GHANA HEALTH FINANCING STRATEGY

2023-2030

MINISTRY OF HEALTH
ACCRA, GHANA

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Ghana Health Financing Strategy 2023-2030

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TABLE OF CONTENT

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LIST OF FIGURES

ACRONYMS

BoG	Bank of Ghana
CAPEX	Capital Expenditure
CHAG	Christian Health Association of Ghana
CHPS	Community-Based Health Planning and Services
CSO	Civil Society Organisations
CSR	Corporate Social Responsibility
DAH	Development Assistance for Health
DPs	Development Partners
EHSP	Essential Health Services Package
EML	Essential Medicines List
FCDO	Foreign, Commonwealth & Development Office, UK (Formerly DFID)
GDP	Gross Domestic Product
G-DRGs	Ghana Diagnostic-Related Groups
GHS	Ghana Health Services
GIFMIS	Ghana Integrated Financial Management Information System
GoG	Government of Ghana
HeFRA	Health Facilities Regulatory Agency
HFS	Health Financing Strategy
HFS-IP	Health Financing Strategy Implementation Plan
HR	Human Resources
HRH	Human Resources for Health
HRMIS	Human Resource Management Information System
HSMTDP	Health Sector Medium Term Development Plan
HSS	Health Systems Strengthening
HTA	Health Technology Assessment
IGFs	Internally Generated Funds
IP	Implementation Plan
KPIs	Key Performance Indicators
LMIC	Low Middle Income Countries
M&E	Monitoring and Evaluation
MMDAs	Metropolitan, Municipal and District Assemblies

MoF	Ministry of Finance
MoH	Ministry of Health
MP	Member of Parliament
MTEF	Medium Term Expenditure Framework
NCD	Non- Communicable Diseases
NDPC	National Development Planning Commission
NHIA	National Health Insurance Authority
NHIL	National Health Insurance Levy
NHIS	National Health Insurance Scheme
NHP	National Health Policy
NICL	National Insurance Commission Levy
NITA	National Information Technology Agency
NoP	Network of Practice
OOP	Out – Of - Pocket
P4P	Pay-for-Performance
PFM	Public Financial Management System
PHC	Public Health Care
PHIs	Private Health Insurance System
PoW	Programme of Work
PPMED	Policy Planning, Budgeting Monitoring and Evaluation Division
PPNs	Preferred Provider Networks
PPPNs	Preferred Public Health Care Provider Networks
RBF	Results-Based Financing
RMU	Resource Mobilisation Unit
SDG	Sustainable Development Goal
SSNIT	Social Security and National Insurance Trust
TWG	Technical Working Group
UHC	Universal Health Coverage
USAID	United States Agency for International Development
VAT	Value Added Tax
WHO	World Health Organisation

Foreword

As we progress with the implementation of sustainable health financing in the long- term, we are pleased to introduce the Ghana Health Financing Strategy (2023 - 2030) which signifies a critical stage in complementing Ghana's efforts towards achieving Universal Health Coverage (UHC).

This strategy document aligns with the Ghana UHC roadmap 2020-2030 and reflects the broader objectives set out in the Health Sector Medium Term Development Plan 2022 - 2025. It demonstrates the Ministry's commitment to creating a robust healthcare system that guarantees equitable access to quality healthcare services for all citizens. The alignment of these objectives and strategies exemplifies our comprehensive approach to enhancing healthcare delivery in Ghana.

The Health Financing Strategy acknowledges Primary Health Care as the foundation of our healthcare system, emphasising its role in preventing diseases, promoting health, and delivering essential services. The objective of the strategy is to among others, strengthen the capacity of our Healthcare facilities, ensuring that they serve as the first point of contact for our citizens, delivering cost-effective and quality care.

One of the principles essential to delivering Universal Primary Health Care is the Network of Practice. It is designed to enhance collaboration, coordination, and communication among healthcare providers within the healthcare ecosystem. It adopts an approach of shared knowledge and best practices, ensuring that innovations in healthcare financing are swiftly translated into tangible benefits for the Ghanaian population.

The Health Financing Strategy emphasizes improving health financing mechanisms as financial barriers are among the most significant impediments to healthcare access.
Therefore, this strategy outlines comprehensive measures to enhance revenue mobilisation, optimise resource allocation, and establish efficient mechanisms for risk sharing and equitable distribution of resources.

As we implement this document, it is important to recognise that the success of this Strategy depends on the collective dedication and efforts of all stakeholders. The vital role of each stakeholder cannot be underestimated in transforming these strategies into tangible outcomes. Our ability to implement the strategies of healthcare financing, adapt to evolving challenges, and innovate sustainable solutions will determine our success in achieving Universal Health Coverage.

I express my profound appreciation to the dedicated teams within the Ministry of Health, our esteemed Development Partners, Academia, Civil Society and our many stakeholders who have contributed immensely to the development of this Strategy. We invite other stakeholders to join in the implementation of this strategy.

KWAKU AGYEMAN-MANU (MP)

HON. MINISTER FOR HEALTH

EXECUTIVE SUMMARY

Chapter 1: Introduction

Ghana is currently at the crossroads of a transition towards a more comprehensive and sustainable approach to health financing that supports comprehensive and quality primary health care (PHC) for all. Over the past 30 years, Ghana has shown its strong political, legislative, and fiscal commitment to health system reform to make progress towards universal health coverage (UHC). While these efforts have been beneficial, more work is needed to address persistent health financing and service delivery challenges in Ghana. These challenges not only threaten health-related goals, including UHC and improving service delivery especially at the primary care level, but are also a hindrance to overall societal well-being.

Chapter 2: Vision, Goals, Objectives, and Guiding Principles

Ghana's commitment to UHC is the foundation for this HFS, with the goal to establish equitable, efficient, effective, transparent, and sustainable heath financing mechanisms that contribute to achieving improved health outcomes, financial risk protection, consumer responsiveness, and access to quality essential health care and population-based services for all by 2030.

The objectives of the HSF are to:

- Improve resource mobilization to ensure sufficient and predictable revenue
- Efficiently allocate and use health sector resources
- Promote equity in the distribution of health resources and use of health services
- Reduce financial barriers to access health care
- Motivate, incentivize and stimulate service delivery and quality improvement and increase population satisfaction and involvement in their own health
- Strengthen governance, management, transparency, and accountability in the mobilization and use of health resources
- Enable financing for strong population-based public health functions that can prepare for and respond to emerging threats

These objectives are underpinned by the guiding principles:

- Sustainable financing and efficiency
- PHC as the level of emphasis
- Gradual shift from narrow program- or scheme-financing to broad system financing

- Strengthen inter-sectoral approach
- Enhance financial management capacities at all levels of the system
- Rationalize distribution of resources, including health workforce
- Commitment to global initiatives (Paris, Abuja, Ouagadougou declarations)

Chapter 3: Country context, current financing situation and challenges

The 2022 Ghana Health Expenditure Review: public health expenditure for UHC at the time of COVID-19 clearly lays out the challenges faced by the health financing system. Despite lower-than-average total health spending per capita, the relatively high share derived from public sources underpins positive trends related to both service coverage and financial protection. There has been a rebalancing in the distribution of public spending on health, whereby 80% is channeled through the Ministry of Health budget and only 12% channeled through the National Health Insurance Scheme (NHIS) as of 2020; 90% of domestic government of Ghana revenues dedicated to workforce compensation. This poor balance in the proportion of compensation vs. non-compensation costs undermines services delivery and creates pressure to increase out-of-pocket payments. External assistance for health has also decreased dramatically in recent years and as of 2019 comprised 11% of total health spending, heightening the tsunami hitting service delivery operating costs.

Coupled with macro-fiscal challenges and shifting health spending dynamics are structural issues that necessitate this renewed and refocused HFS to better utilize available resources. The NHIS is at clear risk due to structural financing issues, delays in disbursements of funds, an unsustainable payment system, and caps in the amount of earmarked funds that can be transferred. Fragmentation in budgeting processes between MoH and NHIA limits the ability of health care managers to allocate resources efficiently and to align to service delivery objectives. Health financing adjustments will be central to implementing the network of practice model as a means to establish structure needed to deliver universal PHC.

