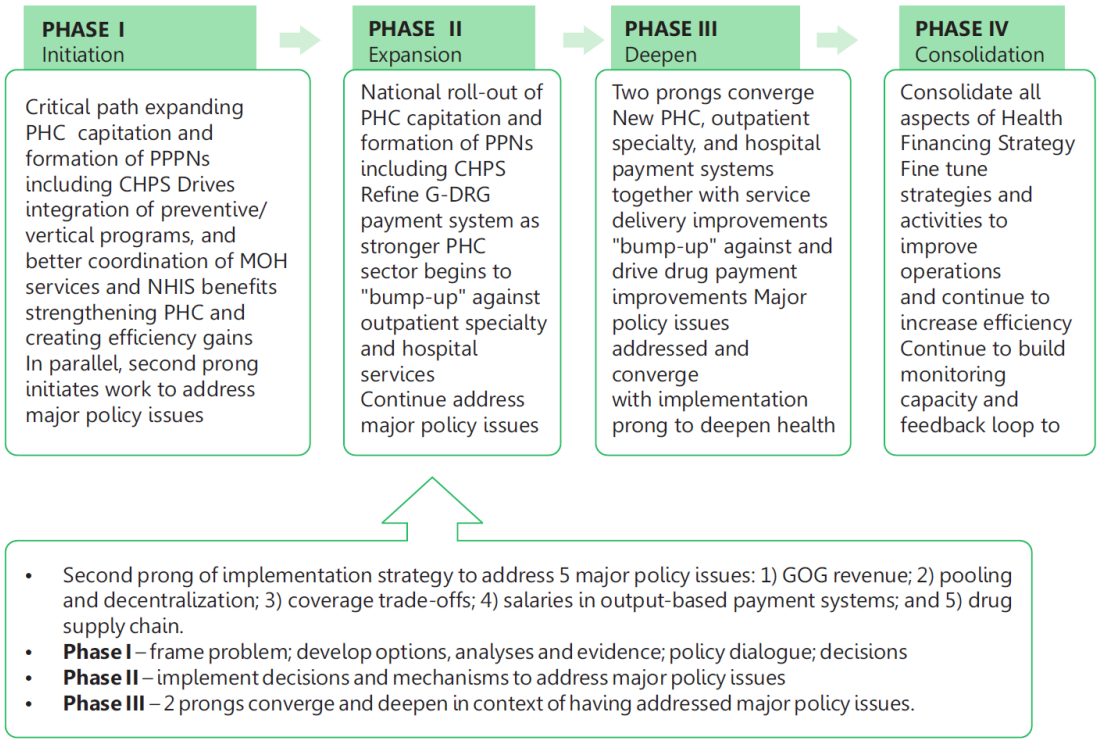
HFS-IP envisions four implementation phases entitled Initiation, Expansion, Deepen, and Solidification. The black boxes in the table below show the expected timeframe for each phase. The gray area in the

table portrays the extensive preparation required for Phase III Deepen which will both build on Phase I and II implementation and address major health financing policy issues, finally leading to solidification in Phase IV.

Table 3: Overall Implementation Strategy and Sequencing

Phase	2014-2017	2018-2020	2021-2023	2024-2026
Initiation				
Expansion				
Deepen				
Solidification				

Figure 1: Four Implementation Phases



5.2.1 Phase I (Initiation) Activities

Phase I Initiation starts HFS-IP critical path activities focused on improving health purchasing and the relationship to service delivery. The intended result is improved expenditure management, efficiency gains enabling movement towards UHC, financial sustainability and improving quality of health care. The core Phase I Initiation activity is expansion of NHIS PHC capitation payment system and the related key activities of formation of Preferred PHC provider networks (PPPN), specifying services included in PHC

capitation payment contracts, and establishing a population choice payment for going around the covered benefit of accessing PHC through the provider in which you enrol (gatekeeper function). It also initiates improving costing for provider payment system rate-setting.

5.2.2 Phase II (Expansion) Activities

Phase II Expansion is planned to expand health purchasing improvement started in Phase I by national roll-out of PHC capitation payment system and PPPN formation including CHPS. In addition, it moves up the levels of service to improve purchasing for outpatient specialty and hospital services by refining Ghana Diagnostic-Related Groups (G-DRGs). Build ng on the base of strengthened purchasing and provision of PHC services initiated in Phase I, Phase II improves purchasing and financial incentives to reduce the number of costly hospitalizations and improve service delivery or necessary hospitalizations and outpatient specialty services.

5.2.3 Phase III (Deepen) Activities

Phase III Deepen is where the two implementation strategy prongs of step-by-step implementation and addressing major policy issues converge. At this stage, the Phase I and Phase II implementation produce a new phase where key policy issues to deepen HFS implementation are taken to address the core challenges in health financing. Here, the emphasis is on efficiency gains moving towards UHC and service delivery improvement. It is also expected that the critical path of national roll-out of PHC capitation and formation of PPPNs including CHPS would have led to integration of prevention/vertical programs and convergence of MOH services and NHIS benefits package. The resulting service delivery improvements and efficiency gains could at this stage enable NHIS coverage expansion to the extent that the long-term plan of PHC capitation payment for priority services and benefits for the entire population is realised.

5.2.4 Phases IV (Solidification) Activities

Phase IV Consolidation will consolidate, solidify and institutionalize the new health financing system for sustainability. The two prongs of the overall HFS Implementation Strategy would have fully converted into one track with long-term revenue sources clearer and health purchasing improvement driving efficiency gains moving towards UHC and service delivery realignment and improvement. Phase IV Consolidation can continue indefinitely to solidify the new health financing system.

6 Status of Health Financing Implementation Plan

In reviewing the HFS-IP, there were a number of cross-cutting issues that became very visible from the start. First, one of the core Phase I Initiation activity was the expansion of NHIS PHC capitation payment system and the related key activities of formation of Preferred PHC provider networks (PPPN), specifying services included in PHC capitation payment contracts. This run through several of the strategies, notably Strategies 6, 7, 9, 12 and 13. The transitioning of the government meant that the capitation did not continue, rendering these activities redundant. Secondly, the M & E plan to accompany the HFS-IP was not initiated as envisaged from the start. This meant that the feedback loop which was expected to run through from Strategies 14 and 15 to Strategy 1, was also missing. As a result, it has been difficult to assess the successes or failures of the plan with the lack of routine evidence on the progress of the plan. This process would have also allowed the activities to be sharpened and put in the relevant context. The plan remained static,

Overall, implementation has been adhoc and rather limited on activities that have been carried out by individual directorates or units of the MOH. There is very minimum cohesiveness in implementation, pointing to the lack of a TWG or steering committee to ensure that the activities were being implemented. This also shows that the plan did not sit in the broader development space, to allow other stakeholders outside the health sector to participate in its implementation. The lack of a monitoring and evaluation plan with clear indicators for tracking the progress of implementation has also hampered the cohesiveness of implementation. The remaining section presents the main findings from the review based on the broad activities of the HFS.

