HEALTH FINANCING ASSESSMENT: GHANA

June 17 2019

Preliminary Report prepared by

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DELIVERABLE 1

BACKGROUND

Ghana is a West African country bordered by Togo on the east, Burkina Faso on the north and northwest, Côte d'Ivoire on the west, and the Gulf of Guinea to the south. The country has a population of approximately 30 million, 39% of these below the age of 15 years, and an annual population growth rate of 2.2% [1], [2]. Ghana is a lower middle income country (LMIC) with a GDP per capita of USD 1641, and a 2019 projected economic growth rate of 7.4% driven mainly by the industry sector, especially oil, gas and mining [2]. It is estimated that 13% of Ghana's population are poor, living below USD 1.9 per day [3].

Ghana's governance is structured into 3 political-administrative units; the central government, 16 regions, and 275 districts [4]. In 2009, Ghana passed the Local Government Instrument 1961 (LI 1961) to devolve a set of functions from the central government to the country's 216 Metropolitan, Municipal, and District Assemblies (MMDA) [5]. The Ghanaian health system is pluralistic with prominent roles played by both the public and private sector in the provision of health services [4]. The national Ministry of Health (MOH) has retained policy, regulation and planning functions, as well as the management of the 3 tertiary teaching public hospitals and transferred service delivery and implementation to the Ghana Health Service (GHS). The GHS is a semi-autonomous agency with the mandate to ensure access to health services at the community, sub-district, district, and regional levels [4]. The GHS has the responsibility for managing and operating public facilities. The public health system has five main levels layers outlined in figure 1.

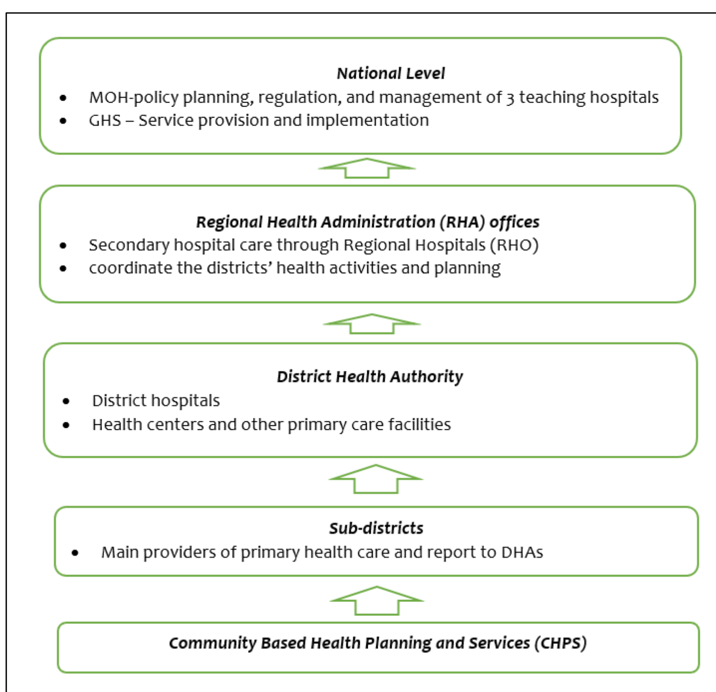

Figure 1: Organizational structure of the Ghana public healthcare system

While for a long time the leading causes of mortality and morbidity in Ghana have included communicable diseases such as malaria, HIV and AIDS, and maternal, neonatal, and , and nutritional diseases, the recent past has seen increasing contribution of non-communicable diseases such as such as stroke, congenital defects, and ischemic heart disease (figure 2)[6].

