



# GHANA'S ROADMAP FOR ATTAINING UNIVERSAL HEALTH COVERAGE 2020 - 2030

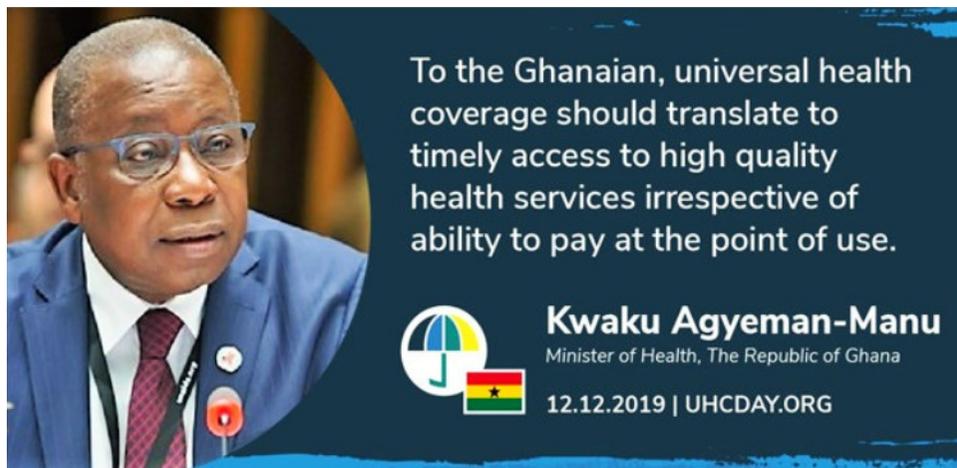


Ministry of Health



**MINISTRY OF HEALTH**  
ACCRA, GHANA

## FOREWORD



This UHC roadmap is the commitment of the government and people of Ghana to shape the future of health care in Ghana. We have reflected carefully on the Sustainable Development Goals, Global Action Plan for Healthy Lives and Well Being, Declaration on Primary Health Care in Astana (2018), UHC 2030 Compact, initiatives of UHC 2030 and the Political Declaration of UHC adopted at the UN High Level Meeting in September 2019. These provide us with a clear framework for action. Through broad based consultations and consensus building with various stakeholders, civil society, private sector and development partners, a set of priority services and interventions have been agreed to be made universally accessible to all persons living in Ghana. We believe that these actions will serve as a catalyst to transforming our health systems, efficiently mobilize and apply domestic resources to need; and strategically leverage partners resources for long term sustainability.

The UHC roadmap takes inspiration from the National Health Policy and sets the strategic direction for the health sector in the next 10 years. It also emphasizes health in all policies with the aim to stir action in other sectors for health and Human Capital Development as articulated in the National Health Policy. We are committed to achieving a critical set of goals, targets and milestones by 2030. These are ambitious but hopeful and achievable targets. We urge all stakeholders and partners to align their programs and harmonize their financing towards the implementation of this roadmap.

  
Hon. Kwaku Agyeman Manu  
Minister of Health  
January 2020

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# 1. Policy direction



## 1.1 Context

Ghana is committed to attaining the Sustainable Development Goal Declaration, principles of the African Union Agenda 2063, Global Action Plan for Healthy Lives and Well Being, Declaration on Primary Health Care in Astana (2018), UHC 2030 Compact, initiatives of UHC 2030 and the Political Declaration of UHC adopted at the UN High Level Meeting in September 2019. At the heart of this are the principles of human rights, equity, gender and people-centered approaches.

The country over the years has undergone several health sector reforms aimed to improve health outcomes. The current National Health Policy (2019) emphasizes systems strengthening, improving service availability for the population through community health services and expansion of public health interventions. A social health insurance scheme was also introduced to ameliorate catastrophic expenditure particularly for the poor and vulnerable. A detailed context is provided in annex 1. This roadmap further deepens the reach and scope of previous interventions while improving access and quality of services provided.

### i. Vision

Ghana defines UHC as: **“All people in Ghana have timely access to high quality health services irrespective of ability to pay at the point of use.”**

### ii. Goal

Increased access to quality essential health care and population-based services for all by 2030.

### iii. Objectives

- a. Universal access to better and efficiently managed quality health care services
- b. Reduce unnecessary maternal, adolescent and child deaths and disabilities
- c. Increase access to responsive clinical and public health emergency services

## 1.2. Guiding principle

The needs of the health sector are many and multi-faceted, but resources are limited. This requires that choices are made to leverage investments into essential services, key interventions and systems that target scalable high impact, high multiplier areas to deliver value. The actions will catalyze change and scale up access to essential nutrition, health promotion interventions, smart curative care, disease prevention, palliative, rehabilitative, emergency care and mental health services.