6.1 Policy, Legal and Regulatory frameworks

Strategy 1 is developing health financing policy and legal and regulatory framework. The specific objectives of policy development and legal and regulatory framework are improved policy, increased stakeholder participation, clear and executed laws and regulations, and public accountability. Some of these activities were expected to be undertaken as part of the activities under Strategies 2, 5, 6, 8, and 9. It was also expected that detailed plans to align and facilitate preparation for addressing major policy issues would be developed. Strategy 1 would also tie in with Strategies 14 and 15 where plans would be developed to inform, implement and monitor policy decisions.

A functioning health financing implementation committee was supposed to drive Strategy 1. Unfortunately, the funding to support this process did not materialize and therefore the committee met occasionally and eventually the activities ceased. On improving the legal and policy framework for codifying health financing policy decisions, the first step was to have a clear definition for 'primary health care' in Ghana. This was accomplished and contained in the GHS Act and CHPS policy. On driving major policy issues, the first step was for the MOH to engage with the NHIA and expand its supervisory functions. Currently, there is a dedicated and functioning NHIA desk at the MOH (Table 3).

Table 4: Progress on Health Financing Policy

Strategy	Broad Activities	Specific activities initiated since 2015	Progress
1. **Developing health financing policy and legal and regulatory framework**	Policy dialogue decisions and refinements on major policy issues	Strengthen the role of MOH in NHIS activities	Dedicated and functioning desk at the MOH in place but it is expected that the MOH has more oversight roles within the NHIS.
	Strengthen health financing policy dialogue mechanisms and processes to ensure open, transparent and participatory dialogue	Functional Health Financing Implementation Committee	Working group met occasionally but lack of funding to keep the activities going meant the group meetings ceased.
	Amend and implement legal and implement regulatory framework to codify health financing policy decisions	Policy decision on definition of primary health care for Ghana	These are contained in the GHS Act/ CHPS policy.
	Incorporate feedback from M&E into evidence-based policy dialogue		This was not achieved since an M&E plan was not developed for strategy.

Key challenges

1. Lack of functional HF implementation committee means many of the activities scheduled in the Phase I and II lacked oversight, funding authority, and motivation therefore were not completed.
2. Incorporating feedback from M&E into evidence-based policy dialogue which was expected to be a vital part of the feedback loop within the entire framework was absent.

6.2 Revenue collection and Resource Mobilisation

All three revenue collection strategies (Strategies 2, 3, 4) are intended to ensure sustainable financing in moving towards UHC. Strategy 2, centres around efforts to improve resource mobilisation. This is similar to the Strategy 2.1.5 of the 2007 National Health Policy (NHP), which mentions relatively low fiscal space, declining donor funding, inadequate innovative DRM, poor exemption-targeting and unrealistic tariff regime as key challenges to resource mobilisation (MOH, 2019). Strategy 2 activities include developing options and analyses to engage in dialogue with Parliament, Government and MOF on level and source of GOG revenue allocated to health as well as advocacy and systems strengthening to help ensure timely and complete collection and transfer of GOG revenue.

Some of the activities initiated in 2015 as part of Strategy 2 first steps, was the process of engaging in dialogue with Government and MOF, to meet the 15% Abuja target (health share of GOG total expenditure); the drive to increase the National Health Insurance Levy (NHIL) or VAT tax from its current 2.5% to 3% and also the introduction of 'sin taxes'. After extensive work during the review of the NHIS in 2015, the proposal was turned down. Discussions with key experts, indicate that there is very minimal fiscal space for more taxes. Also, the literature on the inclusion of sin taxes shows that there is minimum expectation that the gains from initiating this tax regime may be enough to offset the cost of its implementation (Allcott et al., 2018). Furthermore, the introduction of any more taxes has not been viewed favourably by the government and the general population. The MOH, however hopes that with the introduction of the Global Financing Facility (GFF), it will be able to build an investment case for the health sector especially as the shift from donor funding becomes apparent.

For finding other innovative ways to improve resource mobilisation, there is potential for streamlining the component of the District Assembly Common Fund (DACF) that is spent on the health. Experts from the Ministry of Finance (MOF) indicated that these will form part of the reforms of fiscal decentralization, where DACF used for health activities will be captured as part of the health budget. Although the MOF will not have oversight responsibility on the financial management at the decentralised levels, it will set standards to be maintained as well as indicators and measurements needed to track implementation. Currently, 6-10% of DACF is spent on health (service delivery and infrastructure), in addition to the allocations made to MPs from the MOF and from the NHIS to support capital infrastructure in their regions.

6.2.1 Refining NHIS premiums

Strategy 3 includes activities to refine NHIS premiums, strengthen premium collection systems, and develop creative ways to increase NHIS premium payments and encourage informal sector participation. Conversations with the NHIA indicate that increases in premiums must be agreed by Parliament and this is unlikely to happen a year before elections. The window of opportunity to advocate for increases in premium payment could safely be done in 2021. However, the premiums have been inching up

incrementally since 2004. The minimum payment in 2004 was GHC 7 compared to current minimum of GHC 20.

Another goal was to improve means-testing and better target NHIS exemptions to poor and vulnerable populations. The NHIA has collaborated with the Ministry of Gender, Children and Social Protection (MoGCSP) to carry out this exercise. The NHIA will rely on MOGCSP to complete the Ghana National Household Registry so that it will link its database to registry and automatically renew the membership of individuals identified as indigents.

6.2.2 Private sector funding

The involvement of the private sector as a funding source for the health sector has also been highlighted under Strategy 4. The Ministry of Health is developing a corporate sector engagement strategy towards leveraging and harmonizing Corporate Social Responsibility (CSR) and private sector support for health development. A profiling/mapping of corporate bodies engaged in CSR has also been carried out. There are windows of opportunity for more resource domestic resource mobilisation if the MOH widens the scope to including churches and corporate organisations.