Chapter 4: Health Financing Strategy Approach

The 2022 Ghana Health Financing Strategy (HFS) builds on the foundation of health vision, policy, strategy, and priorities contained in the UHC Roadmap and Health Sector Medium-Term Development Plan 2022-2025. The HFS digs deep to identify, explore, and propose solutions to key, intractable, and longstanding health financing issues. It also develops specific strategies for the health financing functions of revenue collection, pooling and purchasing.

This two-pronged approach of addressing key, longstanding issues and further strengthening the three health financing functions creates dynamic, sequenced interaction and synergies between targeted activities and comprehensive strengthening, avoids duplicating the UHC Roadmap and ensures sufficient depth of strategies and plans to make progress in addressing the continued health financing and service delivery challenges in Ghana.

Chapter 5: Strategies to Address Key Health Financing Issues

The HFS lays out specific strategies and activities to directly address the key, longstanding issues facing Ghana's health financing system. These strategies focus on efficiency and expenditure management while considering how to tackle a critical revenue problem.

Strategy 1: Strengthen purchasing of PHC services

At the heart of the UHC Roadmap and HFS guiding principle that PHC is the level of emphasis to improve service delivery is PHC structure and purchasing services. The UHC Roadmap identifies networks of practice (NoP) as a key strategy to strengthen PHC and achieve UHC in Ghana. Accomplishing this vision requires a fundamental reorientation of many health financing functions.

Strategy 1 activities:

- *Coordinate NoP establishment, management and financing to purchase their services:* NoP implementation plans at the district-level should be closely coordinated with National Health Insurance Agency (NHIA) to enable harmonization with PHC payment contracts, systems and processes; harmonize credentialing and regulatory processes; and improve facility-level financial management capacities.
- *Differentiate front-line PHC services, outpatient specialty services, and the related payment systems to providers or management entities that deliver them:* The NHIS benefit package and payment systems should clearly differentiate between PHC and outpatient specialty services to enable shifting funds and payment for priority frontline PHC services.
- *Active or passive enrollment of 100% of population for entitled front-line PHC services:* Through a combination of active and passive enrollment into NHIS the entire population are either enrolled or assigned to a PHC service provider. Active enrollment ensuring choice will be strongly promoted including through NoP. While catchment area enrollment can be used at PHC-level, active enrollment will still be required for

outpatient specialty or inpatient services.

- *PHC person-based payment, purchases PHC services and shifts financing to lower levels of health system delivering front-line PHC services.* PHC person-based payment with its certain and predictable payment amounts will push funding to the frontlines and enable PHC NoP and their health centre hubs to establish stable high-quality service capacity, perform the gatekeeper function, and develop and manage a strong foundation of front-line PHC services for the entire population.

Strategy 2: Enhance service provider autonomy, management, and accountability to receive, use and manage funds.

Health care financing and management are two sides of a top-down and bottom-up process involving national institutions focused on policy, financing and purchasing health services, and service agencies and more autonomous service providers focused on receiving, using, and managing funds. Activities are categorized by the UHC Roadmap and HFS priority of NoP with health centre hubs and all public and private service providers.

Strategy 2 activities

- *2.1. Strengthen health centre financial management and governance and prepare them for their role as NoP hubs.* This activity encompasses the autonomy health centres will require to receive funds directly, the nature of their response to financial incentives, and their financial management platform or how they manage funds including planning, budgeting, procurement, internal controls, accounting, financial reporting, and their facility governance and accountability.
- *2.2. Establish, manage, govern, and coordinate NoPs nationwide including their health centre hub and surrounding PHC and community level spokes.* Operationalizing the NoP model will require the determination of clear financial management roles, relationships, responsibilities, rules, procedures, and processes for NoP receipt of funds and revenue sharing.
- *2.3. Strengthen provider financial management and governance for all public and private service providers.* An assessment is needed of health financing, purchasing, PFM, management, and governance from the bottom-up or service provider point of view to provide insight into public service provider autonomy and PFM. This will serve as the basis for the strengthening of service provider financial management systems, which will be extended to service provider level.

Strategy 3: Address NHIS revenue issues including NHIL/SSNIT caps and transfer delays

The NHIS revenue challenge is large and increasing which worsens the proportion of compensation vs. non-compensation costs, undermines purchasing of benefit package services, leads to increasing out-of-pocket costs, and hampers movement towards UHC. Concrete efforts are needed to increase the amount, timeliness, certainty, predictability, and fairness of revenue forecast, collection, and transfer. Activities are categorized as policy and technical issues to improve NHIS revenue collection and a reform transition investment.

Strategy 3 activities

- *3.1. Verify, increase transparency, and advocate for management of Ghana's 25% earmark cap in a way that ensures full funding of statutory NHIL and SSNIT contribution.* The current caps placed on NHIL (VAT tax), SSNIT contribution based on the Earmarked Funds Capping and Realignment Bill 2017 has impacted NHIS revenue, and concerted effort is needed to address these constraints to enable financing to enable the vision laid out in the UHC Roadmap and in this HFS.
- *3.2. Reduce delays in the reconciliation and release of NHIS funds from Government.* Resolving these longstanding delays will involve steps to speed up or fast track the release of earmarked VAT funds and enable their direct transfer to NHIA.
- *3.3. Premium increases and reform transition investment.* As part of overall revenue considerations and the clear need for investments in service delivery and financing structures, premium increases should be considered for NHIS premium-based enrolled given it has remained fixed for almost 20 years. In addition, options for a reform transition investment of domestic and international funds should be considered to enable shifting funds to purchase frontline PHC services and buy time to realign purchasing of inpatient and outpatient specialty services.

Strategy 4: Improve mix of compensation and non-compensation operating costs

The proportion or mix of investment in compensation and non-compensation operating costs is a key longstanding health financing issue. Activities will improve both system-wide and service provider level mix of inputs to health service delivery, reduce fragmentation and improve incentives.

Strategy 4 activities

- *4.1. Introduce simulation model to support HR rationalization, distribution and redistribution according to facility utilization and need.* This HFS activity will develop and implement a simulation model for staff allocation to health facility level to enable national government, local government, and health facilities to support HR rationalization, distribution and redistribution, with a focus on improving staffing in health centres and NoPs.
- *4.2. Extend planning and budgeting to facility level and introduce managerial accounting and capacity building to improve management, transparency and facility level proportion of compensation and non-compensation costs.* Refining existing or introducing new systems to extend annual planning and budgeting to health facility-level is needed for better HR management, improved planning and budgeting, shift to output-based payment, provider autonomy, management and accountability, and to ensure the appropriate balance between compensation and non-compensation costs.
- *4.3. Coordinate with HR function to enforce HR policies, improve HR recruiting and management, and implement financial and non-financial incentives to stimulate performance and improve staffing in underserved areas*. Better matching HR budgeting and payment to priority health services, purchasing of NHIS benefit package services, and motivated staff driving provider service delivery management is critical to achieving the UHC Roadmap and related objectives of efficiency, equity, and high-quality services.
- *4.4. Engage in dialogue and develop long-term plans to improve pooling and corresponding purchasing arrangements for both compensation and non-compensation costs.* Sequentially develop and implement actions to work towards pooling compensation costs and incorporating them into comprehensive purchasing of benefit package services by NHIS.

Strategy 5: Improve the prioritization and investment across types of health services

Optimizing, aligning and prioritizing financing levels and levers is needed to ensure population-based, public health services are established and strengthened to balance with high-quality individual health services. This involves realigning and defragmenting fund flows to improve efficiency and enable service delivery objectives, while ensuring PFM systems enable prioritization and realignment.

Strategy 5 activities

- *5.1. Improve programme budgeting to help ensure sufficient funding, prioritization, and budget visibility for population-based public health services, including pandemic preparedness.* Re-evaluating the current programme-budget structure to better align and portray budget formation and inputs to explicitly portray population-based, public health programmes will enable better prioritization and clear identification of funding needs to support advocacy for increased health revenue allocation.
- *5.2. Develop concrete plans, including timelines, for external assistance for individual services in MOH priority programmes to transition to NHIS benefit package and purchasing.* Clearly lay out the services, commodities and activities that donors are currently funding as part of overall efforts to harmonize, increase transparency and improve coordination of MoH essential health services package/priority programmes and NHIS benefit package processes.

Chapter 6: Health Financing Strategies by Function

This second aspect of the two-pronged approach is organized by health financing function together with governance at both the front end and the back end of a continuous improvement cycle that links the resolution of key, longstanding health financing issues with comprehensive health financing strengthening.

Strategy 6: Strengthen health governance including health financing policy and legal and regulatory framework.