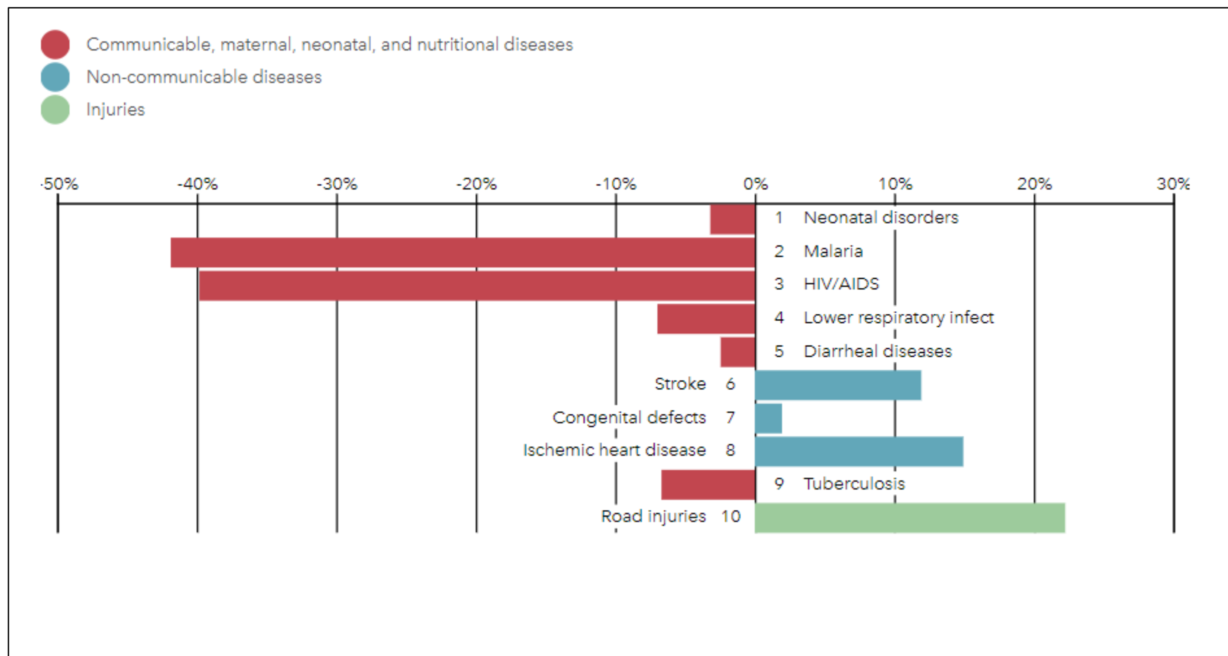

Figure 2: Top 10 causes of disability-adjusted life years (DALYs) in 2017 and percent change, 2007-2017, all ages, number [6].

Ghana has made a strong political, legislative, and fiscal commitment to reforming its health system to achieving Universal Health Coverage (UHC). To this end, the country has implemented several reforms that include, the introduction of a public health insurance program for its entire population and earmarked significant revenues to finance the scheme [7]. Despite these, faster progress is still required to achieve UHC. On financial risk protection it was estimated that Also 5.25% of Ghanaians incurred catastrophic healthcare expenditure at the 10% of consumption expenditure threshold in 2005 [8]. Further, 2% of Ghanaians were pushed into poverty because of out of pocket healthcare costs [9]. On service coverage, the UHC service coverage index is estimated to be 45%. Table 1 outlines service coverage levels of key priority interventions included in the service coverage index [9].

Table 1:Service coverage levels in Ghana [9].

Service	% population coverage	Year
Family Planning	43%	2015
Antenatal care, 4+ visits	87%	2011
Child Immunization (DPT3)	88%	2015
Pneumonia care seeking	56%	2014
HIV treatment	28%	2015
TB Effective treatment	28%	2014

Health financing plays a critical role in a country's health system, and is critical lever for UHC [10].The Ghanaian health system is financed by revenues from (1) The government through taxes and donor funding. (2) Premium contributions to the National Health Insurance scheme (NHIS) (3) Premium contributions to private health insurance companies (4) out of pocket spending by citizens at points of care. NHIS funds are pooled centrally by the National Health Insurance Agency (NHIA). Other taxes are centrally collected and allocated to regional and district levels [11]. Purchasing of healthcare services is carried out through: (1) Supply-side subsidies to public facilities by the governments; (2) The NHIS, which contracts public and private healthcare facilities in Ghana and pays them for services provided to its enrolled members. (3) Private health insurance companies that contract private healthcare facilities and pays them for service provided to their enrolled members.

Purpose of the Consultancy

The objective of the consultancy is to provide support to WHO on health financing strategic development and implementation in the country, by providing coordination, policy dialog and targeted technical assistance. The consultancy has the following deliverables:

Deliverable 1: Report on summary of health financing related work and priorities, including:

- In consultation and coordination with Ministry of Health, description and list of key priorities and issues to be addressed through a comprehensive health financing support and analysis in Ghana
- Workplan and roadmap for WHO support for health financing in Ghana and its linkages with ongoing reform and technical areas

Deliverable 2: Comprehensive dialog and coordination across Ministry of Health, National Health Insurance Agency, Ghana Health Service and international partners in Ghana, including:

- Summary of ongoing health financing-related work supported by partners and the Ministry of Health, including key findings and recommendations
- Report that describes, analyses and consolidates ongoing work into a systematic report to be shared
- Participation in Ghana health financing coordination meetings and calls, both with Ministry of Health and technical partners
- Briefing document and support for Ghana country office staff working on health financing

Deliverable 3: Coordination of a health financing summit in Ghana to bring together government and partner stakeholders on comprehensive and coordinated and engagement on health financing priorities for reform, including:

- Meeting information and related report that describes outcomes and priorities from meeting
- Incorporation of input from WHO study on the transition to program budgeting in Ghana and potential implications to address cross-programmatic inefficiencies

This report presents an analysis of deliverable 1 and deliverable 2.