6.2.3 Development partner coordination and Transition planning

Another broad activity under Strategy 4 is to improve coordination between the country and development partners to maximize impact and increase sustainability. Currently, the Ministry of Health has implemented structural reforms for increased efficiency which included the formation of the Resource Mobilization Units (Multilateral, Bilateral and Domestic) to coordinate the engagement with the donor platform and support. However, evidence gathered from interviews with the RMU show that there are challenges coordinating or pooling donor funds. Sometimes, there are budget lines that can be easily synced and donors agree to allow one partner to carry that cost and the remaining funds spent on other programmatic items. Unfortunately, some donors insist on moving on parallel lines, even when there is clear evidence of efficiency gains in managing one portfolio. Mechanisms to gradually incorporate donor payments into country systems, rather than the vertical systems that are currently implemented has not received enough attention.

Efforts have been made to mobilize resources by individual vertical programmes. For example, the Malaria Control Programme has developed a Domestic Resource Mobilization Strategy to mobilize additional domestic resources to support Malaria Control. Beyond that, an investment case for Malaria has also been developed. Although, the HFS under Strategy 4, allows for specific diseases/conditions to mobilise resources, it expects that these will fund services that would be integrated into the health system rather than further expanding vertical programs.

The RMU of the MOH has explained that completed its transition plan but a continuous dialogue with the MOF on mitigating the risks associated with transition is needed.

Table 5: Progress on Revenue Collection and Resource Mobilisation

Strategy	Broad Activities	Specific activities initiated since 2015	Progress
2: **Increase GOG revenue allocated to the health sector.**	Develop options, analyses and evidence to engage in dialogue with Parliament, Government and MOF	Increasing the National Health Insurance Levy (NHIL) or VAT tax from its current 2.5% to 3%.	Extensive work done by MOH and NHIA. This proposal was turned down. The current focus of advocacy is to push the government to release the 2.5% on time and fully to allow the NHIA to meet its obligations.
	Advocacy and systems strengthening to help ensure timely and complete collection and transfer of GOG revenue	a) Generate the evidence for and against the introduction of 'sin taxes'	Proposal for evidence and analysis ready. Outcome of the study will be an input into the review of the NHIS but currently, minimal fiscal space to accommodate this in the 2020 budget.
		b) Analysis of Abuja declaration for policy advocacy and engage in dialogue with MOF to help ensure health is one of the highest priorities for distribution of country resources.	This analysis is conducted every budget season and Ghana is close to the target - around 14% currently. The main challenge is with the denominator, whether it should include loans or IGF.
	Engage in multi-sectoral advocacy and promotion of results to contribute to increasing revenue and mobilizing resources	Develop a comprehensive advocacy plan and business case	Not done
3: **Continually refine NHIS premium specification and improve means-testing to better target NHIS exemptions to poor and vulnerable populations**	Refine NHIS premiums, strengthen premium collection systems, and develop creative ways to increase NHIS premium payments and encourage informal sector participation (e.g. engage local government or civil society to promote enrolment, publicize subsidization of premium contributions)	Review of NHIS premium to consider long term changes to premium structure and levels and ways of improving premium accounting and member enrolment.	Premiums have been inching up incrementally since 2004; the lowest then was GHC 7 compared current minimum level of GHC20. Mobile premium collections being explored as a way of improving member enrolment.
	Improve means-testing and better target NHIS exemptions to poor and vulnerable populations including developing common targeting across sectors and programs	Analyse the dynamics of NHIS exemptions for poor and vulnerable populations, and coordinate with Min. of Gender, Children and Social protection and other stakeholders to	Work is ongoing with Min. of Gender. Adapted MOG means testing. Pilot started in 10 districts. Current increases in coverage of poor and vulnerable is attributed to the HIP project.

		improve means-testing for NHIS exemptions	
4: **Innovative resource mobilization and coordination of health revenues**	Explore, develop, and leverage innovative private resource mobilization mechanisms	Start work on how to mobilise resources from the private sector (mining companies etc.) for specific disease conditions	The Ministry of Health is developing a corporate sector engagement strategy towards leveraging and harmonizing Corporate Social Responsibility and private sector support for health development. A profiling/mapping of corporate bodies engaged in CSR has also been carried out.
	More active country and development partner coordination to maximize impact, increase sustainability and manage the transition including intensifying planning to fill gaps created by declining donor funding	Improved mapping of donor funding projections by year to identify the critical junctures in the decline of donor funds and then development of plans to strengthen remaining partner coordination and initiate replacement of donor funds.	Individual donors often have their own funding projections and therefore difficult to coordinate funding from them. It has been difficult to harmonise a number these processes because of the rigid nature within which these funds operate. A transition plan has been developed to guide domestic resource mobilization.

6.3 Pooling of funds

The specific objectives or aims of pooling of funds under Strategy 5 are to increase redistributive capacity of prepaid funds and align different revenue sources for complementarity. The HFS agrees that risk pooling (or a large proportion of the population together in one pool in order to share health risk) is necessary to insure people against the risk of catastrophic health expenditures. Therefore, to be consistent with both GOG policy and international health financing best practice, the HFS-IP perspective is to separate health finance and management functions with a functional specification of centralize finance and decentralize management in the health sector.

The pooling of funds activities includes continuously assessing and to the extent possible improve pooling of funds related to both decentralization policy and the two MOH revenue streams of general revenue health budget and NHIS funding. However, the HFS, indicates that pooling of these two streams of revenue is not envisioned in the short-term but rather accomplished as part of Phase III deepening activities where major decisions are expected to be taken. The first step is to develop a health sector functional specification assigning appropriate functions including financing and management to each administrative level based on both Ghana's context and international experience. This functional specification will allow proactive development of health sector pooling of funds and decentralization options, analyses, conclusions and proposal to prepare for engaging in policy dialogue consistent with the Government process. It also includes the assessment of geographic disparities in resource allocation and efforts to

address these disparities by mechanisms such as further pooling of funds or geographic equalization formula. However, both of these steps were not undertaken.

Table 6: Progress on Pooling of Funds

Strategy	Broad Activities	Specific activities initiated since 2015	Progress
5: **Improve pooling of funds**	Continuously assess and to the extent possible, improve pooling of funds related to both decentralization and the two MOH revenue streams of general revenue health budget and NHIS funding	Develop a health sector functional specification assigning appropriate functions including financing and management to each administrative level based on both Ghana context and international experience	Activity not undertaken.
	Assess geographic disparities in resource allocation and address by mechanisms such as further pooling of funds or geographic equalization formula.	Data collection, analysis and comparison of total government health funds flowing to different regions of the country including salaries, other health budget and NHIS payments	Activity not initiated.