The specific objectives or aims of policy development and legal and regulatory framework are improved policy, increased stakeholder participation, clear and executed laws and regulations, and public accountability.

Strategy 6 activities

- *6.1. Strengthen health financing policy dialogue processes to ensure open, transparent and participatory dialogue.*
- *6.2. Policy dialogue, decisions and refinements on major policy issues.*
- *6.3. Amend and implement legal and regulatory framework and guidelines to codify health financing policy decisions.*
- *6.4. Strengthen and realign institutional structure, roles and relationships.*

Strategy 7: Gradually increase revenue and mobilize resources for MoH services and programs, particularly in the context of declining external donor funding for public health, disease prevention and promotion programs.

Reliably delivering well-managed and high-quality health services requires sufficient, stable and predictable funding and implies gradual increases in revenues for the health sector.

Strategy 7 activities:

- *7.1. Develop evidence and make a business case for increased general revenue allocation to health in a tight fiscal space environment*
- *7.2. Strengthen public-private partnerships (e.g. business investment)*
- *7.3. Pursue a variety of resource mobilization opportunities including corporate social responsibility, district assembly health allocations, and local drug/vaccine production*

Strategy 8: Identify and implement improvements in pooling of funds

While pooling of funds has been a strength of the Ghana health financing system, emerging structural issues related to fragmented funds flows will need to be addressed to improve the proportion of compensation and non-compensation costs, align with purchasing arrangements, and enable service delivery objectives including the NoP model with its health centre hub underpinned by PHC per person payment.

Strategy 8 activities

- *8.1. Continue to engage in dialogue on functional specification in health defined by central pooling and purchasing arrangements and decentralized service provider autonomy and management*
- *8.2. Develop and implement plans to reduce fragmentation in pooling and purchasing arrangements for non-compensation costs in the short-term and compensation costs in the long-term*

Strategy 9: Better define what to purchase or benefit packages

As the MoH essential health services package is finalized as the overarching policy on what benefits and services are to be purchased for the population, efforts are required to implement and refine service and benefits packages, and improve coordination including actively incorporate MoH programmes, services, or inputs (e.g., drugs) into the NHIS benefit package, particularly as donor funding declines.

Strategy 9 activities

- *9.1. Implement MoH essential health services package (EHSP)*
- *9.2. Continuously refine NHIS benefit package*
- *9.3. Coordinate EHSP and NHIS benefits package*

Strategy 10: Improve purchasing of all health services and programmes including operating systems

To establish purchasing and provider payment systems to use resources more efficiently, better match payment and incentives to priority services, as well as to improve management, transparency and accountability this strategy will focus on activities in support of refined payment, claims management, aligned incentives, public financial management, and information systems.

Strategy 10 activities

- *10.1. Refine NHIS inpatient and outpatient specialty payment systems and their claims management systems and realign around strengthened PHC purchasing*
- *10.2. Improve purchasing or budget execution of MOH programmes (e.g. population-based public health, health professions education and training, science and research)*
- *10.3. Improve capital planning, purchasing and management*
- *10.4. Strengthen public finance management (PFM) systems and interoperability of PFM, health information and claims management systems at all levels including service providers.*

Strategy 11: Monitor and evaluate HFS implementation and strengthen communication

A performance framework and monitoring indicators is necessary for routine HFS monitoring and will specifically leverage and align with indicators from the Performance for Results and health financing progress matrix frameworks. All strategies, activities and related objectives will require a purposeful, responsive, and inclusive communication approach.

Strategy 11 activities

- *11.1. Design of HFS comprehensive monitoring framework and indicators*
- *11.2. Develop and implement HFS M&E system*
- *11.3. Develop and implement a communications strategy to inform and educate stakeholders, promote health sector results and advocate for resource mobilization, financial risk protection, efficiency gains and quality improvement.*

Chapter 7: Conclusion

The 2022 Ghana HFS presents a cohesive and aligned set of strategies and related activities that will support and enable implementation of the vision for Ghana's health system laid out in the 2019 UHC Roadmap that places PHC strengthening built on NoP platforms at the centre of quality, effective and affordable health services for the entire population in Ghana. The HFS begins with the direct nexus of service delivery and financing and places an effective PHC per person payment system, and related benefits, for 100% of the Ghanaian population at the heart of the strategy. Enabling this focus on the lower levels of the health system requires the sequenced establishment and management of willing and motivated NoP that have increased autonomy along with accountability. This will involve a bottom-up focus on facility-level financial management systems and related capacities.

In matching the bottom-up service delivery and management focus with top-down pooling and purchasing actions, this HFS represents a long-term commitment to Ghana's health system and the health of the population. It will require long-term funding increases, HR rationalization to drive a better proportion of compensation and non-compensation costs, and NHIS realignment of inpatient and outpatient specialty provider payment systems. As Ghana faces fiscal challenges, this long-term domestic, public funding focus can be complemented with reform transition investment or short-term funding from domestic and donor investments to clear NHIS arrears, create a new pool of PHC funding, and to enable a smooth transition in the provider payment system realignment. This investment process also will enable the Ghana Health Service to establish and develop NoPs and their health centre hubs through a process of bottom-up dialogue and regulation for infrastructure, equipment, financial management systems, capacity building, targeted service delivery and clinical practice improvements, and realignment of roles and responsibilities to increase autonomy and accountability.

See Appendix 1 for a detailed implementation plan table and related timeline.

CHAPTER ONE

1.1 Introduction

Ghana's commitment to UHC, as clearly laid out in the 2019 UHC Roadmap,[1] is long-standing and places the country at the forefront of broader regional and global UHC-oriented initiatives.[2] This commitment is summarized by SDG Goal 3.8 to "achieve UHC 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."[3] At its heart, Ghana this HFS demonstrates Ghana's dedication to the principles of human rights, equity, gender, and people-centered approaches.[4]

Ghana is currently at the crossroads towards a more comprehensive and sustainable approach to health financing. Over the past 30 years, through strong political, legislative and fiscal action, Ghana has instituted health system reforms to make progress towards UHC, and has been at the forefront of many health system reforms, both in Africa and globally. While not all reforms have the same degree of success, the principal reform aimed at moving the country towards UHC has been the introduction of the National Health Insurance Scheme (NHIS Acts 650 and 852). This health financing and institutional reform has had a ripple effect throughout the health sector, with the potential to leverage positive changes in service delivery though the introduction of strategic purchasing.[5]

While these efforts have been beneficial, more work is needed to address persistent health financing and service delivery challenges in Ghana. These challenges not only threaten health-related goals, including UHC, but are also a hindrance to overall societal well-being. The Government is facing these challenges while also seeing a decline in external assistance for the health sector and increasing debt servicing obligations. Achieving the health system goals of improving health outcomes, providing financial risk protection, and increasing system responsiveness to consumers requires direct actions from health financing and clear relationships to other health systems functions.

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[1] UHC Roadmap 2019

[2] These include Ghana's commitment to the Sustainable Development Goal (SDG) 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), Universal Health Coverage (UHC) 2030 Compact, initiatives of UHC 2030 and the Political Declaration of UHC adopted at the UN High Level Meeting in September 2019.

[3] From the Review of Ghana's National HFS

[4] From UHC Roadmap 2019

[5] 2019 HFS Review

The December 2019 launch of the UHC Roadmap[6] clearly demonstrates consensus over what Ghana needs to do to achieve UHC, including a renewed investment in primary health care (PHC) as the foundation for UHC. The roadmap localizes the global UHC goals to appropriate and feasible national targets and milestones and guides the development of detailed strategies and operational plans to deliver health services for the entire population over the next decade. The Health Sector Medium Term Development Plan 2022-2025 (HSMTDP)[7] will support realization of the UHC Roadmap and enable timely access to a core package of health services for the national population.

The Ghana Health Financing Strategy (HFS) builds on the foundation of health vision, policy, strategy, and priorities contained in the UHC Roadmap and HSMTDP 2022-2025. It is also informed by the recently completed Public Expenditure Review,[8] 2015 HFS,[9] 2019 Review of Ghana's National HFS,[10] and the output of the Health Financing Forum 2019.[11] The HFS digs deep to identify, explore, and propose solutions to key, intractable, and longstanding health financing issues. It develops specific strategies for the health financing functions of revenue collection, pooling and purchasing.[12] This two-pronged approach of addressing key, longstanding issues and further strengthening the three health financing functions avoids duplicating the UHC Roadmap and ensures sufficient depth of strategies and plans to make progress in addressing the continued health financing and service delivery challenges in Ghana.