ASSIGNMENT METHODOLOGY

The execution of this work adopted two approaches namely:

- A review of documents
- Interviews and discussions with stakeholders

I carried out the assignment in three phases, first, I carried out a desk review of relevant health sector published and grey literature. Second, I held discussions with government actors in the health financing space. Third, I held discussions with development partners supporting health financing reforms in Ghana. I held discussions with a total of 24 stakeholders. Annex 1 outlines the individuals contacted. Lastly, I synthesized information from these three sources to develop assignment findings.

FINDINGS

In this section, I discuss gaps in the health financing system in Ghana that will form a basis for identifying reform priorities that could be taken forward by WHO Ghana. These gaps are clustered around 6 thematic areas, namely (1) governance, (2) revenue generation, (3) risk pooling, and (4) healthcare purchasing, (5) public finance management, (6) cross-cutting efficiency.

GOVERNANCE AND STEWARDSHIP

Gap 1: inadequate involvement of health sector stakeholders in the development of key health sector policies

The Ghana health sector has a health financing strategy [12] that should in theory identify health financing reform priorities and guide the implementation of health financing interventions. The MOH is also developing the following guiding policies.

- A health sector policy
- A health sector UHC roadmap

Discussion with development partners revealed that they were aware and involved in varying degrees in the development of the health sector policy. However, none of them were aware or involved in the development of the sectors, UHC roadmap. It is also not clear whether and to what extent the new UHC roadmap is aligned with the health sector financing strategy. While there is a health financing working group, it is not active. The MOH has also set up a working group focused on improving the collection of internally generated funds from the health sector. Development partners do not seem to be aware of or participating in either of this.

Gap 2: The Ghana health financing strategy: strategy on paper rather than in practice

The 2015 Ghana health financing strategy outlines 5 health financing objectives as follows:

- 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
- 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
- Strengthen governance, transparency and accountability

The health financing strategy identifies 15 strategy areas aimed at achieving these objectives. Government and development partner discussions revealed the following gaps with the health financing strategy:

- There is no monitoring and evaluation framework for the health financing strategy, and Ghana's UHC reforms more broadly. Neither government nor development partners are clear on the progress made in implementing the health financing strategy, and there is consensus that health financing reform in Ghana are not guided by the health financing strategy

Gap 3: Multiple uncoordinated agencies in the health sector

The cross-programmatic efficiency analysis report, as well as assertions by development partners and government officials identify the existence of multiple MOH agencies with overlapping or unclear roles as a reason for inefficiencies in the health sector [13]. Highlighted examples include:

- The distinctive roles of the Ministry of Health, and the Ghana Health Service were not clear. It was felt that while on paper the MOH's role was policy and regulation, and the GHS role was implementation, in practice the MOH carried out some implementation functions, and the GHS carried out some policy making functions.
- The roles of the Health Facilities Regulatory Agency (HEFRA), the Ghana Health Services, and the National Health Insurance Agency regarding health facility accreditation was not clear

Gap 4: Uncoordinated donor support for health system strengthening and health financing

Both development partners and MOH respondents highlighted that development partner support for health financing the Ghana MOH was uncoordinated. This has resulted in a fragmented approach to support that is likely to result in duplication and support gaps.

Gap 5: health sector capacity and preparedness for decentralization

In 2009, the Ghanaian parliament passed Local Government Instrument 1961 to devolve key sectors and functions from the central government to the MMDAs [14]. While other sectors have been devolved, devolution has not occurred in the health sector. Some stakeholders in the health sector are resistant to decentralization which may partly explain the slow transition to decentralization in the sector. Despite the resistance, and slow transition, it is certain that the sector will eventually be decentralized. However, government and development partners both felt that the capacity of local government to take up health sector decentralized functions is inadequate. These functions

include service delivery, financial management, human resource management, and governance and administration of the health sector. There is therefore a need to anticipate system challenges and capacity strengthening needed once decentralization takes effect.

Gap 6: There is no clear understanding (among ministry of health and partners) of what the governments "Ghana Beyond Aid" policy means for the health sector

Ghana's President launched "Ghana beyond Aid" as his long-term vision for the Country[15]. This vision has been interpreted as a push to reduce and ultimately eliminate donor dependency. The interpretation of this vision has however not been translated and communicated to the health sector in a coherent and consistent way. Both government and development partner respondents felt that there is no common understanding among actors in the health sector on the policy of Ghana beyond aid and there is no formal government articulation of what the vision entails for the health sector.