Primary health care is the level of emphasis. Systems would be put in place to enhance access to specialized care. The value proposition follows a five-point guiding principle:

- Target group: Focusing on the poor and vulnerable; particularly children and adolescents, women, and the aged.
- Financial risk protection: Eliminating physical and financial barriers to accessing PHC services; especially those most at risk of incurring adverse health expenditure at the incidence of ill health.
- Strategic Partnerships: Build sustainable partnership and a harmonized agenda between government, private sector, non-state actors and development partners to upscale service delivery and secure predictable financing for long-term results.
- Effective Decentralized Management: Cement district level service governance with the district assemblies and improve intersectoral collaboration to synergize resource mobilization, efficient use and accountability particularly at the PHC levels of service delivery.
- Domestic Financing Re-Prioritized: Rationalize allocation and expenditure of domestic resources to focus on primary health care and manage existing and any new co-financing requirements within a realistic budgetary framework.

## 2. Context of the PHC system



### 2.1. Strengths and opportunities

The structure of the primary health care (PHC) system is as in figure 1. Maternal, child health and nutrition services constitute the largest proportion of the PHC package. Non-communicable diseases, mental health services, preparedness, response and management of all types of emergencies including road traffic accidents, clinical and public

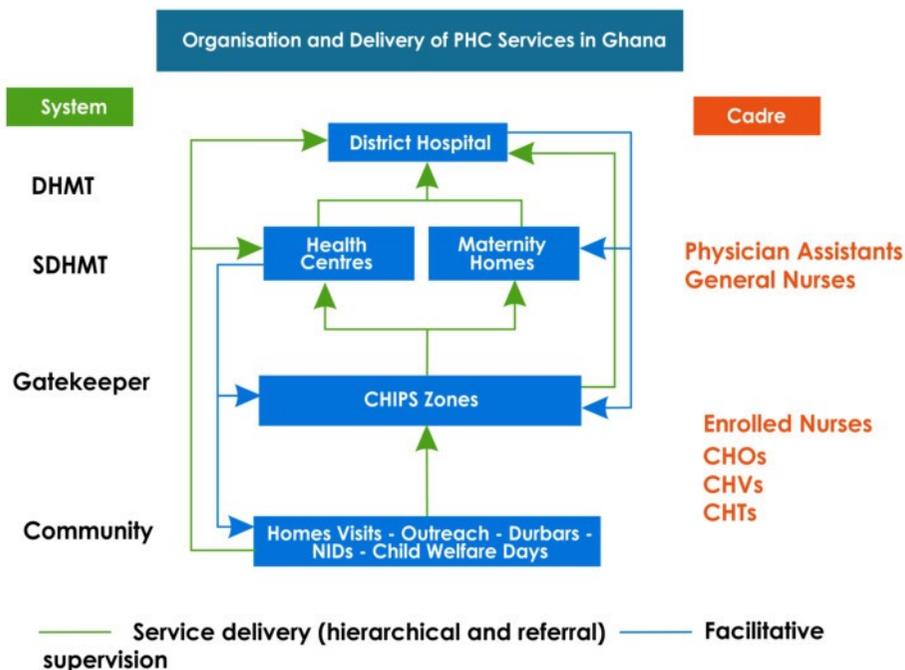


Fig. 1: PHC System

health emergencies and issues related to natural disasters and floods are emphasized. There is significant potential to increase the proportional contribution of PHC to service delivery over the next ten years. In 2018, all immunization services, 52% of skilled deliveries and 53% of 1<sup>st</sup> antenatal care visits are conducted at the primary level. Women receiving postnatal care within 48 hours provided was 34%.

## 2.2 Challenges

Access to services by the population is uneven. Service availability and quality of care is generally below expectation as shown in figure 2. Avoidable institutional maternal and newborn deaths continue to be of concern. While DPT3 coverage is over 95%, other vaccination coverages could be better. While prevalence is low, progress in pediatric HIV and AIDs response is modest. Tuberculosis case detection is low. Micronutrient deficiencies resulting in anemia and obesity in children (stunting 8%) and in pregnant women puts them at risks of death. Under-nutrition negatively affect the growth and cognitive capacity of children. There is observed increase in non-communicable diseases particularly for hypertension and diabetes among the general population. There is insufficient and inappropriate staff mix at the primary level disproportionately affecting the deprived districts.

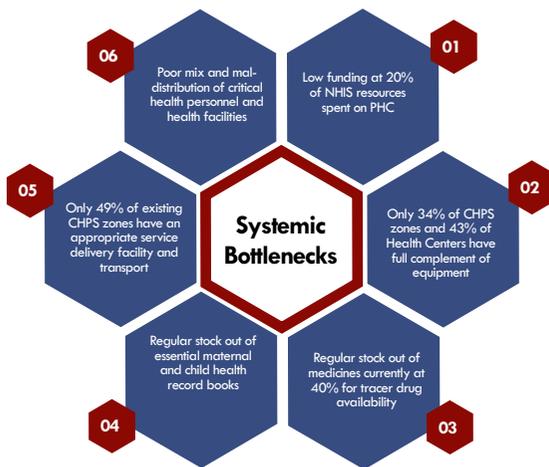


Fig. 2: Systemic Bottlenecks

Basic infrastructure and equipment is not available in over 50% of primary level facilities. The role of procuring commodities used in primary health facilities is splintered across several entities affecting coordination of medicines supply. Framework contracting is being piloted as one of the possible solutions to shortages in basic medicines.