The HFS also reflects the lessons of the COVID-19 pandemic, including the need for responsive, flexible and accountable health financing and institutional arrangements that can respond to individual needs and also establish a strong public health foundation for health security. Even before the COVID-19 pandemic, the UHC Roadmap had signaled the need for greater investments in emergency preparedness and response functions, as well as the importance of eliminating earmarked diseases. These are now taken forward in this HFS. This Ghana HFS is a guide to improving health financing performance. It is divided into six sections. Following this introduction, Section 2 presents the vision, goals, objectives, and guiding principles; Section 3 describes the country context, current financing situation and challenges;

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[6] UHC Roadmap 2019

[7] Health Sector Medium Term Developomnet Plan 2022-2025

[8] Health Public Expenditure Review 2022

[9] 2015 HFS

[10] 2019 Review of Ghana's national HFS

[11] Health Finanacing Forum 2019

[12] Revenue collection is the source and level of funds, pooling is the accumulation of prepaid revenues on behalf of a population and purchasing is the transfer of pooled funds to providers on behalf of a population.[12]

Section 4 puts forward the health financing strategy approach and dynamic framework; Section 5 lays out the key longstanding health financing issues and strategies; Section 6 presents health financing function strategies; and Appendix 1 contains the implementation plan table.

CHAPTER TWO

Vision, Goals, Objectives, and Guiding Principles

2.1 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."[13] Consistent with the 2015 HFS and 2019 UHC Roadmap, the vision of the Ghana HFS is moving towards UHC. The vision is comprehensive including all types of public and private financing. It balances revenue increases and improved expenditure management. Expenditure management includes efficiency gains to extend coverage and increase sustainability together with direct links to desired service delivery and quality improvements.

2.2 Goal

The goal of the Ghana HFS is equitable, efficient, effective, transparent, and sustainable heath financing mechanisms that contribute to achieving improved health outcomes, financial risk protection, consumer responsiveness, and access to quality essential health care and population-based services for all by 2030.

2.3 Objectives

The objectives of the Ghana HFS are to:

- Improve resource mobilization to ensure sufficient and predictable revenue
- Efficiently allocate and use health sector resources
- Promote equity in the distribution of health resources and use of health services
- Reduce financial barriers to access health care
- Motivate, incentivize and stimulate service delivery and quality improvement and increase population satisfaction and involvement in their own health
- Strengthen governance, management, transparency, and accountability in the mobilization and use of health resources
- Enable financing for strong population-based public health functions that can prepare for and respond to emerging threats

[13] UHC Roadmap

2.4 Guiding Principles

The guiding principles below are principles, standards, values, and expectations that have been considered in the development of the HFS:

- Sustainable financing and efficiency
- PHC as the level of emphasis
- Gradual shift from narrow program- or scheme-financing to broad system financing
- Strengthen inter-sectoral approach
- Enhance financial management capacities at all levels of the system
- Rationalize distribution of resources, including health workforce
- Commitment to global initiatives (Paris, Abuja, Ouagadougou declarations)

CHAPTER THREE

Country Context, Current Financing Situation and Challenges[14]

Ghana's estimated population was 31.7 million in 2021 with a growth rate of 2.1% and population density increasing from 103 to 137 people per sq. km between 2010 and 2020. The population between 15- and 64-years old stands at 60%, with 37% under age-15 and 3% older 65-years and older. The total fertility rate is 3.8 births per woman and about 42% of the total population lived in rural areas as of 2021. Life expectancy has increased from 61 years in 2010 to 64 years in 2021. Ghana's gross domestic product (GDP) was estimated at 459,130 million Ghana cedi in 2021 ($77,594 million USD) which places the country as a lower-middle income (LMIC) with GDP per capita of 14,469 Ghana cedi ($2,445.3 USD).[15]

Ghana is entering into this new HFS at a different position than where it was in 2015. While many of the same health financing issues persist, the health system and overall macro-fiscal environment has evolved. The 2022 Ghana Health Public Expenditure Review presents this context, as well as priority areas to address through the health financing reforms laid out in this strategy. The content below is referenced directly from this 2022 Ghana Health Public Expenditure Review.

Health spending

On average, Ghana's total health spending is lower than comparator Sub-Saharan African and lower-middle income countries (Table 3.1). However, it has a relatively higher share of health spending derived from public sources as compared to out-of-pocket sources. The predominance of public financing for health is viewed as an important factor in Ghana's improved health system performance, whereby the UHC service coverage index improved from 41.6 in 2010 to 49.1 in 2019, with an average annual increase of 1.8% between 2015 and 2019. Financial protection is relatively good with 1.3% of the population spending more than 10% of their household income on health in 2012. Despite this good performance, out-of-pocket spending as a share of total health spending has remained relatively even and estimated at 36% between 2015 and 2019 (Figure 3.1).

[14] Ghana Health Expenditure Review: public health expenditure for UHC at the time of COVID-19, May 2022
[15] Above paragraph data taken from World Bank, World Development Indicators, accessed 19 October 2022.

Table 3.1: Ghana's performance in selected health-financing indicators compared to relevant comparator countries in 2019

	Ghana	Sub-Saharan Africa	Lower-middle income countries	Cote d'Ivoire	Senegal	Zambia
Current health expenditure per capita, PPP (current international $)	193.2	189.8	284.3	179.6	144.8	192.5
Domestic general government health expenditure per capita, PPP (current international $)	77.8	73.0	109.3	52.2	36.2	77.2
Current health expenditure (% of GDP)	3.4	5.0	3.8	3.3	4.1	5.3
Domestic general government health expenditure (% of general government expenditure)	6.5	*8.9**	*6.2**	5.5	4.3	7.0
Out-of-pocket expenditure (% of current health expenditure)	36.2	30.0	48.2	37.3	51.0	10.2
External health expenditure (% of current health expenditure)	11.3	13.0	2.9	15.2	17.9	43.7
Domestic general government health expenditure (% of current health expenditure)	40.2	39.5	39.1	29.1	25.0	40.1

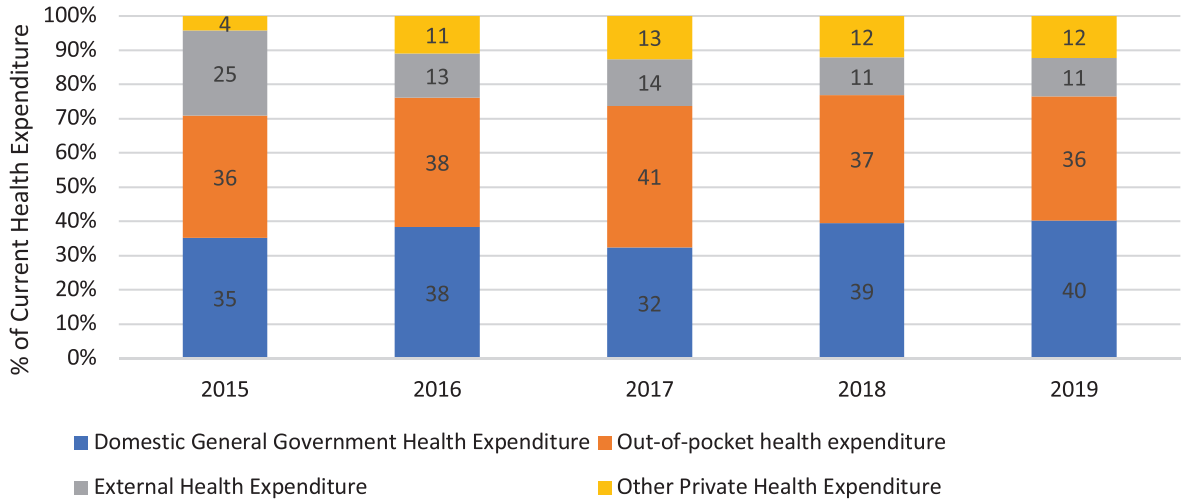
* 2018 data, computed using Population Weighted Average, taken from 2019 Ghana Health Public Expenditure Review

Source: World Bank, World Development Indicators and World Health Organization, Global Health Expenditure Database, accessed 19 October 2022

Total public spending on health has almost doubled between 2015 and 2019. This overall positive trend masks important variations. There has been a rebalancing of public spending on health, whereby on average 80% is channeled through the MoH budget and the NHIS spending share declining from 24% to 12% between 2015 and 2020. Of the MoH budget, those funds from domestic Government of Ghana revenues contributed 67% in 2020, with over 90% of those funds allocated to workforce compensation. The remaining sources of funds from Internally Generally Funds (IGFs), which include NHIS claims payments, and external assistance primarily fund the non-wage recurrent expenditures and capital expenditures (CAPEX).