6.4 Health Purchasing

According to the HFS, the overarching health purchasing priority is optimizing relationships between the two funding streams (general revenue health budget and the NHIS funding) to enable good expenditure management and efficiency gains. It does so under six broad areas; Benefit package and coverage (Strategies 6 &7), Human Resource (Strategy 8), Provider payment systems for PHC (Strategy 9), Capital Investment (Strategy 10), Strengthening PFM at all levels (Strategy 11) and Establish preferred provider networks (PPNs) (Strategy 12).

6.4.1 Benefit package and coverage

Strategy 6 is improving breadth, scope and depth of services and benefits. Major policy decisions on the breadth, depth and scope of benefits are considered a Phase III activity and will be considered within the scope of the UHC roadmap. HFS encourages dialogue on improving specification or even reducing MOH services and NHIS benefit package. A step by step framework is expected to be developed to reduce cost of services, reduce duplicative or unnecessary services, strengthen evidence-based standards and practices, and focus on priority service delivery programs. On the benefit package, the NHIA is relying on the current actuarial model which is being developed to determine what constitutes a feasible package. The NHIA intends to start stakeholder engagements with the public and other stakeholders to decide on what the non-negotiable benefits should be within the available resources.

Strategy 7 is coordination of MOH services and NHIS benefits including prioritization of preventive and primary health care services. On coordinating NHIA and GoG funds, the GHS believes these are two different funding streams, with the NHIA funding clinical care and GoG funds covering the other functional areas of the health sector. There are suggestions that the salaries of health providers should be included in the NHIS tariffs, so a full recovery cost is paid as the tariff and salaries are no longer managed from the central source.

Table 7: Progress on Benefit package

Strategy	Broad Activities	Specific activities initiated since 2015	Progress
6: **Improve breadth, scope and depth of services and benefits**	Incorporate population choice payments into expansion of PHC capitation payment system and formation of PPNs including CHPS into which population will enrol	Phase I Initiation activity on the critical path (in concert with scale-up of PHC capitation payment system, formation of PPPNs, integration of vertical programs, and coordination of MOH services and NHIS benefits	Capitation was started but not scaled up.
	Perform assessments and develop options and analyses to generate evidence informing policy dialogue and decisions on major policy issue of breadth, scope and depth of services and benefits in moving towards UHC		This is more of a Phase III activity and will be included in the UHC roadmap.
7: **Coordination of MOH services and benefits including prioritization of preventive and primary health care services.**	Continual policy dialogue on breadth and scope of benefit package	Review the benefit package	Build on the current actuarial study being undertaken by the NHIA.
	Prioritize, educate and facilitate improvements in coordination of MOH services and NHIS benefits arising from the critical path of expansion of PHC capitation payment system, formation of PPNs including CHPS, population choice payments, and integration of vertical programs.	First step is initiating conceptual development of a unified service and benefits framework (assuming no further pooling of general revenue health budget and NHIS funding).	This was not developed but expected to be included in the UHC roadmap.
	Depending on whether addressing major policy issues result in more pooling of general revenue health budget and NHIS funding, either develop and implement a unified service and benefits framework to contribute to improving MOH service and NHIS benefit coordination or refine NHIS benefits to incorporate MOH services.	Health purchasing mechanisms will be used to mitigate pooling fragmentation in the short-term with better coordination of MOH services and NHIS benefit package serving as one of these mitigation activities.	This step was not achieved.

6.4.2 Human Resource

Strategy 8 is improving health worker motivation and performance. Health worker salaries are a high proportion of total health costs and key to both efficiency gains and the relationship between health financing and service delivery. Better personnel management at all levels will improve management, productivity and efficiency. Currently, several Phase I activities have been initiated. Staffing norms have been conducted by the MOH to give policy direction for the recruitment and retention of health workers. A human resource forecasting was conducted as part of the staffing norms and projected the human resource requirement up to 2030 and identified the skills gaps anticipated for achieving UHC.

The Human Resources for Health Policy has also been developed to provide strategies to address some of the key challenges identified. The policy is in its draft stage and currently with Cabinet for approval, but in the meantime, some of the key strategies are being implemented but have faced some resistance from the sector largely due to the resistance to change. HRH directorate is using the evidence gathered during the forecasting study to counter the resistance and expects the staffing norms to be reviewed every 5 years.

Table 8: Progress on Human Resource

Strategy	Broad Activities	Specific activities initiated since 2015	Progress
8: Improving health worker motivation and performance	Support incremental implementation of MOH Human Resources for Health (HRH) policies, increases in productivity, and improving human resource distribution in rural and underserved areas	Complete the staffing norms	Analysis for the critical health workers completed. Planning to move to support staff.
		Develop and implement redistribution plan	Planning stage - workforce analysis will guide the development of the plan
		Review of the HR strategic plan, policies and procedures	Policy is in its draft stage and currently with Cabinet for approval
		Modelling current and future HR demand and supply including cost/pay bill	Ongoing - Initiate assessment of different cadres of health workforce
	Design and develop mechanisms and systems to gradually incorporate health worker salary payments into output-based provider payment systems	Assess the ramifications of health worker salary increases reducing health budget funds for direct patient care	
		Mapping human resources distribution and converting it to monetary terms to analyse equity across regions in MOH services and NHIS benefits	

		Developing a detailed plan to define problems; develop options, analyses, and evidence; engage in policy dialogue; and make and implement a policy decision on incorporating salaries into output base provider payment systems	

6.4.3 Provider payment systems for PHC

Strategy 9 is improving and harmonizing provider payment systems for variable costs of direct patient care. Activities for provider payment systems for variable costs of direct patient care include (each payment system and level of care includes NHIS, health budget and donor funds):

- Refine provider payment systems for PHC
- Refine provider payment systems for outpatient specialty and inpatient or hospital care
- Improve drug payment in concert with addressing major policy issue of drug supply management
- Improve payment systems for other health-related programs such as population based
- public health and medical education

The HFS expected that the expansion of PHC capitation payment in Phase I will inevitably would lead to the refinement of provider payment systems for outpatient specialty and hospital care which will also lead to the need for refinements in G-DRGs in Phase II and then result in even greater need to improve payment for drugs in Phase III. Since the capitation system was not expanded, the subsequent activities were impeded. However, traction has been achieved with the efforts to improve drug payment in concert with addressing major policy issues of drug supply management. One of the initial activities was to pilot health technology assessment in collaboration with NICE. HTA is expected to ensure that new interventions in the health sector are effective both for treatment and costs. The pilot was conducted in 2016 and informed the decision on which medicines to include on the STG, which also informed the medicines to be included on the NHIS reimbursement list. The HTA steering committee has been launched by the MOH in October 2019 and a TWG and secretariat (managed by MOH and NHIA) have also been established. The National Medicines policy was launched in 2018 to institutionalize HTA. The MOH has identified HTA as an essential tool within the medicines policy and will eventually be operated via legal means but is currently being implemented by policy.