Government non-wage budgetary allocation to health other than NHIS and total budget as a percentage of GDP has reduced significantly. The national health insurance scheme

currently covers only 36% of the population in 2018; a decline from 2016. This means over 64% of the population are exposed to out of pocket expenditure or are simply not accessing normative care.

Direct service delivery expenditure mainly comes from the National Health Insurance Scheme which constitute 80% of all payment of services. Seventy-nine (79) percent is spent on secondary and tertiary care. Primary health care only constitutes 21% of the insurance scheme's expenditure. There are irregular payments of claims. Primary level operating was capital of approximately \*GHC 357 million in 2018 of which 48% were held in NHIS debt. When open market creditors are accounted for, the primary level will record a negative balance of \*GHC 58 million. This is due to unpaid debt owed to suppliers.

Most public health interventions had significant financing input from development partners. Financing was stable until recently when several development partners began transitioning out with change in development status of the country as an LMIC. It is estimated that Ghana will need an average of US\$350 million annually to fund its vaccine and other commodity commitments in co-payments and transition out of arrangements by 2027. Vitamin A and folic Iodates have occasionally run out since donor support seized. Supply of family planning commodities have also reduced significantly. The country introduced framework contracts for the supply of some essential medicines. Implementation has had some difficulties.



## 3. Priority interventions



There is growing recognition of the value of innovation in accelerating progress towards quality universal health coverage. This requires the adoption of bold and innovative service delivery models and health technologies; and employing new ways of thinking in delivering essential services of good quality.

### 3.1 Essential services for the population

- Optimizing the basic essential services:

The basic universal services is as in box 1 below. This roadmap recognizes the importance of all services. It however places greater emphasis on interventions that needed to be consolidated, scaled up and to attain universal health coverage.

Box 1 Essential universal services		
Primary services	Preventive services	Rehabilitative services
All out patient care; birth deliveries and attendance; newborn care; acute respiratory tract infection, diarrheal disease, skin disease and ulcers, hypertension, sickle cell, rheumatism, anemia, intestinal worms disorders, fevers; ear, eye, nose and oral health services; diabetes mellitus; mental health, STIs including HIV/AIDS, asthma, cervical and breast cancer treatment; diagnostic and laboratory services; surgeries; fistula management, caesarean sections and management; blood and blood products	Growth monitoring, dietary supplement, immunization; mass residual spraying, chemotherapy and chemoprophylaxis including for helminths and vector borne diseases; screenings for cancers, HIV/AIDS, PMTCT, TB, sickle cell, hypertension and diabetes; family planning, antenatal and post-natal care, IPT for malaria in pregnancy, availability of water, sanitation and hygiene services	Optical aids, hearing aids, orthopedic aids, physiotherapy, dentures, geriatric care, pediatric cardio enablers, speech and language therapy; birth, burns and accidents reconstructive surgery; post-trauma and psychological therapy and counseling
Specialized and emergency services	Promotive services	Palliative services
Mental health; poisons, injuries, burns and pre-and-in hospital emergencies; incision and drainage of abscesses, and excision of lumps and hemorrhoidectomy; child cardiological and congenital surgeries; fistula management, cervical and prostate cancer case management; caesarean sections and management; blood and blood products	Control of use of alcohol, tobacco and harmful substances; awareness on: regular medical check-ups, mental health, cancers, diabetes, renal disease, safe sex, STIs and family planning, road safety, healthy eating, physical activity and wellbeing, gender-based violence, hygiene and sanitation and environmental safety	Home-based care of the aged; terminal point care

Maternal, child and adolescent health services will be made universally available at all levels of service delivery. Malaria, Tuberculosis, HIV/AIDS, antenatal, postnatal, skill birth attendance, immunization, neonatal care, diabetes, hypertension and mental health services will be deepened. Dietary deficiency related conditions including under-nutrition, anemia, obesity and micronutrient deficiencies will be given adequate attention at the primary level. Efforts will be made to reduce gender related socio-cultural barriers to access including stigma, abuse of patient confidentiality and rights. In addition, sickle cell, cervical and breast cancers in women and children, prostate cancer, congenital conditions in children, factors contributing to deformities and disabilities in children including club foot, cleft lips and pallets will be universally available at all levels. Palliative and rehabilitative care has also been identified as important areas for further development.

Care of the aged will be integrated into home-based and primary health care. In Ghana old age is itself a cause of vulnerability due to limited financial protection and limited services. This roadmap recognizes the potential of cognitive and physical decline at this stage of life. For example, impairment arising from Alzheimer's disease and other forms of dementia are more likely in later life, with important implications for financial inclusion. There is also a unique problem of gender or geographical location that impact older persons. Specific products, services and financial incentives will be developed to promote elderly care.

Most communicable diseases are linked to water and sanitation. Inadequate access to these amenities is of public health concern. Emphasis will be laid on working across sectors to ensure access to regular supply of portable water, toilet, waste disposal and sanitation facilities in communities, health, workplace and education facilities as part of infrastructure development.