External assistance for health has decreased dramatically as a share of total health spending between 2015 and 2019, falling from 25% to 11%. This number is higher on average as compared to other lower-middle income and there is a concern about a lack of significant policy measures needed to facilitate a transition process whereby previously supported donor interventions are sustained with domestic, public financing.

Figure 3.1: Current Health Expenditure by Financing Source



Source: WHO Global Health Expenditure Database, accessed 19 October 2022

Health financing system challenges (2017-2021)

The 2022 Health Public Expenditure Review raises a number of issues that go beyond spending dynamics to highlight structural challenges that continue to constrain the health financing system and overall health system more broadly. These issues serve as the basis for the priorities that are at the centre of this HFS.

There are clear concerns related to slowing economic growth and increased debt burden (e.g., interest payments comprised an average of 25.8% of the government budget in 2022). However, the structural issues point to areas where improved health financing mechanisms can better utilize existing resources. Currently, the health sector receives the SSNIT premium payment, as well as only a fraction of the now 2.5% VAT[16] earmarked for the provision of health services. The untimely release of funds from MoF to NHIS raises clear challenges in how those funds can be used. Since 2017, funds released to the NHIA for claims payments and

[16] COVID levy reference

other expenditure incurred in that particular year as a proportion of the budgeted releases for that year (excluding arrears payment) has reduced from 69.6% to 6.7% between 2017 and 2021. This means that only 6.7% of the 2021 expenditures could be taken care of after arrears payments.

In addition, the medical loss ratio for NHIS was only 52% in 2020, down from 92% in 2009 and below the suggested minimum of 80%. Additionally, only 17% of NHIA expenditures goes to the subdistrict-level and below, with 58% of NHIA expenditures going to district-hospital level. This bias towards higher-level, district hospital-based care also reflects that the NHIS benefit package does not include cost-effective, preventive services. Rather these services, which are excluded from the NHIS benefit package, are heavily dependent on donor funding, including for HIV/AIDS, tuberculosis, and vaccines for childhood immunization.

The separate financing flows for specific priority services is particularly concerning in the context of declining external assistance for health. These funds are predominantly off-budget, with between 61 and 73 percent of total DAH between 2016 and 2018 not recorded in the MoH budget. This raises questions as to the sustainability of these services, as well as broader system fragmentation of inputs and services due to differential financing flows and incentives.

NHIA enrollment has increased in recent years, reaching 54% of the total population over the course of the entire 12 months of 2021. However, the share of indigent population enrolled has decreased from 15% to 8% of total active members between 2014 and 2020. A similar decline is seen in the Free Maternal Care program. These declines also reflect important regional disparities. The expansion of NHIS coverage for the poor and most vulnerable sub-populations is an urgent action needed to make progress towards UHC.

Ultimately, this fragmentation in funding has consequences throughout the system and has direct implications for service delivery. Fragmentation in budgeting processes between MoH and NHIA limits the ability of health care managers to allocate resources effectively and efficiently. The combined issues related to the large share of the MoH budget going to compensation, along with how IGFs, which includes NHIA claims payments, are budgeted leads to complexity and possible duplications across the system. More broadly, these divergences contribute to an opacity in overall financial management, as demonstrated by the MoH expenditures outpacing its budget allocations.

Given the ongoing challenges faced by the Ghana health financing system, combined with ever-increasing economic pressures, efficiency of resources is central to the reform agenda. A

shift in NHIS payment methods from fee-for-service and G-DRGs towards more strategic purchasing systems that provide better value for money and align service delivery with population health needs is seen as a key change that is needed in the system. These shifts, combined with full implementation of programme-based budgeting, will enable a more flexible and accountable form of resource allocation. These health financing adjustments will be central to implementing the network of practice model as a means to establish structure needed to deliver universal PHC.

Persistent longstanding health financing system challenges (2022)

The 2019 review of the 2015 HFS implementation lays the groundwork for the key long-standing issues that are highlighted in this 2022 HFS. First was the discontinuation of the envisioned expansion of the NHIS PHC capitation payment system and the related key activities of formation of preferred PHC provider networks. This HFS intends to address this unfinished business, along with other key issues, through concrete strategies and activities.

The five key longstanding health financing issues that are proposed to be addressed through the strategies and actions in this HFS include:

1) **PHC structure and purchasing services:** To resolve longstanding issues and realize the UHC Roadmap vision by creating synergies between strengthening PHC structure through networks of practice (NoP) and purchasing integrated first point of contact front-line PHC services through output-based provider payment.
2) **Service provider autonomy, management, and accountability:** To strengthen service provider financial management. This includes facility autonomy to receive, use and manage funds as well as improving public financial management (PFM) systems to ensure sound facility management and accountability.
3) **Address NHIS revenue issues including LNIL and SSNIT capping and transfer:** To mitigate the impact of capping and reduce delays in transfers between Ministry of Finance and the National Health Insurance Fund to enable a more predictable and timely flow of funds.
4) **Mix of compensation and non-compensation costs:** To address the rapidly worsening proportion of public funding for compensation and non-compensation costs as well as the fragmentation and conflicting financial incentives between MOH budget (input-based payment) and NHIS purchasing of benefit package through output-based payment.

5) **Prioritization and investment across types of health services**: To improve programme budgeting structure and visibility for population-based public health services including pandemic preparation and manage the transition of external assistance for MOH priority programmes.

The linkages of these issues with the broader health system and UHC goals are portrayed in Figure 4.1 and described detail in Section 5.

CHAPTER FOUR

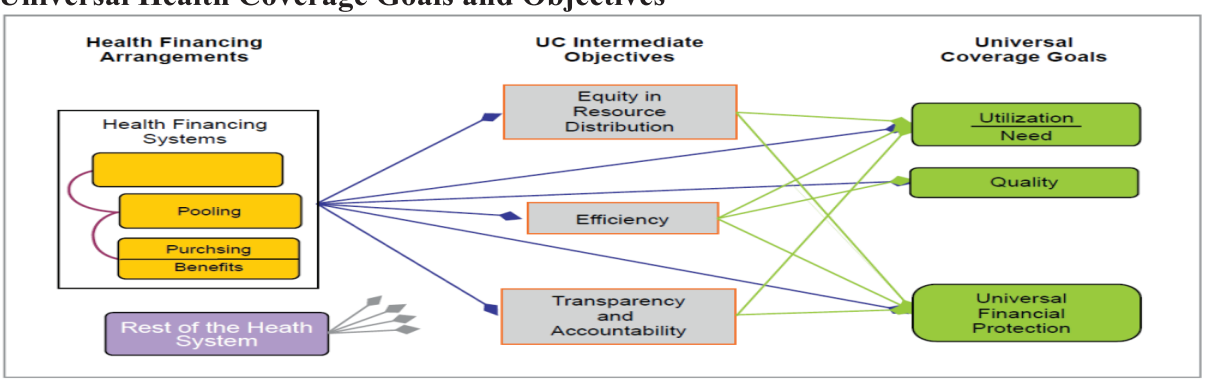
Health Financing Strategy Approach and Dynamic Framework

4.1 International Concepts and Experience

The World Health Report 2010 states that financing systems need to be specifically designed to provide all people with access to needed health services (including prevention, promotion, treatment, and rehabilitation) of sufficient quality to be effective and ensure that the use of these services does not expose the user to financial hardship. Consistent with the principles and policy of the Ghana UHC Roadmap, international health concepts and experiences over the last decade have raised the visibility of the goal of attaining UHC.

As shown in Figure 4.1 there is a strong and direct relationship between HFS and UHC goals and objectives. This conceptual relationship is also practical and country-specific as it's based on the three health financing functions of revenue collection, pooling of funds and health purchasing which allows formulation of country-specific strategies and action steps in each function, and also links the functions together consistent with country environment and context. Countries can't simply spend their way to UHC such that getting beneath commonly used labels such as "tax-funded systems" or "social health insurance," moving from schemes to systems, not compromising equity including recognition of the role of general revenue in cross-subsidization, and prioritizing strategic health purchasing as the main health financing instrument for promoting efficiency in the use of funds are gaining prominence in pathways to UHC.[17] This emerging international experience and consensus is consistent with Ghana UHC Roadmap policy and serves as the foundation of the Ghana HFS.