The MOH plans to reform drug supply chain through the implementation of a Drug Supply Chain Master plan. The Logistics Management Information System is expected to be rolled out by the end of 2019, or by first quarter of 2020, as part of the E-health project. A pilot of framework contracting arrangements (for procurement) that considered the cost drivers of medicines reimbursements was implemented in 2017/2018. Fifty-four (54) medicines were contracted in the first instalment of the framework contracts pilot in 2017/2018. The second instalment has been launched, incorporating the lessons learnt from the pilot and applying the lessons learnt to improve the process. The medicines have also been increased to 64. Once the LMIS is fully operational, we expect to see a reduction in the costs and length of procurement for the hospitals. A warehousing optimization study was conducted to determine the possibility of establishing three strategic hubs to augment the existing RMS as part of the supply chain management improvement process.

On pricing, government taxes form 40% of prices on medicines. In response to advocacy efforts, the VAT on all Essential Medicines List (EML) were removed to reduce the prices of drugs. There has not been the expected response from the private sector to pass on the tax saving to consumers, and advocacy efforts will continue once the NHIS arrears reach the legal 3-month period.

Table 9: Progress on improving and harmonizing provider payment systems for variable costs of direct patient care

Strategy	Broad Activities	Specific activities initiated since 2015	Progress
9: **Improving and harmonizing provider payment systems for variable costs of direct patient care**	Refine provider payment systems for PHC	Expansion of PHC capitation to UER, UWR and Volta in 2015	Suspension of the capitation payment mechanism. Plan to roll this nationally was not done.
		Work with stakeholders to set out capitation rates	The costing of CHPS is currently being done.
	Refine provider payment systems for outpatient specialty and inpatient or hospital care		A new DRG rate has been submitted to the Minister for approval.
	Improve drug payment in concert with addressing major policy issue of drug supply management	Piloting health technology assessment in collaboration with NICE	Pilot completed and HTA institutionalized in Ghana.
		Incorporate drug procurement mechanism such as framework contracts setting	A pilot of framework contracting arrangements (for procurement) that considered the cost drivers of medicines reimbursements was implemented in 2017/2018.
		Review the Standard treatment guidelines	Draft is ready - going through final editing
	Improve payment systems for other health-related programs such as population-based public health and medical education		This activity was not initiated.

6.4.4 Capital Investment

Capital expenditure (CAPEX) continues to receive the lowest allocation among the three pillars of government health spending. In 2019 allocation to CAPEX was about 15 percent of the total allocation. Strategy 10 is improving capital purchasing. Planning of capital investment is an important aspect of both cost containment and service delivery improvement. HFS-IP envisions capital planning and investment including facility infrastructure and major equipment purchases continuing to be kept separate under MOH. The first activity starts with the development of a comprehensive and step-by-step capital investment planning and regulation framework. According the Infrastructure Directorate of the MOH, the Capital Investment plan was finalised and spanned a period of 3 years (2016-2019). Currently, the World

Bank is supporting the development of a 4-year Infrastructure Strategy that will address some of the inherent problems such as financing capital investments and maintenance.

The second broad activity is to clarify and publicize threshold for facility level capital investments and encourage all health facilities to develop a capital investment and maintenance plan. According to the Infrastructure Directorate, this objective is unclear since issues to do with thresholds are clearly stated in the Procurement law. According to the Directorate, these thresholds are fixed per Budget Management Center (BMC), and this is clearly understood. Institutions who have had issues with these thresholds in the past, and have gone around the system, have later regretted not following the standards and specifications set by the Directorate. The evidence is visible – uncompleted buildings/facilities etc. The recommendation is that the broad objectives under Strategy 10 will need to be revised in line with the current strategy being developed to make it more relevant.

To address the second issue of clarifying responsibilities for operating vs. capital costs and capital maintenance, information gathered from the interviews point to the need to critically look at the maintenance culture in the health sector. According to the Directorate, many institutions set up facilities with very little set aside for maintenance. Although these directives are clearly stated in the Preventive Maintenance Manual developed by the Ghana Health Service (GHS) Estate Management department, many institutions still expect the government to cover their maintenance costs. Maintenance is never captured as a line in the budget, which means institutions must take this into account when drawing up their expenditure plans for their IGF.

The Directorate is also addressing another challenge with the District Assemblies where they use their DACF to provide CHPS without the mandate of the Ministry and therefore produce facilities that are outside the MOH design and specifications. These facilities are often not fit for purpose. Efforts are being made to address these problems. The current strategy being developed will include measures to address these current challenges. It will be a coherent infrastructure plan that is easily accessible to all people and grounded on quality and equity principles.

A relevant objective is to find ways of changing the attitudes of institutions towards a better maintenance culture to cut down the waste in the systems and the total reliance on GoG and DPs to provide resources to fund recurrent and capital costs.

Table 10: Progress on Capital Investments

Strategy	Broad Activities	Specific activities initiated since 2015	Progress
10: **Improving capital purchasing**	Assess, design, and implement improvements to capital investment planning capital regulation (e.g. certificate of need), capital purchasing or payment systems, and accounting for and managing capital costs	Develop capital investment policy and plan	Capital Investment plan was finalised and spanned a period of 3 years (2016-2019). Currently, the World Bank is supporting the development of a 4-year Infrastructure Strategy.
	Clarify thresholds and responsibilities for operating		Some of these measures will be included the Infrastructure strategy being developed.

	vs. capital costs and capital maintenance		

6.4.5 Strengthening PFM and Improve information systems supporting purchasing

HFS-IP envisions improvements in PFM including GIFMIS across all functions and at all levels including budgeting, payment, funds flow, accounting, financial reporting, internal controls, and audit to strengthen the operating foundation of health purchasing. First steps are to: 1) improve content and timeliness of financial reporting by MOH and its agencies; 2) develop a unified costing system to improve planning, provider payment rate-setting, and facility management; and developing plans to be more transparent and accountable to public.