Gap 7: lack of harmonization of donor transition plans

As a lower middle-income country, Ghana is in the phase of donor transition[16]. Donor transition is however uncoordinated with individual donors developing their own transition plans without reference to other donor transition plans. As a result, Ghana MOH is faced with uncoordinated transition plans.

RESOURCE MOBILIZATION

Gap 8: Declining health sector resources

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

- Low and declining per capita expenditure on health
- Low public expenditure on health
- High dependence on out of pocket expenditure
- Fiscal pressure from donor transition co-financing requirements

According to the 2015 national health accounts, per capita healthcare expenditure in Ghana increased from USD 13.6 in 2002 to USD 83.85 in 2013 (figure 1) [17]. However, between 2013 and 2015, per capita healthcare expenditure declined to USD 80.58. The budget prioritization of the health sector by the government is low; Ghana's budget allocation to the health sector as a proportion of the total government budget declined/increased was estimated to be 7% while public health expenditure as a proportion of the country's GDP was estimated to be 2.5% in 2015 [17]. It is estimated that LMIC country's public expenditure on health should be a minimum of 5% to achieve meaningful improvements in service coverage, health outcomes, and financial risk protection [18].

The health sector has a high dependence on out of pocket expenditures, which accounted for 36% of total health expenditure in 2015 (figure 2). User fees are charged at all levels of the public healthcare delivery system. Discussions with government and development partners revealed that the government of Ghana had not allocated a budget for service provision (expect for salaries) to the health sector for over 2 years. Public health facilities were hence dependent on internally generated funds (user fee collections from patients) and donor funds from vertical programmes. This situation likely incentivises facilities to intensify user fee collection which predisposes patients and households to the financial risk, and financial access barriers. For instance, development partners indicated that there are reported cases of public healthcare facilities charging user fees for services that are donor funded and intended to be offered for free. There is a sense that there is a return of the *cash and carry system* in Ghana.

Revenue mobilization is also adversely affected by co-financing obligations from the donor transition processes in the health sector. The DFID supported analysis of Ghana's transition from external finance projected that Ghana's health sector will face an external financing **reduction of USD 104 million** 2025 as compared to 2018 [16]. Further, the analysis projected that the government will also need to budget **for co-financing requirements of USD 2 billion from 2019 to 2025** [16]. Both government and development partners felt that co-financing obligations had put a fiscal pressure on the health sector, resulting in reduced or low allocations to other priorities. For instance, some of the funds earmarked for allocation to the National Health Insurance Agency (NHIA) were used to meet co-financing obligations reducing the resources available to the NHIA. The health sector also needs to mobilize additional resources for training and capacity building to sustain operational effectiveness after development partners transition out of the sector.

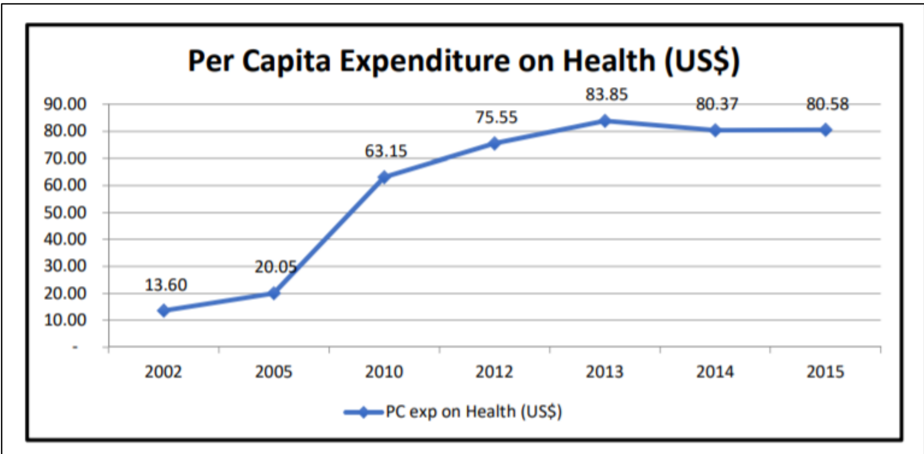

Figure 3: Total health expenditure by financing agents in Ghana [17]