Figure 4.1: Relationship between Health Financing Functions and Arrangements and Universal Health Coverage Goals and Objectives



Source: WHO

17

4.2 Ghana Health Financing Dynamic Framework

The HFS is a vehicle to enable Ghana to realize its vision of moving towards UHC. Achieving the goals and objectives stated above requires converting theory to practice through an overall approach and implementation sequencing that reflects the nature of the Ghana context and environment. A dynamic framework illustrating the relationships and action inherent in the HFS is shown in the chart in Figure 4.1. It encompasses the entire HFS and portrays the relationships between the 11 specific strategies contained in Sections 5 and 6. It includes all sources of funding, as well as all institutions and stakeholders involved in health financing, and enables addressing challenges and connecting goals and objectives to specific activities. It also incorporates the broader public health response and resilience in the context of COVID-19 and other emerging global public health threats.

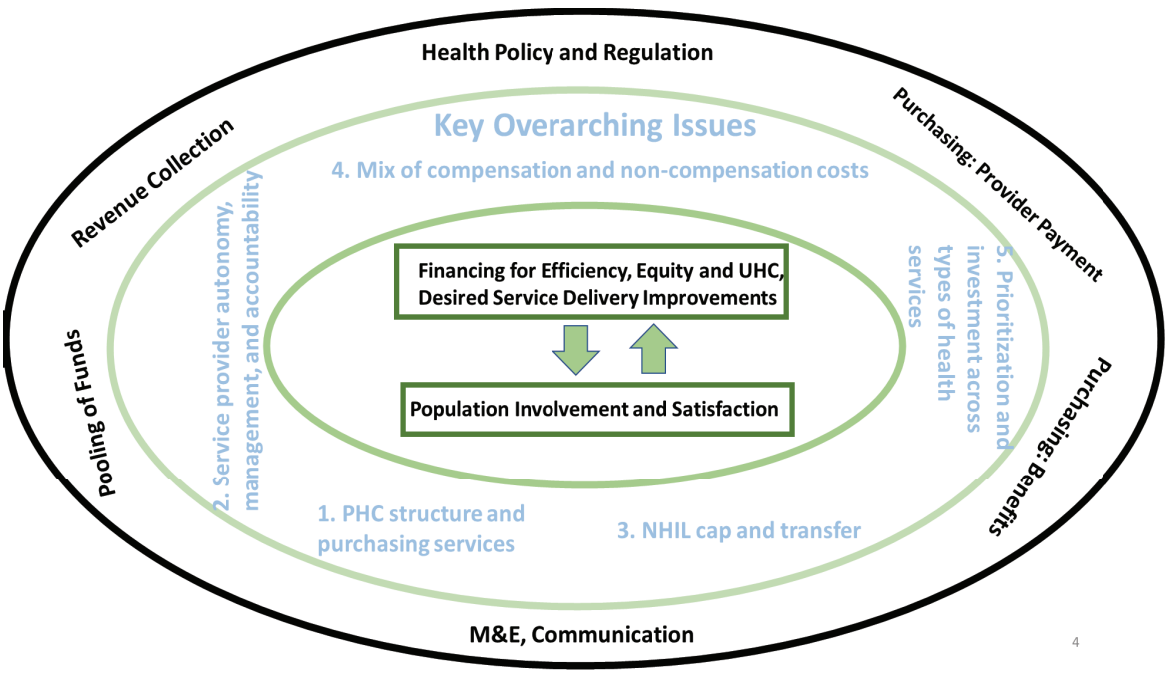
At the center of the circles in the dynamic framework is the continuously iterating and improving relationship between increased financial risk protection from more equitable and efficient financing which together with improved service delivery move towards UHC, and population and community satisfaction and involvement in their own health. A two-pronged HFS approach encircles this health system and population relationship. First, is recognition of the five persistent and intractable or key longstanding health financing issues in Ghana described in the challenges section above and shown in the circle in blue in Figure 4.2. The second prong or element of the Ghana HFS approach is portrayed in the outer circle of Figure 4.2 and is based on the three health financing functions together with governance/health policy and regulation, M&E and communications. The overarching strategy is to create synergies between a deep dive to resolve key longstanding health financing issues and the general strengthening and realigning of the health financing functions.

There are many similarities between Ghana HFS 2015 and HFS 2022 frameworks as they are both based on the health financing functions prioritizing health purchasing and more efficient use of resources. The main distinction relates to the five key longstanding issues that emerged from lessons learned over the 10-20 years. Many of the key health financing issues sit at the intersection of health financing/PFM and health service delivery. Creating a new intersection and solidifying it will be an HFS priority. NHIS was established in 2003 and is now a matured health financing mechanism such that its challenges are unlikely to dissipate over time and should be proactively addressed. Persistent service delivery challenges also exist including the nature of PHC structure. In the next generation of health financing in Ghana, health purchasing

and its relationship to PFM will be solidified including shifting funds and strengthening PHC purchasing. The service provider side will further develop by strengthening PHC structure and the establishment of management entities to both respond to purchaser incentives and serve as a basic business management platform upon which to build desired service delivery improvements and increase population involvement and satisfaction. Linkages and synergies between health financing and service delivery will emerge as portrayed in the dynamic framework.

Health Financing Strategy (HFS) 2022 contains 11 strategies. The five key health financing issues represent HFS Strategies 1, 2, 3, 4, and 5. The key health financing issue sections go into depth and contain a description of the persistent longstanding issue as well as the strategies intended to resolve it. A governance, health financing policy and monitoring and evaluation (M&E) feedback loop represents Strategies 6 and 11. The health financing function of revenue collection is Strategy 7, pooling of funds is Strategy 8, and the health purchasing function is Strategies 9 and 10. Most strategies contain a short implementation sequencing description consistent with the overarching strategy and dynamic framework. An implementation plan table is contained in Appendix 1. It contains the HFS structure of 11 strategies sub-categorized by activities under the strategy. The table details activities, responsible parties, timeframe, and indicators.

Figure 4.2: Ghana Health Financing Strategy Dynamic Framework



CHAPTER FIVE

Strategies to Address Key Health Financing Issues

The five key and longstanding health financing issues portrayed in Figure 4.2 set the foundation for the HFS priorities. The issues are:

1) PHC structure and purchasing services;

2) service provider autonomy, management, and accountability;

3) NHIS revenue issues including NHIL and SSNIT cap and transfer;

4) mix of compensation[18] and non-compensation costs; and

5) prioritization and investment across types of health services.

They are the focus of a deep dive to explore options and develop, implement, and refine solutions. The issues were identified through a combination of UHC Roadmap, HFS 2015 experience and lessons learned, close interactions and discussions with key stakeholders in the Ghana health financing system, HFS 2022 Technical Working Group (TWG) meetings[19] and global health financing experience. They are corroborated by the findings of the 2022 Ghana Health Public Expenditure Review and the Review of Ghana's National HFS 2019. The five key issues focus on efficiency and expenditure management together with a critical revenue problem and they are described below with corresponding strategies for improvement.