6.4.5.1 Strengthening PFM

GIFMIS replaced Budget and Public Expenditure Management System (BPEMS) project, which began operation from 1999 and ended in the year 2009. GIFMIS started as a pilot in 2009 and was fully rolled out in 2012. Within the health sector, GIFMIS is currently being implemented in all cost centres (health sector institutions) for GoG funding. GIFMIS is implemented in a few facilities for managing IGFs. Donor funds are yet to be managed via the system and are currently their expenditures are imputed into the system ex-post. The use of GIFMIS for public financing management is authorized by ACT 921. A GIFMIS roadmap is being developed to ensure that it is implemented at all institutions for all the three main sources of revenue (GoG, IGF and Donor funding). GIFMIS is expected to be fully deployed in the health sector in 2021 and nationwide in 2024. A financial management improvement plan has also been developed since 2015 and it is expected to be added to the roadmap to roll out the GFMIS across all sectors as part of the Financial Management Improvement Plan.

6.4.5.1.1 Challenges with implementation of GIFMIS:

- It requires an internet connection to operate. The government is working with the National Information Technology Agency (NITA) to extend internet connection all across the country, but the process has been restricted by limited funding. A number of the key informants cautioned that not addressing the connectivity challenges has led to several delays with payments.
- It requires dedicated infrastructure, including computers, to operate.
- The implementation of GIFMIS was not costed either and will be included in the roadmap being developed.
- Operational manuals will need to be updated to help personnel manage the new setup.
- Legal backing needed to ensure compliance and where necessary punitive measures deployed.
- There is a pilot of the HRMIS, the HR module of GIFMIS on the GHS platform and a number of the challenges listed above continue to hamper some of the HR processes. For example, the CAGD opens the system for processing during a specific period and all institutions log on at the same time to complete their forms. This slows the system down considerably, making simple tasks very laborious.

6.4.5.2 Improve, standardize, and unify health information and other supporting systems

The HFS–IP includes activities that will improve, standardize, and unify health information and other supporting systems and is key to increasing efficiency, ensuring effective operations. Strategy 2.1.7 of NHP

notes that data availability in the health systems is fragmented, unreliable and difficult to access in real time (MOH, 2019). The first step is to strengthen NHIS claims verification and management and accelerate e-claims scale-up. This activity is ongoing, all teaching hospitals are on e-claim. Another step is to assess level of standardized information currently submitted by private providers and develop plans to improve information submission to enhance private sector regulation and comprehensive health sector planning. The NHP indicates that data from other sectors that influence health is not included in the data sets. Additionally, legal and governance frameworks for reporting and data capturing (including from private sector) are issues that need immediate attention.

The following projects have been implemented to standardize and unify health information:

- The eHealth project led by the MOH, provides an interface with other data platforms in the health sector. The interfacing the eHealth platform with other data platforms (DHIMS2, LMIS, Ghana Integrated Financial Management Information System (GIFMIS), DHL) started in 2017. It is expected to be completed by 2019.
- In 2018, teaching hospitals continued the process of developing key performance indicators which will be uploaded on the DHIMs to improve data capture in the sector. The unified Key Performance Indicators will help to harmonize reporting of data to aid peer review performance among TH, and aid in standardized reporting to the Ministry of Health for its monitoring and performance review activities and holistic assessment reporting.
- Development of a 3-year plan to connect all health facilities within the country.

Table 11: Progress on Strengthening PFM

Strategy	Broad Activities	Specific activities initiated since 2015	Progress
11: **Strengthening public finance management (PFM) and information systems supporting health purchasing**	Strengthening PFM at all levels of the system and harmonize with output-based provider payment systems	Improvements in PFM including GIFMIS at all levels. Development of a comprehensive sector PFM plan	A Financial Management Improvement plan has also been developed since 2015 and it is expected to be added to the roadmap to roll out the GIFMIS across all sectors.
		Review Resource Allocation	Proposal ready for discussion
		Conduct hospital costing	Agencies have started doing their costing, which will feed into the tariff review.
		Conduct Health sector PER	This has been completed.
	Improve, standardize and unify to the extent possible health information and other supporting systems.	Continuous strengthening of NHIS claims verification and management and accelerate e-claims scale-up	The NHIA has implemented an electronic claims management system for all teaching and regional hospitals.

	Strengthen regulatory framework and operational procedures to receive standardized information from private providers		HeFRA in collaboration with the Ghana Health Service (GHS licensing of private and other health facilities in accordance with Section 20 of Act 829) is expected to make reporting onto DHIMS2 a condition for all licensed private health facilities.
	Strengthening internal controls within the Health Sector through strong Internal audit presence at all levels that provides assurance, consultancy and advisory services through value addition	Build capacity for Internal Auditors to carry out risk-based audits in procurement, construction and compliance with laws and regulations	Ongoing training needs for auditors completed. Training manual being developed.

6.4.6 Ensuring that health purchasing stimulates desired service delivery and quality improvements

Strategy 12 is ensuring that health purchasing stimulates desired service delivery and quality improvements. Health purchasing can contribute to broader health delivery system restructuring including shifting from a hospital-based to PHC-based system and strengthening PHC and the periphery of the health system especially in rural areas. One of the broad activities was to establish preferred provider networks (PPNs) including CHPS to enable contracting for comprehensive PHC services as part of scaling up the capitation payment system. The following activities have been ongoing as part of efforts to improve service delivery at the periphery:

- The Ministry of Health conducted a comprehensive CHPS verification exercise. The objective of the study is to reposition the CHPS program by ascertaining the functionality, challenges, map up the location of all CHPS infrastructure and help to redefine the zone concept towards the UHC drive (APOW, 2019).
- For the formation of PPP Networks (PPPN) which include CHPS, there is a pilot ongoing in the Volta region. The GHS is keen that for CHPS, the emphasis should be more on prevention and health promotion rather than clinical care. To improve efficiency, financial management should be a requisite for line managers and they must be trained on how to be able to forecast and implement budgetary controls to manage their resources.
- In 2019, the GHS refined its District Health Service Operations (DiSHOP) training modules for district directors and is reintroducing new modules to train district management teams and district hospital management teams The training covers modules on how to set budgets, forecast spending, control, and manage budgets. The training modules are implemented over two-weeks (one week didactic, one-week practical lessons) and are currently being tested in the field. The training under DiSHOP will equip managers with skills to effectively manage administration, logistics and clinical work.
- Recently recruited district directors are being trained on some of these core courses at Sunyani during the week of October 21st. They hope to institutionalize the system, move the training to

the sub-district level but eventually maintain it as a Continuous Professional Development course to be taken on-line and used as part of the appraisal process.