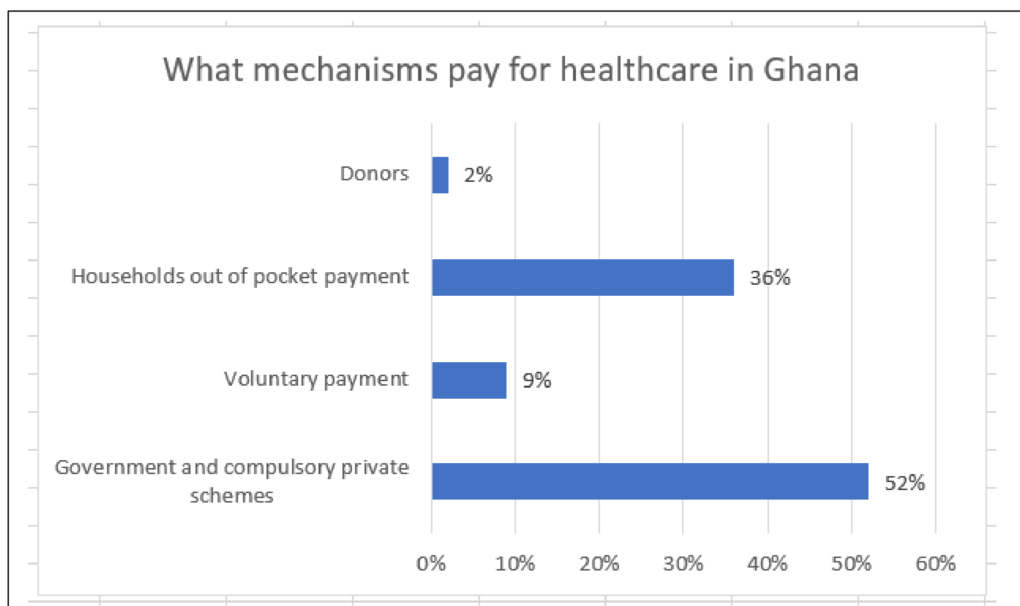

Figure 4: Contribution of different mechanisms to healthcare financing in Ghana [17]

Gap 9: Sustainability of Ghana NHIS

The financial sustainability of the NHIS has been questioned[19], [20]. Stakeholders highlighted that the funds allocated to the NHIS were not sufficient. Further, allocations from earmarked reviews to the NHIS not 100% also there is dipping in these funds to fund co-financing plans. A World Bank review reported that growth in NHIS claims outpaced growth in revenues between 2009 and 2014 leading to a deficit [19]. By 2014, this deficit had widened to GH¢300 million. Rising NHIS claims expenditures were driven by an increase in utilization, expansion of population coverage, and rising unit costs [19]. Alhassan et al (2016) observed that the financial sustainability of the NHIF is threatened by fraud and corruption, abuse of the gatekeeper system where clients are supposed to first report to a primary health provider and subsequently referred to a higher level facility when necessary, low premium payments, broad benefits package, and a large exemption group [20].

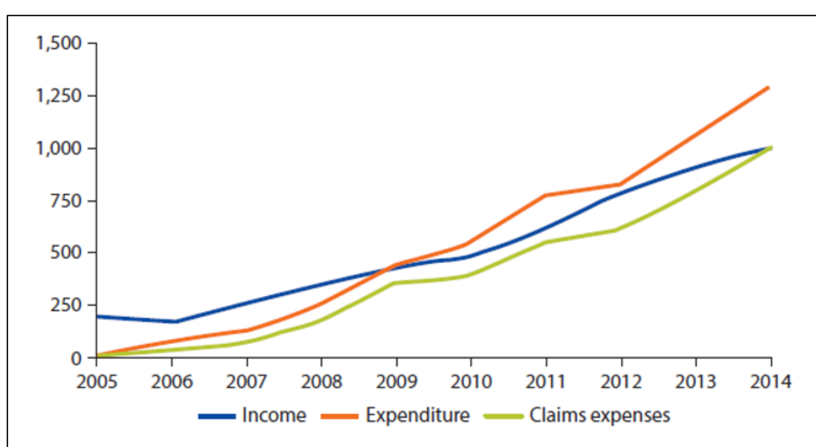

Figure 5: NHIS Revenues and Expenditures, 2005–14 (GH¢ millions)

RISK POOLING

Gap 10: Low population coverage by the NHIS

Population coverage by the NHIS is estimated to be between 30-40%. Given that all levels of public and private healthcare facilities in Ghana charge user fees, this means that more than 60% of the population does not belong to any risk pooling mechanism. A key challenge identified, that partly explains the low NHIS population coverage is the poor retention of enrolled individuals. Both formal and informal sector members are required to re-enroll annually with the NHIS. Formal sector employees are required to pay Ghana cedes 5 while informal sector employees are required to pay Ghana cedes 25 annually to re-enroll. The poor are exempt from making re-enrolment fees. Both informal and formal sector members find this process inconveniencing, characterized by long queues and waiting times. Further, formal sector individuals, who automatically make payments through an earmarked 2.5% social security deduction are further inconvenienced by a requirement to personally reconcile their payment records between the Social Security and National Insurance Trust (SSNIT) and the NHIA. This is because the SSNIT and NHIA databases are not synched. This lack of synching between the SSNIT and NHIS databases results in most formal sector members being considered to be inactive members of the NHIS unless they physically update their records in the annual re-enrollment process. In 2018, the NHIS introduced a mobile re-enrollment application that is aimed at improving the convenience of re-enrolment. While this eliminates the inconvenience of long queues to re-enroll, it does not eliminate the inconvenience of physically updating SSNIT payments with the NHIS. The NHIS indicated plans to link the NHIS registration with the national ID card and hence eliminating the need to obtain a separate NHIS card. This will also reduce enrollment barriers.