5.1 PHC structure and purchasing services

At the heart of the UHC Roadmap and HFS guiding principle that PHC is the level of emphasis to improve service delivery[20] is PHC structure and purchasing services. The six main UHC Roadmap challenges shown in Figure 5.1 relate to PHC-related priorities. Resolving these challenges requires substantial health financing and management contributions inherent in the key issue of PHC structure and purchasing services (challenge 1). They are also contained in the other four key longstanding health financing issues whose resolution is the HFS foundation: NHIL cap and transfer (challenge 1); mix of compensation vs. non-compensation operating costs (challenge 6); service provider autonomy, management, and accountability (challenges

[18] Salaries and allowances

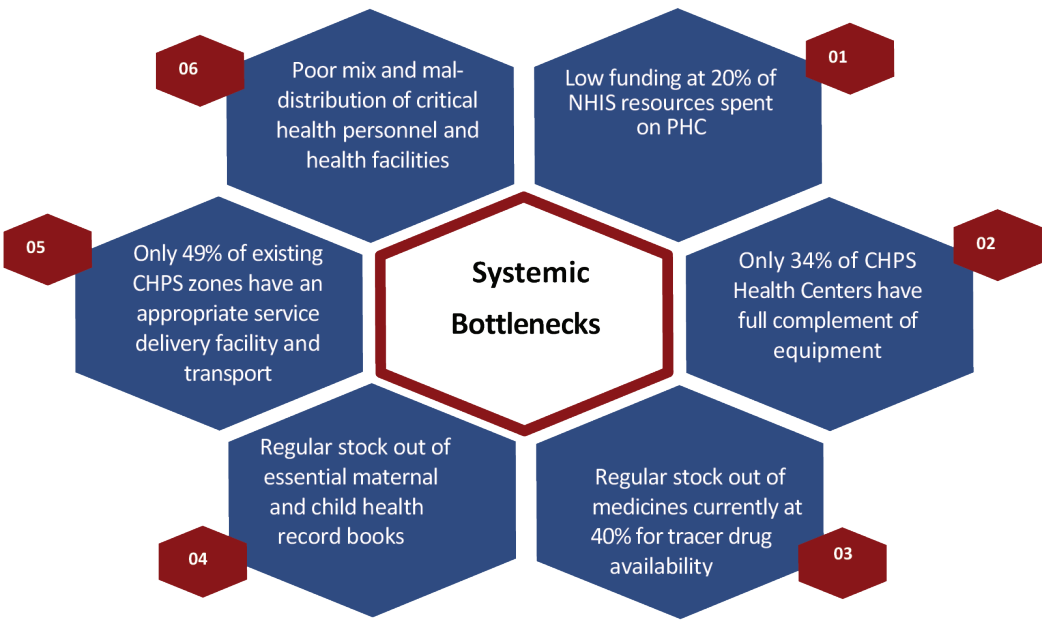
[19] Appendix 1 documents TWG meeting dates, number of participants and presentations made by Ghana agencies

[20] From UHC Roadmap

2, 3, 4, 5); and prioritization and investment across types of health services (challenges 2, 3, 4, 5).

Government non-salary budgetary allocation to health and total budget as a percentage of GDP has reduced significantly since 2010.[21] Direct service delivery expenditure mainly comes from NHIS, which constitute 80% of all payment for non-salary operating costs of services. PHC only constitutes 21% of NHIS expenditure and 79% is spent on secondary and tertiary care. The UHC Roadmap priority intervention for health financing is "NHIS financing framework and management will undergo reforms to improve its efficiency. The NHIS will prioritize PHC and allocate at least 50% of its resources to fund PHC expenditure."[22] A pre-condition for shifting funds to PHC is sufficient and functioning PHC structure.

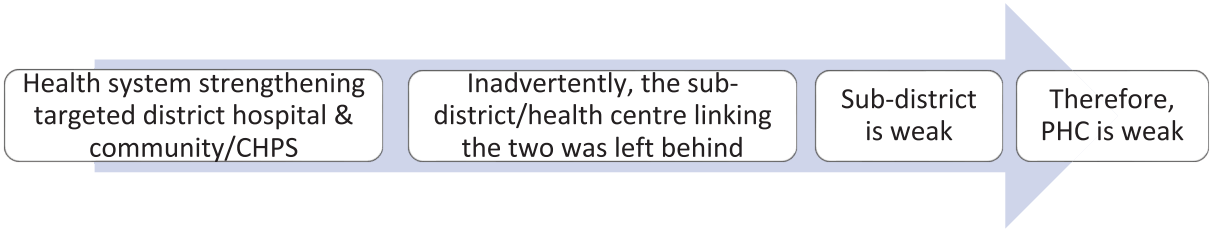
Figure 5.1: The six main UHC Roadmap challenges, as related to PHC-related priorities.



PHC structure

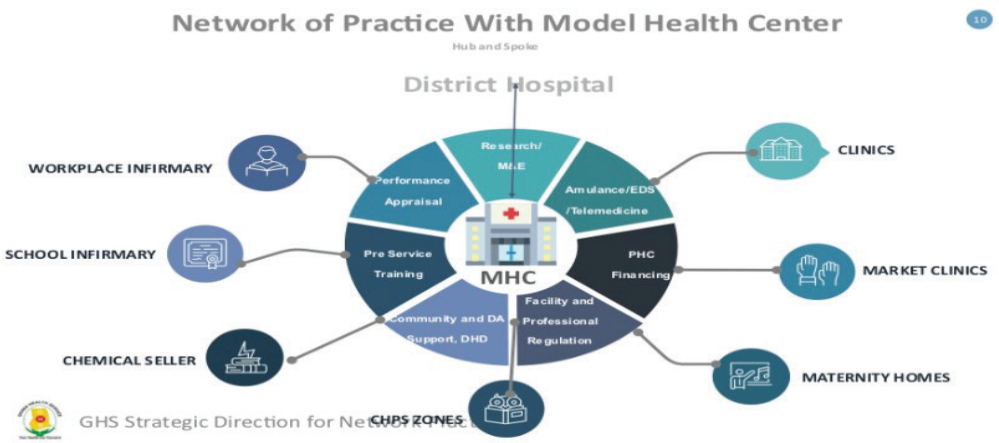
As shown in Figure 5.1, dialogue led to the conclusion that health centres are the weakest link in the PHC system with issues in systems, service delivery, operational efficiency, and demand generation.[23]

[21] https://data.worldbank.org/indicator/SH.XPD.GHED.GD.ZS?locations=GH
[22] From UHC Roadmap
[23] Ghana Health Service Network of Practice Presentation to HFS TWG meeting



Lack of clear vision on PHC structure has hampered the purchasing of PHC services. The UHC Roadmap identifies networks of practice (NoP) as a key strategy to strengthen PHC and achieve UHC in Ghana. NoP are a group of public and private PHC facilities in a specified geographic area functionally connected to each other to maximize efficiency and improve service delivery. As shown in Figure 5.2 below, they are designed with health centres as hubs at the NoP center and a variety of other types of service providers as spokes surrounding the center.

Figure 5.2: Network of Practice with Model Health Center



Purchasing PHC services

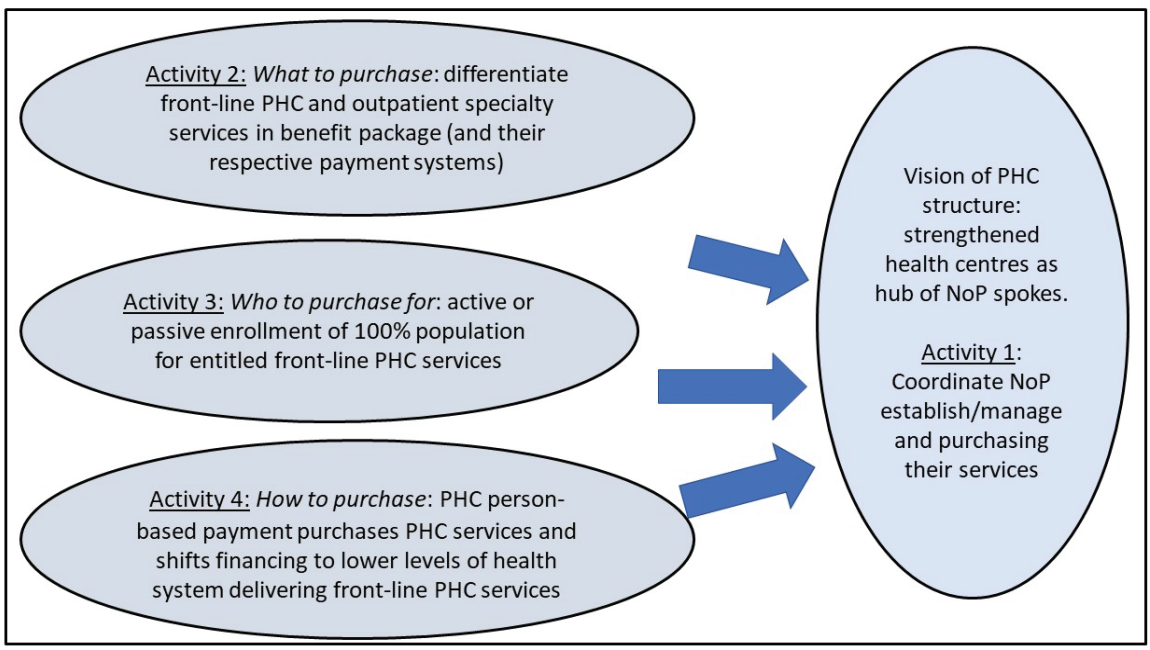
Years of dialogue, development and pilot interventions support the conclusion that many health systems functions and disciplines did not perform well on the high priority task of strengthening PHC: 1) service delivery structure and management were not well-developed; 2) health service and benefit package prioritization was not clear, not realized, or did not include important preventive and promotive-oriented services and commodities; 3) enrollment for the most equitable and cost-effective PHC services never approached 100% (hovering well under half the population at 30-50%); and 4) together MOF/MOH input-based budget and NHIS fee-for-service are less than optimal provider payment systems to purchase front-line PHC services.