Table 12: Progress on Establishing preferred provider networks (PPNs)

Strategy	Broad Activities	Specific activities initiated since 2015	Progress
12: **Ensuring that health purchasing stimulates desired service delivery and quality improvements**	Establish preferred provider networks (PPNs) including CHPS to enable contracting for comprehensive PHC services in the capitation payment system expansion.	Map providers and formation of PPPNs including CHPS and harmonise provider payment at the community levels	Initially piloted in two districts of the Volta region (with recent expansion to an additional 3) districts) and likely to be scaled up.
	Identify specific desired service delivery improvements and refine health purchasing mechanisms and provider payment system incentives to enable achieving them (e.g. priority programs such as malaria or family planning, strengthening preventive services, improving continuum of care, rational use of drugs, quality assurance and quality improvement)		The GHS has refined its DiSHOP training modules for district directors and is reintroducing it with seven modules to train district management teams and district hospital management teams. Managers are expected to have skills to manage their budgets and manage risks. Adopting the use of the HTA tool to improve efficiency in the health system.
	Increase health facility autonomy and build management capacity at all levels of the health system in general and in the context of decentralization		Appeared in the budget statement but has not been done

6.5 Public/Private Financing Relationship

Strategy 13 contributes to improving relationships and coordination between public and private financing. Ensuring that private financing can fund health services in public providers and public financing can fund health services in private providers helps to level the playing field between public and private provision of health services. The first step is an assessment on whether there are any regulatory barriers for PHC capitation payment contracting with PPPNs including private providers. This process was not initiated with the suspension of the capitation payment mechanism. Another step is to develop plans and activities consistent with these Ghana's private sector strategies but specific to the health sector. Some efforts have been made by the NHIA to engage with the private sector. The NHIA has regular oversight over the PHIs, but the National Insurance Commission (NIC) is also having a re-look at the insurance industry. The NHIA has made sure that all private insurance that were previously registered as mutual but were operating as commercial have all been fully converted to commercial health insurance. PHIs have a requirement for an escrow account which has a specific amount to cover claims if they go out of business. The NHP notes the

need for establishing mutually beneficial public-private partnerships and points to future where mixed service delivery should be encouraged and supported (MOH, 2019).

Table 13: Progress Public/Private Relationships

Strategy	Broad Activities	Specific activities	Progress
13: **Improving relationships and coordination between public and private financing**	Continuously strengthen the regulatory framework for private health insurance and ensure that there are no regulatory barriers to contracting with private providers	An assessment on whether there are any regulatory barriers for PHC capitation payment contracting with PPPNs including private providers.	This assessment was not initiated as the capitation mechanism was suspended. ??
	Develop plans and mechanisms to improve coordination and leverage public and private financing in the context of moving toward UHC.	Develop plans and activities consistent with these Ghana's private sector strategies but specific to the health sector	The NHIA is engaging with the private sector to improve service delivery. NHIA has regular oversight over the private health insurance system (PHIS).

6.6 Monitoring and Evaluation/ Communication Strategy

Improving M&E for all aspects of the Ghana HFS is critical to guide continuous refinement of interventions, institutionalization and increased ownership at all levels of the health system. All four Strategy 14 M&E activities will be implemented in all four HFS phases. The general dynamics will be developing mechanisms in Phase I and strengthening them in Phases II, III, and IV. In addition, it is expected that HFS implementation will create demand for M&E particularly related to further health purchasing improvements (e.g. costing for provider payment system rate-setting, operations research studies). The first step was to develop performance framework and monitoring indicator package for routine HFS monitoring. However, this step was not done as funding was not available to put together a team to produce it. However, the NHA has been institutionalised and regularly conducted to provide the requisite information which feeds into the national budget.

The purpose of the communications strategy was to inform and educate stakeholders, promote health sector results and advocate for resource mobilization, financial risk protection, efficiency gains and quality improvement. The communication strategy was not initiated due to lack of funds to engage a team to roll this out.

Table 14: Progress on Monitoring and Evaluation

Strategy	Broad Activities	Specific activities	Progress
14: **Strengthening monitoring and evaluation (M&E) and monitoring Health Financing Strategy implementation**	Monitoring HFS implementation including development of a performance framework and monitor indicator package, indicator data collection and analysis, and regular indicator results reporting and dissemination through health summits and other forums	Develop performance framework and monitor indicator package for routine HFS monitoring	Not done
	Institutionalize NHA and strengthen expenditure tracking, public expenditure reviews and costing	Institutionalize Health Accounts; develop a unified costing system to improve planning, provider payment rate-setting and facility management (see also Strategy 11) and implementing previously developed plans to institutionalize NHA and related expenditure tracking.	Since 2010, the NHA has been regularly produced. The 2017 NHA is being finalised.
	Design and completion of periodic policy analysis, operational research studies or evaluations to generate evidence for policy dialogue and review	1) using HFS objectives to determine the basis for the analytic agenda; and 2) selection and completion of a health purchasing policy analysis, operations research study or evaluation	Not done
	Strengthen mechanisms for active feedback of M&E information and evidence into next generation policy dialogue	Active development and implementation of plans to generate relevant information and feed it back into policy dialogue	Not done
15: **Develop and implement a communications strategy**	Design and develop a communication strategy to communicate policies, promote health sector results and advocate for health sector priorities to all stakeholders.	Design and develop a communications strategy	Not done
	Implement communications strategy		Not done

7 Conclusion and recommendations

The review covered all 15 strategies identified in the HFS. A number of gaps were discovered and the report draws a number of conclusions and makes recommendations that could improve future health financing strategies. The framework for evaluating the HFS was based on several questions gathered from the background review of similar work conducted in LMICs. Overall, majority of the activities planned for Phases I and II were not achieved due to process and implementation challenges. A summary of the results is presented in Table 15.