Gap 11: Adverse selection

NHIS sustainability is also affected by adverse selection. It has been observed that NHIS members are more likely to be in high-risk age groups [19]. Compared to national census data, the NHIS membership has a greater concentration of children under the age of five and individuals over the age of 55 [19]. Further there is a high attrition rate of NHIS members. Out of all active members in January 2014, only 42 percent remained in the scheme in January 2015 [19]. This suggest that members may enrol during periods when they anticipate needing medical care, then leave the system once they have received that care.

Gap 12: There is not resource allocation formula

The allocation of healthcare resources across regions and local governments is not based on an explicit resource allocation formula. This allocation is based on funds availability and historical budgets, rather than a needs-based resource allocation formula. Government and development partner discussants also felt that most of the available funds in the health sector had been earmarked, reducing the flexibility of resource allocation according to dynamic priorities.

PURCHASING

Gap 13: Payment delays by NHIS to healthcare facilities

Claims payment by the NHIS to healthcare can take up to 6 months to get paid. This delay is attributed to delays in three processes. First, given that healthcare facilities manually compile and submit their claims, claims submission is typically delayed. Second, once claims have been submitted by healthcare facilities, the NHIS processes claims manually. Third, once the NHIS has processed claims and is ready to pay, disbursement of payment is delayed due to unavailability of funds. While the NHIS is in the process of implementing an e-claims system, currently only 20% of claims are processed using the e-claims system. Claims processing is hence labour intensive and inefficient. Claims are vetted on an individual basis and most are evaluated manually. It has been estimated that the NHIS spend 1,200–4,800 staff weeks vetting each month's claims [19]. There are also inefficiencies associated with the lack of integration between the claims management system, membership management system, and financial management system of the NHIS.

Gap 14: Weak referral systems

It was reported that while Ghana has a referral policy, this referral strategy is poorly adhered to. There is no effective gate keeping mechanism and hence citizens hence often bypass lower level healthcare facilities to seek care in higher level healthcare facilities without appropriate referrals [20]. This results in inefficiency in the sense that the unit costs of similar care is higher in higher level healthcare facilities compared to lower level healthcare facilities.

Gap 15: Challenges with the NHIS benefit package

The NHIS benefit package lists healthcare services and medicines. The benefit package promises to carter for 95% of the healthcare needs of enrolled members. There are a several weakness with the benefit package and the process of its development. First, the benefit package is biased towards curative care, and gives little priority to preventive and promotive care [19]. Second, the benefit package development process is not guided by evidence-based criteria. For instance, while the

MOH had carried out an economic evaluation to inform the revision of the benefit package [21], this analysis is yet to be considered in the updating of the benefit package.

Gap 16: Challenges with NHIS provider payment mechanisms

The NHIS uses two provider payment mechanisms: diagnostic related groups for the payment of inpatient and outpatient healthcare services, and fee for service for the payment of medicines. The NHIS provider payment mechanisms are characterized by several challenges. First, the fee for service payment of medicines has experienced escalating value of claims for medicines [19]. Medicine claims now constitute approximately 50% of total NHIS claims. Among others, this is due to the overprovision incentive inherent in fee for service payment mechanism [19]. Further, there is significant variation in medicine prices, with average medicine prices in Ghana reported to be seven-fold that of international reference medicine prices. Second, Ghana DRGs has design weakness. These include narrow bundling of services, and inadequate controls. The DRG system is hence characterized by miscoding which further escalates costs. While the NHIS is considering re-introducing capitation payment mechanisms for outpatient services, the political economy of capitation payment in Ghana has led to resistance to the payment method.

PUBLIC FINANCE MANAGEMENT

Gap 17: Low uptake and system vulnerability of PFM information systems

Ghana has implemented the Ghana integrated financial management system (GIFMIS). However this implementation is characterized by low usage. For instance, the Ghana Health Service, which is the implementing agency of the health sector and hence controls the bulk of health sector resources does not use GIFMIS but rather uses a parallel system. Where GIFMIS is used, it is characterized by vulnerabilities that provide opportunities for fraud. Respondents reported their being multiple dummy accounts in GIFMIS that have clearance levels that could facilitate high value financial transactions. Further, not all transactions are currently captured in the GIFMIS system at the local government offices [22].