- *Child and Adolescent Centered School Health:*

School-Based Infirmaries (SBIs) will become an important point of access to health care for children and young adolescents. SBIs reduce barriers to care such as cost to the patient, access, missed work for parents/guardians, and transportation. Adolescents who utilize SBIs have been found to have increased rates of preventive visits and immunizations, improved chronic disease management outcomes for asthma, obesity, and mental health care, and

decreased health care costs. Every primary and junior secondary school within one-kilometer radius will have an SBI located in a designated school to serve the student population. Every senior high school and tertiary institution will be required to establish an SBI located on their campuses. These SBI will be managed by qualified professional registered nurses. An appropriate service package will be defined. Every student on holiday will be given short medical record reports to take with them during holidays to ensure continuum of care.

- *Workplace centered healthcare:*

Every workplace or places co-located within one-kilometer radius will collaborate to establish a Work Place Infirmary (WPI) to serve its employees. Every permanent market place in urban and peri-urban areas will be required to establish Market Place Health Centers (WPHCs). These WPIs and WPHCs will be managed by qualified professional registered nurses. Government will sign partnership agreements with the private sector for its establishment and management.

- *Organization of Services as networks:*

Community health services has led to significant outcomes and will continue to be emphasized as the foundation of primary health care. Homebased care, outreach services and community participation in the delivery and governance of service will be re-enforced. The roadmap ensures optimal access to PHC services through a systematic development of facilities at four levels to promote continuum of care and enhance quality and availability. CHPS Compounds (Level “A” Health Centers) for a minimum of 1,500 population operating as part of a CHPS zone coterminous with electoral wards. Level “B” Health Centers will either be built or existing facilities up-graded to cater for populations of 2500 and above. For every 5,000 population a Level “C” Health Center will be provided. The policy of one district hospital in every district will also continue. The district hospital will be designated as the lead facility for the oversight, coordination and supervision of all clinical services provision in the district. Public health services will be integral to all PHC service delivery.

All SBI, WPI, WPHCs, CHPS, Health Centers and District Hospitals will be drawn together

as networks of practice at the district level. The district hospital will be the Coordinating Hub to which these are linked as satellite facilities. The network will enable adherence to enforce quality standards; optimize use of resources, available staff and skills mix, support professional development, strengthen primary level referral system for continuum of care. . A performance-based financing mechanism will underpin the management incentive system to reinforce efficiency in common and shared resource use, quality of care and standards; data management for measurement, transparency and accountability.

## **3.2. Management of clinical and public health emergencies**

### **Clinical emergencies management:**

Road traffic accidents, poisons and domestic accidents have been on the increase recently. There is also the continuing need to transfer patients requiring critical care to hospitals. The system of pre-hospital and hospital emergency care will be strengthened. Hospital beds and mass casualty management system will be improved. All facilities from health center level C and above will be supported to build capacity for handling emergencies and equipped with a functional emergency reception and management system appropriate to the level. District Emergency Command and Call Centers will be established under a system of bundled development with the Fire Service, Ambulance, National Disaster Management Organization (NADMO) and Police Service. These might require some infrastructure upgrades. Additional ambulances will be deployed to improve availability of services. Adequate staffing, capacity building and essential equipment will be provided for paramedics. The private and non-state sector will be encouraged to participate in the provision of pre-hospital and clinical emergency care service provision.

### **Emergency preparedness and response:**

The Ebola crises in Africa demonstrated the urgent need to strengthen systems for health security. Joint External Evaluation (2017) shows that there is no national policy and strategy defining structures, roles and responsibilities. The National Action Plan for Health Security has been drafted aimed to prevent avoidable epidemics; detect disease outbreaks; establish a system for multisectoral responses; establish and sustain capacity for effective public health response at the points of entry; and develop and maintain core capacities for chemical and radio-nuclear emergencies and events. The animal and public health disease surveillance, control, elimination and eradication will be strengthened especially at the primary health care level. The Ghana Center for Disease Control will be

established with a fully functional emergency operations system in place. The GCDC will also have a training center made available for sub-regional training. A national infectious diseases treatment center will also be completed. A strong information technology hub will buttress a series of protocols to create a seamless network of facilities including laboratories to form the ecosystem of the CDC. Community surveillance will be strengthened and integrated into community health services and district public health management systems. Three Field Coordinating Centers will also be completed during the period. Ghana will aim to have all its emergency preparedness and response treatment, laboratory and field coordinating centers accredited on international ISO standards and become a regional hub.

### **Eliminate earmarked diseases:**

Onchocerciasis, yaws, yellow fever, schistosomiasis and other soil transmitted helminths will be targeted for elimination. Polio, Lymphatic Filariasis, Trachoma and Measles will be put under high surveillance to ensure there is no recrudescence of disease. Outbreaks of cholera and meningitis will also be controlled to levels where they will no longer be diseases of public health concern.

## **3.3 Improve quality of care and information management**

### **Improve quality of care:**

To promote service quality, a focused approach as in Fig. 3 will guide implementation. The government will develop an overarching national framework for continuing total quality of care improvement that harmonizes the tools and process among various regulatory bodies. A more systematic approach will be introduced for (i) facility-based assessment of entry-level quality; (ii) the preparation of a facility-specific Quality Improvement Plan (QIP); (iii) the implementation of the QIP through supervision/quality counseling; and (iv) the development of harmonized monitoring tools. Emphasis will be placed on accurate diagnosis and treatment protocols. Rational medicines prescription and use will be strengthened. An active program to contain Anti-Microbial Resistance (AMR) will be implemented to stem microbial resistance and anti-biotic abuse. Patient and client satisfaction surveys will be undertaken to inform the development of people centered care standards.