Table 15: Summary of process and implementation indicators of the HFS review

Indicators	Process	Comments
1	Was the HFS explicitly linked to broader sector/national strategies and are not stand-alone efforts?	The HFS was narrow in scope, relying mainly on key directorates within the MOH to carry out its primary activities.
2	Was there a broad sense of ownership for the strategy or resistance from stakeholder groups?	There was a sense of detachment from health directorates who perceived they were not directly involved with the HFS formulation.
3	Was the process guided by a multisectoral steering committee?	Active TWG during process of developing the HFS, but committee became absent during implementation.
	Implementation	
4	Was the 2015 Ghana Health Financing Strategy successfully implemented or not?	Progress made across majority of the strategies in Phase I and II was slow, given that most of the activities relied on the scale up of the capitation payment mechanism which was not carried out as expected.
5	How were the costs of the strategy determined?	This was to be determined through the budget-constrained approach of identifying the potentially available resources during the strategy period. However, this process was not followed through with actual cash disbursement for most of the specific activities in the plan.
6	Is there an effective monitoring and evaluation plan?	M&E plan, including indicators, which was meant to act as a feedback loop for dialogue and advocacy of health financing targets was absent.

Generally, the interviews revealed that the HFS was not known by many of the key directorates within the MOH. Some expressed dissatisfaction with the way the plan had been put together without specific inputs from their directorates. They agreed that health financing is critical but then the mandate for effectively implementing the plan should go beyond the MOH. To achieve the vision of the HFS, which is to balance revenue increases with improved expenditure management, policy makers and implementers must include programs and activities that ensure efficiency gains and increase sustainability. Reasonable levels of financing are needed to achieve the desired service delivery and quality improvements. Continuous dialogue between partners about how to improve resource mobilisation, financial management, reduce

waste and inefficiencies to feed into the monitoring and evaluation mechanism did not materialize. Since intersectoral and multisectoral action has a significant impact on health outcomes, stronger and more sustainable financing mechanisms are needed. The review clearly showed that to improve scale-up of many of the pilot health financing activities, incentives across the service delivery interface need to be properly aligned to goals of the HFS. For process and implementation lessons and recommendations, see Table 16.

Table 16: Implementation lessons and recommendations

	Institutions	**Recommendations**
Process lessons		
	MOH/ Other agencies	• Clearly mapped out activities that show the involvement of other key stakeholders. • The parameters should be widened to draw in more stakeholders and make units accountable for specific responsibilities. • The strategy should be all encompassing and must prioritize appropriately, particularly around reducing waste and improving efficiency.
	DPs	• DPs should ensure that strategies and plans are not only formulated but there are funds to support implementation.
Implementation Lessons		
	MOH/Other agencies	• Sustain a technical working group to ensure the effective implementation of the plan. • Strengthening mechanisms for active feedback of M&E information and evidence into next generation policy dialogue. • The M&E Strategy must include broad activities that include the design and completion of periodic policy analysis, operational research studies or evaluations to generate evidence for policy dialogue and review. • Policy makers in ministries of health and other institutions to see the usefulness of interpreting multiyear trends in health financing data
	DPs	• Sustainable financing of projects to ensure activities are carried out and not end up in plans and policy papers. • Helping to ensure transparency and accountability, beefing up reporting systems, supporting transition planning etc.
General lessons	All	• UHC roadmap can become a rallying point for the public, advocates and politicians. • Depoliticise health programs to ensure continuity.

Specific recommendations for the following MMDAs:

Ministry of Health (MOH):

- Greater ownership could be fostered by ensuring a functioning Health Financing Working Group or implementation steering committee that has representation at Directors' level from the key agencies and equivalent levels from other stakeholders, with adequate resources and regular accountability for its performance to the Minister and Chief Director. This group should be able to discuss and coordinate all key health financing activities in the sector and generate the platform to discuss issues that affect partners.
- Strategy 13 contributes to improving relationships and coordination between public and private financing. The strategy direction is to ensure that private financing can fund health services in public providers and public financing can fund health services in private providers helps to level the playing field between public and private provision of health services. However, best practice discourages the use of private financing in favor of public financing for UHC. NHIS aims to use public funds primarily to finance a very generous benefit package, if successful, the room for complementary private financing should be limited.

Ministry of Finance:

- MOF should build close consultation and negotiations with the MOH in order to promote better coordination and alignment with government resources as well as better predictability of future financing.

Ghana Health Service (GHS):

- GHS must be play a more active role in the HFS as it was not featured explicitly as responsible for any of the activities in the HFS. Reduction of overlapping, duplicative or unnecessary services, and improving the continuum of care should be part of the HFS with the GHS playing an active role in meeting these goals.

CHAG/Private medical providers:

- The HFS should be clear on the role of CHAG and private medical providers since they are key stakeholders in the provision of healthcare services.

National Health Insurance (NHIA):

- NHIA needs to address the bottlenecks that have stalled the growth of membership, to enable it increase its membership for the attainment of UHC. It is not clear which model the NHIA is using to change this situation.

HeFRA:

The role of HeFRA as a regulating body to impact on key outcomes such as timely reimbursements to the NHIA should be enhanced to ensure adequacy and standard of health care provided.

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9 Annex

10.1 List of Key informants

	Name	Title	Organization
1	Mr. Kwakye Kontor	Director, Budget	MOH
2	Mr. Dan Degbetse	Director, Monitoring and Evaluation	MOH
3	Dr. Kwesi Asibiri	Director, Human Resources for Health	MOH
4	Dr. Gyansah-Lutterodt	Director, Technical Coordination	MOH
5	Mr. Ayindingo Azubila	Financial Controller	MOH
6	Mr. Sam Boateng	Dep. Financial Controller	MOH
7	Dr. Emmanuel Odame	Director, PPME	MOH
8	Mrs. Evelyn Arthur	Director, Budget	MOF
9	Mr. Ernest Owusu Sekyere	Budget Office - Health desk	MOF
10	Mr. Ben Nkansah	Director Infrastructure	MOH
11	Mr. Nicholas Gyabaah	Unit head, Resource mobilisation - multilateral	MOH
12	Dr. Maureen Martey	Unit head, Resource mobilisation - bilateral	MOH
13	Dr. Lydia Dsane-Selby	CEO	NHIA
14	Dr. Nsiah Asare	DG	GHS
15	Mr. Sam Ampoma	Director, Health Information Systems	MOH

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1. Ministry of Health (2015) Health Financing Strategy
2. Ministry of Health (2015) Health Financing Strategy Implementation Plan
3. Ministry of Health (2019) National Health Policy (Draft)
4. Ministry of Health (2018) Final Draft of the Holistic Assessment Report
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