Gap 18: Weaknesses with the budget process

The budget process in the health sector has several weaknesses. First, it was reported that the GHS does not have an integrated budget that brings together all specific programme budgets. This is because major disease programmes are donor funded, with attendant separate budgets that are not harmonized across the agency. This presents challenges for monitoring and implementation of efficiency measures. Second, while Ghana is implementing programme based budgeting, this

process is does not yet influence resource allocation. Third, the health sector has a budget execution problem. According to the MTEF programme-based budget estimates for the health sector, the budget execution rate in 2017 for Government of Ghana allocation was 51%, internally generated funds was 38%, donor funds 26%, annual budget funding amount 17%, while the overall sector execution rate was 43%.

Gap 19: Inefficiencies and ineffectiveness of funds flow

A PFM review carried out the Global Fund identified several inefficiencies in the disbursement and utilization of Global Fund grants by the Ghana health sector [22]. First, there was delays in the disbursement of funds from national level to the regional level [22]. For instance, it was reported that funds disbursed to the TB programme took about 50 working days to reach the regional level [22]. Second, there are reported delays in submission of quarterly forecasts to the Global Fund. For instance, the 2018 second quarter forecast for HIV/TB was submitted at the end of the quarter [22]. Third, the review found poor record keeping by regional and district health authorities [22]. Records of receipts and payments of Global Fund grants were at times recorded in notebooks rather than the prescribed ledgers and times the ledgers were not kept updated [22]. Late and non-submission of statements of expenditures by district health authorities to regional health authorities [22]. This delayed the reporting process and distorted the expenditures on the various programmes in their statutory reports to the Global Fund [22].

OTHER EFFICIENCY CONCERNS

Other efficiency concerns include the fact that the NHIS system does not have capacity for intelligent analytics to inform decision making. Resource allocation by the NHIS is also arguably inefficient – the NHIS spends a significant amount of its revenues on capital investments that are not core to its mandate. This, among others, has led to a low benefit payout ratio of 70%. Further, because of the verticalization of donor funded disease programmes, procurement and supply chain management, key functions such as procurement, warehousing, and distribution is duplicated leading to inefficiencies.

POTENTIAL AREAS OF HEALTH FINANCING SUPPORT BY WHO IN GHANA

Governance and stewardship

- Support a review of the health financing strategy to take stock of its implementation and update health financing policy priorities
- Support the development and implementation of a framework for monitoring and evaluation of UHC broadly, and the health financing strategy implementation specifically
- Support the production of key health financing analytical productions. These include:
  - National Health Accounts
  - Health Public Expenditure Reviews
  - Household expenditure and utilization surveys
- Support the development of a common understanding of ***Ghana beyond Aid*** among government and development partner stakeholders in the health sector
- Supporting the development of a roadmap for PHC for all
- Coordinate development partner support to the MOH on heath financing
- Support a review of health sector organizational arrangements, roles and responsibilities with the aim of reforming this to improve efficiencies by eliminating duplication and overlaps across government agencies in the health sector
- Support health sector preparedness for decentralization. This includes:
  - Supporting an assessment of the capacity of local authorities to perform mandated under the proposed devolution arrangements
  - Supporting capacity strengthening of local authorities in readiness for functional transfer in line with devolution arrangements

Revenue collection

- Support a fiscal space analysis
- Advocacy and engagement between MOH/MOF/PARTNERS to advocate for increased GOG funding for health
- Support an options analysis for revenue mobilizing to meet donor transition and co-payment obligations
- Support the development of a government initiated and government led integrated/harmonized donor transition plan for Ghana
- Supporting the costing of vertical programmes to facilitate GOG budgeting for donor transition

Risk Pooling

- Support process review for enrollment and re-enrolment and its implementation
- Support developing a framework for integration across vertical programmes, and between vertical programmes and the rest of the health system
- Support the development and implementation of a revenue allocation formula for the health sector

Purchasing

- Support business processes review of the NHIS to identify areas that need redesign to improve efficiencies. These include claims processing, payment disbursement, registration of beneficiaries etc
- Support a review and strengthening the implementation of the referral strategy
- Support the development and implementation of an integration plan for vertical programmes
- Support capacity building of Ghana health service/MOH to take up processes and functions previously undertaken by donors under vertical programmes. These include procurement and supply chain functions
- Support the establishment of a systematic and evidence based process for benefit package design. This should include the institutionalization of health technology assessment in the Ghana health system
- Support the development of a medicines pricing and reimbursement strategy
- Support review and refinement of the DGR system to include global budget caps, and possibly more bundling of services within DRGs
- Support design, capacity building, advocacy, introduction and monitoring or capitation payment system
- Supporting better alignment between provider payment mechanisms to avoid inefficiencies and conflicting financial incentives
- Support the costing of healthcare services to inform decisions about benefit package design
- Support the transition of the NHIS from manual claims processes to e-claims. This includes an upgrade of IT systems to manage e-claims
- Support the integration of key NHIS information systems– specifically membership, claims, and finance information systems
- Support the development of a dashboard that provides information for decision making for the NHIS