Fig. 3: Quality Assurance Framework

**Upgrade infrastructure and provide essential medicines:**

All facilities will receive standard level renovation (limited structural repair and painting and modernization) and receive a new standardized Service Delivery Kit (SDK) made up of essential primary healthcare equipment and technology. Vaccine fridges, Laptops, desktop computer, motorbikes, pick-up vehicles, OPD furnishing and combined printer will be part of this SDK appropriate to the level. All primary health care levels will be re-stocked with essential tracer drugs equivalent to three months of their medicine and non-drug consumables requirement. This will also serve as a re-capitalization process following years of indebtedness and stockouts. Vaccines, nutrition supplements and family planning commodities will be secured. To ensure appropriateness and value for money a national system of Health Technologies Assessment (HTA) and a workplan will be institutionalized. Its structures and implementation framework will be determined through consensus among various stakeholders.

### **Reform supply chain management:**

The Logistics Management Information System (LMIS), which supports quantification and planning, ordering and tracking medicines through the supply chain, will be strengthened throughout the PHC system linked to the regional and central medical stores. The aim is to improve the visibility of stocks and consumption at facility level. The Central Medical Stores will be re-organized into an agency responsible for medicines and commodities security, management and availability in both the public and private sector. All the regional and district medical stores will be assigned to it for direct responsibility. The agency will also manage the Last Mile Distribution System and its related LMIS. This will improve strategic purchasing and management of the framework contracting system. It will ensure end-to-end visibility of stocks and movement of goods through the supply chain from suppliers to health facilities. This will also optimize quantification, ordering, buffer stocks and availability of medicines and commodities at the point of dispensing to the patient.

### **Strengthen data and digital health:**

Data on deaths and births will be strengthened through investment in Civil Registration and Vital Statistics (CRVS) systems. This will include the development of e-registry. The patient/client registers and medical record books will be harmonized, digitalized, and the systems integrated to improve efficiency, reduce cost and impact on the environment. Private health sector data will be better integrated into routine information systems. A digital map with health facilities, services and professionals available will be developed, maintained and made easily accessible to the general public. Disruptive health digital innovations aimed at empowering health workers and enriching work content will be adopted. Mobile and portable devices will be integral to this approach. An enterprise architecture for the health sector will be developed and implemented. Software, hardware and information and communication technologies for diagnostics and information processing will be rationalized through standards adoption for consistency and ease of integration.

## **3.4 Enhanced efficiency in HR performance**

Several bold reforms will be undertaken in human resource for health development. The actual design and pace of reforms will be determined and implemented through extensive consultation with all stakeholders, professional associations and regulatory bodies.

### **Rational HRH production:**

Human resource development will emphasize production for primary health care. The MOH, professional regulatory bodies and Ministry of Education will work together to implement a series of far reaching reforms. The teams will work together to enable the regulators and universities introduce co-host standardized examinations to reduce the burden on students and improve quality of products. Most professionals training will be integrated into mainstream tertiary academic education to align certification and licensing. This will allow health professional qualifications to be aligned with the upgrades taking place in technical polytechnics while retaining professional integrity. All government training institutions will rationalize and upgrade their professional certificates to 4-year professional bachelor's degrees. Production of some selected health personnel categories will be systematically phased out. This however will not preclude the training of auxiliary level staff at shorter duration for non-core but essential services in collaboration and partnership with the private sector using memorandum of understandings.

### **Equitable HRH distribution and decentralized management:**

Management of health professionals' training allowances, recruitment and salaries of all categories of nurses, midwives and physician assistants will be decentralized to the district level based on approved staffing norms and projected needs. Promotions will be based on vacancies at districts and in facilities. A system will be put in place to ensure a harmonized grading of health workers in both public and private facilities. There will be positive location allowances indexed to deprived sub-districts and CHPS zones salaries. The sector will actively promote professional migration for work abroad through a regulated system. Deprived area service rotations will be linked to opportunities for managed Africa regional and diaspora service postings and placements.

### **Systematic HRH professional development:**

Universities will be encouraged to introduce masters and specialist programs in family health, oral health, critical care, geriatric care and eye health to fill the existing gaps and for the placement abroad program. These courses in addition to all previous study leaves will be run on short annual academic calendar modular leaves supported by distance learning to reduce the absence time from active duty. The training of Family Medicine Specialists will be prioritized to gradually take over the District Hospitals.

As part of staff development to meet the new goals and aspirations, deliberate and planned sabbaticals for academic development will be introduced. A masters' level qualification in public health, epidemiology, economics, finance or planning and management will be required as compulsory for all heads of the primary health teams in the districts. Scholarships will be introduced in collaboration with the Scholarship Secretariat targeted at developing PhD level nursing and physician assistants' lecturers to guarantee quality of teaching in collaboration with universities and the training institutions. Preference will be given to professionals from same cadre teaching same professional students.