- Support the development of business intelligence system for the NHIS that will provide the right analytics/reports for decision making
- Support capacity building of NHIS on areas relevant to its function and roles. These include data analytics, social health insurance, costing of healthcare services, healthcare purchasing, health financing etc
- Support the development of a clear strategy for health facility accreditation: this includes a review of the roles of the NHIS, Health Facilities, Regulatory Agency (HEFRA), and Ghana Health Services with the aim of clarifying roles to eliminate duplication
- Support a review of the experiences and challenges of pharmaceutical procurement and contracting practices and identify opportunities for reform

Public finance management

- Support capacity building and implementation of programme based budgeting across the health sector
- Support harmonizing and linking (making inter-operable) information systems across NHIS, MOH/GHS

DELIVERABLE 2

ONGOING DEVELOPMENT PARTNER HEALTH FINANCING SUPPORT

THE WORLD BANK

Previous work

- An analysis of the financial sustainability of the NHIS

Ongoing support

- In collaboration with DFID, the World Bank is providing support to the implementation of the mobile Community Health-based Planning services (mCHPs)
- World Bank is working with GHS to reimburse arrears to public health facilities
- Support to the NHIS to implement a facility e-claims system
- Funds flow analysis PFM bottlenecks analysis for immunization services

DFID

- Support the review PFM capacity (with GF)
- Support mapping of funds flow for health with objective of identifying bottlenecks in financing (With GF and WB)
- Develop capacity building curriculum around financial sustainability (through World Bank)

Previous work

- Technical assistance for health financing strategy and implementation plan
- Support to carry out the burden of disease study and economic evaluation of services for inclusion in the NHIS benefit package

USAID

- Supporting an actuarial analysis of NHIS to support benefit package design
- Supporting clinical audits for the NHIS
- Supporting the development of a roadmap for Primary Health Care (PHC) for all
- Supporting the development of a claims dashboard for NHIS
- Supporting strengthening of quality assurance of the NHIS
- Supporting GHS on budget planning and execution
- Supporting GIFMIS implementation
- Supporting the strengthening of social accountability for NHIS
- Supporting private health sector development

JICA

- Budget funding support to the MOH

- Has a health policy advisor seconded to the MOH directorate of health policy, planning, monitoring, and evaluation, in the MOH who is supporting a review and harmonization of health sector policies
- The health policy advisor also has support for UHC reforms in their TOR

GLOBAL FUND

- Supporting internal audit of GHS
- Supporting GIFMIS readiness assessment and funds flow mapping (with GAVI)
- Global fund is providing funding support of USD 2.5 million to be spent on strengthening GIFMIS implementation and an internal audit
- Financial support to NHIS actuarial work
- Assessing supply chain in collaboration with GAVI

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ANNEX 1: List of Health Financing Stakeholders Contacted

No	Individual name	designation	Affiliation
Government			
1	Nana K. Adjei-Mensah		Ministry of Health
2	Emmanuel Odame	Director of Policy, planning, monitoring and evaluation directorate (PPME)	
3	Kwakye Kontoh	Principal planning officer	
4	Dan Osei	• Deputy director, planning, monitoring and evaluation directorate (PPME)	Ghana Health Service
5	Badu Sarkodie	Director of Public Health	
6	Stephen Ayisi-Ado	Ayisi-Ado-Head of HIV programme	
7		Deputy head of TB programme	
8	Benjamin Sakyi-Sarkwah		
9	Lydia Dsane - Selby	Ag Chief Executive Officer	NHIS
10	Francis-Xavier Andoh-Adjey	Director Research, policy, monitoring, and evaluation	
11	Francis Asenso-Boadi	Director, policy and planning	
12	Ahmed Imoro	Director, finance	
13	Ben Kusi	Director, membership and regional operations	
14	Nicholas Afram Osei	Deputy Director, claims	
Development partners			
15	Enoch Oti Agyekum	programme officer (health)	JICA
6	Mark Saalfeld	fund portfolio manager	Global Fund
17	Michelle Marian Schaan	health systems strengthening team lead	USAID
18	Mary Addo – Mensah	project management specialist – G2G, office of health, population and nutrition	
19	Caroline Ly	Health Economist	
20	Anwer Aqil	Senior Advisor HSS M&E	
21	Luise Hamme	Consultant	
22	Rebecca Ferteiger	Consultant	
23	Neetu Hariharan	Consultant	
24	Sally Lake	Consultant	World Bank