### **3.5 Institutional reforms for sector effectiveness**

#### **Stewardship:**

The Ministry of health stewardship functions particularly for policy development and coordination of the health sector will be enhanced. A division for Intersectoral Collaboration will be established to focus on social determinants of health and promote health in all policies. A Health Financing and Economics Unit will also be established to focus on external and domestic resource mobilization, coordination and expenditure tracking. The technical coordinating functions of the MOH will be strengthened.

#### **Public service provision:**

The Ghana Health Service and Teaching Hospitals Act 525, 1996 will be amended to reflect changing trends. The GHS will be more agile under a decentralization framework in line with the reforms envisaged for primary health organization of services to the district assemblies. The Service focus on clinical standards, protocols and issuing of service guidelines for all service providers in the public, private and non-state sector. It will have an enforcing mandate under a new regulation for these standards. The governance, management and operations systems and niche area of the specialist secondary, tertiary and quart-level care hospitals will be redefined to meet the needs for highly specialized care. The aim will be to increase their decentralization, authority and efficiency for resource mobilization, use and decision-making.

### **Regulation:**

The functions of the Health Facilities Regulatory Agency, the National Health Insurance Authority, the Pharmacy Council and the Health Professionals Regulatory Bodies with respect to professionals and facilities licensing, accreditation and credentialing will be harmonized under a common legislative, regulatory and institutional framework. Some institutions such as the Food and Drugs Authority will be encouraged to become autonomous. This will aim to improve efficiency in health sector regulation and reduce transaction cost to clients. Regulation of the private health insurance industry will be delinked from the NHIA to promote its growth and efficiency. A reorganized market framework will be developed to enable the private health insurance market to provide augmented and enhanced insurance for the better wealth quintiles; and essential back up insurance for the population.

### **Purchasing:**

After 15 years of operation the National Health Insurance Scheme is undergoing reforms and achieved significant results. A business and sustainability plan will be developed and implemented looking at the operations and governance efficiency and fiscal resource management. The NHIA has already initiated reforms in the area of membership renewal, benefit package, medicines rationalization and the review of payment mechanisms. This will be further developed in the context of the broader reforms articulated in this roadmap. The information management systems particularly for enrollment, claims and payments under the NHIS will be reformed and integrated onto a single platform to ensure smooth operations management linked with the wider national and service provider data systems. The membership registration and management system will be made simpler and efficient with a technology overhaul. The fund management framework will be independently reviewed to address the issue of delayed releases of funds for payment of claims. The health insurance market will be reassessed to enable the NHIA focus on securing essential health care services for the poor and the vulnerable.

### **Non-State Actors:**

A policy, regulatory framework and action plan for defining and promoting collaboration and partnerships with non-state actors including civil society organizations and private sector will be developed. This is aimed at easing the doing business environment and

promote investments and growth in the non-state sector. To this end, a Chamber of Non-State Health Actors will be established to legalize their coordination platform, strengthen

their capacity and promote self-regulation. This will make them attractive for funding by government and donors and promote a systematic development of the non-state health industry. A deliberate effort will be made to crowd in additional financial and management resources through increased public-private partnerships and investments in this area. Where feasible cooperation agreements will be signed with civil society organizations and private hospitals to establish and manage public health, primary and specialist care on behalf of the public sector. The traditional medicine sector will also be reformed to improve its quality of products and services, marketability and integration into main health service.

### **3.6 Health policy, financing and systems strengthening**

#### **Develop evidence-based policies and plans:**

The health in all policies approach will be adopted. This will require additional evidence, policies and guidelines for effective implementation. Key areas will include evidence on needs and costing of inputs to be provided. A primary health care policy and essential package framework to include schools, workplaces and markets will be developed. Specific documents on human resources decentralization policy, Health Technologies Assessments, a policy on water, sanitation and hygiene including in health facilities and a framework for private management of publicly funded facilities will also be produced. A comprehensive ten-year sector investment case or UHC Prioritized Operational Plan and Cost (UHC/POPC) will be developed. This will be complemented by a glossary of technical assistants for the POPC implementation and essential evidence for policy. A national health research agenda will also be developed and funded by various partners. Academia, expert consultant and research institutions will play a key role in its implementation.

#### **Domestic Resource Use and Mobilization (DRUM):**

Financing is a major challenge. The strategy is to mobilize the equivalent of at least US\$ 7 billion over 10 years in non-wage-resources including GDP allocation. The government will work towards allocating at least an additional one (1) percent of GDP to primary health care and seek additional sources of financing. Emphasis will be placed on optimizing fiscal

allocation and use. The National Health Insurance Scheme financing framework and management will undergo reforms to improve its efficiency. The NHIS will prioritize primary health care and allocate at least 50% of its resources to fund PHC expenditure.

All primary healthcare facilities will have their operations debts paid off and recapitalized using a fundholding approach. These funds will be considered operational credits based on signed performance agreements and ensuring long term financial sustainability. The Ministry of Finance has developed a plan to roll out the Ghana Integrated Financial Information Management System (GIFMIS). The health sector will build on this to introduce an effective Public Financial Management (PFM) system which will be rolled out in all public institutions and facilities at all levels.

### **Strategic donor funds and credits use:**

The health sector over the years had been co-funded by development partners. Donor finances were stable until recently when several development partners began transitioning out with change in development status of the country as an LMIC. Grants and credits will be contracted more strategically based on the development of 5-year health sector medium-term plans. Unsolicited technical assistance and assistance not directly linked to advancing the roadmap agenda will be discouraged.

In aid and development partner management, the principles of the Paris Declaration and the Global Action Plan for Healthy Lives and Wellbeing for All will be followed. All development partners will sign up to a compact in which government and development partners will agree a mutual framework for engagement, acceleration, alignment and accountability. This will serve as a management arrangement and a commitment note to reduce fragmentation, improve resource pooling, matching and predictability. Partners will be required to align their resources with each other and with government through models of co-financing or parallel co-financing arrangements. The aim is to improve synergies. There will be de-emphasis of commercial loans. A commodities, medicines, supplements and vaccine phase-in/phase-out and sustainability framework agreement will be renegotiated with relevant partners and the private sector to improve long term sustainability. A deliberate attempt will be made to crowd in private sector investments and capital.

## 4. Results framework



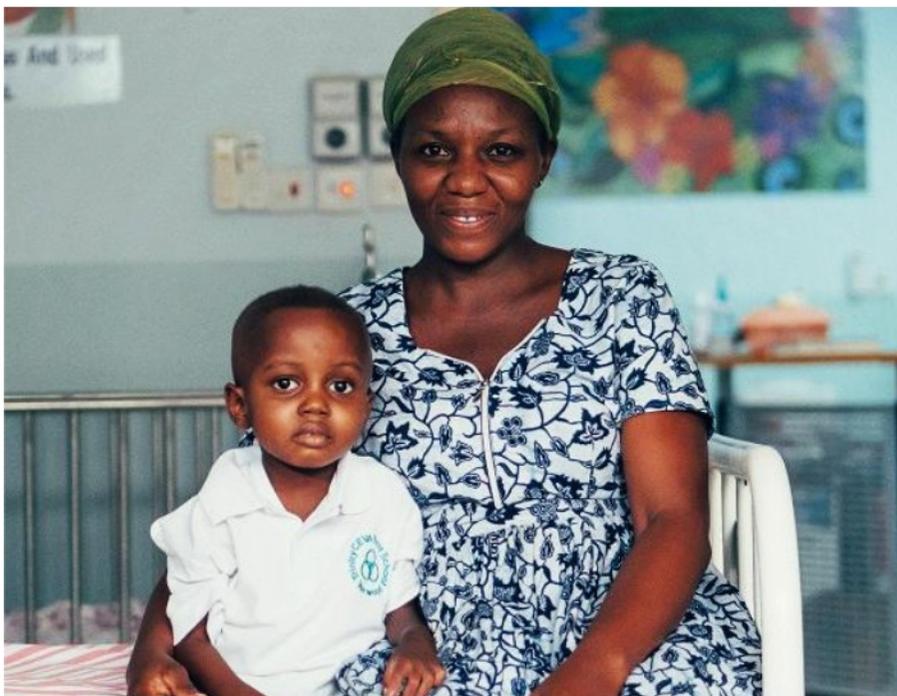
Measuring progress toward attaining UHC in Ghana is leveraged on the existing national and global platforms for measurement, data collection and analysis. This includes the UHC in Africa: A Framework for Action; the Astana Declaration framework and the health-related Sustainable Development Goals targets and indicators.

The overall goal is ***to attain at least 80% coverage of Ghanaians having access to essential health services***. The broad targets are:

- Attain 100 percent health insurance coverage for primary level services
- Reduce maternal mortality ratio by two-thirds over 2017 figures
- Reduce by three-quarters neonatal, child and adolescent disabilities
- Reduce new born, infant and child mortality rates by half over 2017 figures
- Reduce by one-third pre-mature mortality from non-communicable diseases and mental health
- Functional clinical emergency centers in all health facilities
- Reduce occurrence, morbidity and mortality associated with disease outbreaks by half

These twenty-eight (28) indicators are not exhaustive but form the proxies for measuring progress in implementation of the roadmap. All indicators will be disaggregated to account for their equity efficiency ratios by geographical area, income group, educational level, age, gender and vulnerability analysis. The baseline and targets will be defined in various strategic and operational plans. A monitoring and evaluation framework will be developed to include both quantitative and qualitative reviews of all indicators. It will acknowledge the multi-dimensions of curative, preventive, palliative, rehabilitative and emergency care.

Health Status	Nutrition Status	Health and related Services	Health systems and financing
<ul style="list-style-type: none"> <li>• Maternal mortality rate</li> <li>• Under - 5 mortality rate</li> <li>• New born mortality rate</li> <li>• Teenage pregnancy rate</li> <li>• Total fertility rate</li> <li>• Ratio of premature mortality from non-communicable diseases including mental health</li> </ul>	<ul style="list-style-type: none"> <li>• Prevalence of anemia among children of school going age</li> <li>• Prevalence of stunting among children under 5</li> <li>• Prevalence of moderate to severe wasting among children under 5</li> <li>• Obesity in adult population- ages 24-60</li> <li>• Prevalence of type 2 diabetes in children and adolescents</li> <li>• Prevalence of hypertension in persons less than 60 years</li> <li>• Prevalence of mental health among women and young adults</li> </ul>	<ul style="list-style-type: none"> <li>• Ratio of children born free to HIV positive mothers</li> <li>• TB treatment success and cure rate</li> <li>• Total immunization coverage ratio</li> <li>• Malaria prevalence as ratio of total OPD cases</li> <li>• Skilled attendance ratio</li> <li>• Modern Contraceptive Use ratio</li> <li>• Ratio injuries and deaths from road traffic accident</li> <li>• Ratio essential medicines available</li> <li>• Prevalence of onchocerciasis and soil transmitted helminthiasis</li> </ul>	<ul style="list-style-type: none"> <li>• Ratio of facilities (care and diagnostic in public and non-state sectors) with entry point licenses</li> <li>• Ratio of NHIF spent on PHC level and the UHC essential package of services</li> <li>• Health expenditure per capita financed from domestic sources</li> <li>• Ratio of government health expenditure to total government expenditure</li> <li>• Percent of current health expenditure devoted to primary health care</li> <li>• Incidence of financial catastrophe due to out-of-pocket payments</li> </ul>



## Annex 1: The political economy and health

- Ghana is a politically, economically, ethnically and demographically diverse but stable country. The country attained lower middle-income (LMIC) status in 2010, owing largely to the discovery and production of oil in commercial quantities. Per capita Gross National Income (GNI) grew by 85% rising from US\$400 in 1990 to US\$1,380 in 2016. During the same period, the average per capita GNI growth for Sub-Saharan Africa (SSA) and LMICs declined by 46% and 28% respectively. The development dynamic shows that recent growth has not translated to higher wellbeing.
- Quality jobs including in the health sector, particularly for young people remain scarce and structural transformation may be hard to achieve without improving productivity. Many factors contribute to this. The Non-food inflation rate, driven by high import mark-ups and the volatility of the Ghanaian Cedi (which cumulatively depreciated by 8% in 2019 (Bank of Ghana, 2019) contributed to high inflation rate. Inflation averaged around 16% annually between 2005 and 2017. Average food inflation rate for the same period was 8.9% end 2018 and 9.1% in June 2019. The human development indicators have been improving steadily over the past two decades. The Human Capital Index (HCI) for Ghana is 0.44. Even though this is four points higher than the average for Sub-Saharan Africa (SSA) of 0.40, it falls short of the average for Lower Middle-Income Countries (LMICs) of 0.48. About 72% of the population above 15 years have access to basic education of at least 12 years. Approximately 86% of the population have access to improved drinking water of which 92% is urban and 80% is rural. However, sanitation facilities remain a challenge at 14% of the population: 18.8% for urban and 7.7% for rural. Approximately 34% of children aged 5-14 years are engaged in some form of child labour (GSS, 2016b, 2019).
- Ghana's average Life Expectancy at birth is 62.7 years. In 2017 total fertility rate is 3.9 children per woman. The population growth rate is 2.2% reaching an estimated 30 million at end of 2018. About 50.7% are male and 49.3% female. Those aged 0 – 4 and 5 – 24 constitute 23.3% and 38.3% of the population. The other age groups include: 25 – 49 (27.8%), 50 – 64 (7.8%) and 65+ (2.8%). The density is about 133 per square kilometer. The number of poor individuals reduced from 50% to 23.4% and extremely poor from 37% to 8.2% between 1990 and 2017 with

some regions experiencing worsening poverty (GSS, 2018). The origins of economic and social inequality remain between the north and south of Ghana due to: (i) geography - the lower rainfall, savannah vegetation, and remote and inaccessible location of much of the north and the Volta region; and (ii) historical legacies of inequality has hampered development.

- The proportion of married women using a modern contraceptive was 25% (GMHS 2017). Antenatal care for at least one visit was 97%. Maternal mortality rate was 310 deaths per 100,000 live births, contributing 12% of deaths among women. Infant mortality and Under 5 mortality were 41 deaths and 56 deaths per 1000 live births respectively. The main causes of death are hemorrhage and septicemia.
- The proportion of children aged 12-23 months who received all basic vaccinations increased significantly (GSS, 2016c). This improvement is credited to the prioritization of community-level proactive service delivery and the expansion of home visits and community outreach activities. The main causes of ill-health among children are Acute Respiratory Infections, diarrhoeal diseases, malaria and anaemia particularly due to complications from worm infestations. About 13% of children are underweight with 7% classified wasting, or with acute malnutrition (GSS, 2018). Currently, 40% of women within the reproductive age are either overweight or obese, a substantial rise from the 2003 prevalence level of 25%. This has reached levels of public health concern (GSS, 2016c). OPD per capita for the first time since 2012 has recorded an improvement. It has improved by 7.14% from a per capita visit of 0.98 to 1.05. This translates to at least one hospital visit per person in Ghana in 2018.

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