The convergence of these four problems hampered shifting money and staff to the base of the health system pyramid and its priority health services serving people and communities. Resolving this key issue requires addressing it comprehensively from both health purchasing and service delivery sides. This approach will address the weakness of HFS 2015 implementation identified in Review of HFS 2019, where the linkages across health system functions was not strong enough to enable front-line PHC financing and management improvements including PHC per capita payment implementation.

Strategy 1 is strengthening purchasing of PHC services. The strategy is portrayed in Figure 5.3. The four circles comprise the HFS activities to realize this strategy listed and described below and in Appendix 1:

- Coordinate NoP establishment/management and financing to purchase their services
- Differentiate front-line PHC services and outpatient specialty services and the payment systems to providers or management entities that deliver them
- Active or passive enrollment of 100% of population for entitled front-line PHC services
- PHC person-based payment purchases PHC services and shifts financing to lower levels of health system delivering front-line PHC services.

Figure 5.3: Activities to strengthening purchasing of PHC services



<u>Activity 1</u>: Coordinate NoP establishment/management and financing to purchase their services.

Clarity on the PHC structure vision of NoP provides a fresh start and an opportunity to optimally purchase PHC services. However, sequenced parallel activities and substantial coordination of the financing and service delivery sides is required to establish NoP and sustainably manage them to strengthen PHC, increase utilization, and manage gatekeeping and referrals. NoP implementation plan will guide districts on how to set up the networks. These plans and guidelines should be closely coordinated with NHIA to enable harmonization with PHC payment contracts, systems and processes. Specific focal points: to credential or accredit NoP ensure harmonization of Health Facility Regulatory Agency (HeFRA) and NHIA requirements; accredit the right types and levels of facilities (priority in health centre staffing is physician assistants); recognize NoP as one entity; contracting terms and internal NoP financial agreements for revenue sharing; and health centre financial management capacity. In addition, establishment of NoPs could be done in phases. For example, first steps in rural areas and with public providers will buy time to further develop urban NoP model and address the substantial complexities involved in payment rates for private providers that include labor costs.

<u>Activity 2</u>: Differentiate front-line PHC services, outpatient specialty services, and the payment systems to providers or management entities that deliver them.

The NHIS benefit package lumps all outpatient services into the same benefit category (excluding a few MOH priority programs). It contains general and specialist consultations and reviews, diagnostic testing including laboratory, x-ray, ultrasound, Ct sacn, MRI, and drugs on the NHIS Medicines List. PHC services will be defined as services delivered at health centre level and below (primarily by physician assistants).

The same provider payment system may not be optimal for both integrated first point of contact or front-line PHC services and outpatient specialty services. Designing an appropriate payment system for outpatient specialty services is one of the greatest health purchasing challenges due to the difficulty in defining and/or bundling the unit of service for payment and the tendency for supplier-induced demand. In addition, the volume of outpatient specialty visits and diagnostic tests and their corresponding payments may overwhelm the intended shift of funding and services to PHC-level. Therefore, the benefit package and type of payment system will be differentiated for integrated first point of contact, front-line PHC and outpatient specialty

services. Any health centers also providing outpatient specialty services will receive two types of NHIA provider payment.

Activity 3: Active or passive enrollment for 100% of population for entitled front-line PHC services.

The intent of NHIS and its benefit package is that the entire population benefit from accessible, efficient, equitable and quality front-line PHC service delivery. Functioning NoP cannot be established and provide these integrated front-line PHC services in its health centre hub and spokes if it is only paid to serve 30-50% of the population. Enrollment of 100% of the population is needed to invest in a strong system foundation delivering PHC services and providing the gatekeeper function.

This activity will implement a combination of active and passive enrollment in designated front-line PHC service provider (NoP). Passive enrollment means the entire population of Ghana would either actively enroll themselves or be assigned by catchment area to a PHC provider for front-line PHC services. It would enable PHC providers to plan their services for the year including gatekeeper function, prioritize health prevention and promotion, shift funds to PHC, fully implement PHC purchasing/provider payment, establish foundational capacity at the base of the Ghana health system pyramid, and move towards UHC as 100% of population are enrolled and entitled to access benefit package services. Active enrollment would still be required to access outpatient specialty or inpatient services.

Consistent with 100% enrollment, NoP will deliver facility and community level preventive and promotive services to their entire enrolled population. NoP will also strengthen the health system structure foundation to enable PHC to deliver most of the patient-centered services needed and wanted by the population, perform the gatekeeper function, and manage and reduce referrals to higher health system levels. They will also inform the population of their rights and responsibilities under NHIS and promote increases in active NHIS enrollment.

Activity 4: PHC person-based payment purchases PHC services and shifts financing to lower levels of health system delivering front-line PHC services.

Currently, health centres receive little NHIS funding and have difficulty administering claims management. Lack of funding and incentives hampers delivery of PHC and community level preventive and promotive services. The task is to determine how best to pay NoP and its health centre hub to establish capacity and manage delivery of high-quality, integrated, first point of contact, front-line PHC services equitably and efficiently to the population. Strengthening PHC

is about paying for services rendered but also about ensuring sufficient and functioning capacity exists to deliver those services and effectively play the gatekeeper role.

The fundamental question: what is the optimal NHIS provider payment system to purchase NoP PHC services and shift funds to strengthen PHC? It will be almost impossible to use fee-for-service payment to shift funding to integrated first point of contact, front-line PHC services consistent with UHC Roadmap. Fee-for-service relies on the population to access services through a PHC system whose development cannot be supported by the payment system. In addition, fee-for-service escalates cost, is unpredictable and tends to undervalue PHC in comparison with specialized services. Therefore, it will not invest sufficient and stable funding to build a foundation for the most cost-efficient and equitable PHC sector.

Assuming it is purchasing only integrated front-line PHC services and not outpatient specialty services, PHC person-based payment[24] is an appropriate and timely provider payment choice for the UHC Roadmap stated objectives. There is no silver bullet or perfect provider payment system; however, international experience demonstrates there are optimal payment system choices to maximize performance against policy objectives (e.g. efficiency, equity, access, quality) in unique country environments at specific times in their health system reform or development processes. Options considered in the HFS development process were direct, person-based PHC payment to NoP or conversion of person-based payment to a global budget paid to NoP. The two options are closely related but direct PHC person-based payment was selected, as it is more transparent with more direct incentives than conversion to a global budget based on PHC per capita payment.

A second policy or strategy consideration in the specification of a provider payment system is whether output-based payment uses an absolute flat fee or a payment formula. A flat fee pays the same rate for all services for all people in a category and does not vary payment either for cost factors differentiating the service or for desired policy objectives. A formula-based approach has the advantage of incorporating both budget neutrality and payment adjustors for facility or individual level cost differences or other desired policy objectives. Most payment formulas are specified as:

base rate per unit of service*number of service units*payment adjustors.

[24] Global terminology is often PHC per capita payment

Base rate*service units will set the total budget ceiling for the defined services across all health facilities paid using the system. Payment adjustors and their corresponding relative payment weights adjust payment to reflect need, equity, performance, or other policy objectives in payment systems including PHC per capita and case-based hospital payment systems. Relative payment weights reflect the relative difference in cost per unit of service and are calibrated to 1.0 to avoid total payment exceeding the budget ceiling.[25] To be clear, formula-based payment adjustors are well suited to add performance-based payments often referred to as results-based financing, pay-for-performance, or performance-based financing. Performance payments could be targeted at priority health services including mental health. While the detailed activities included in the Implementation Plan in Appendix 1 will determine final PHC payment system design, the design is expected to reflect formula-based policy choice.

All priority health services will be covered in PHC person-based payment including MNCH, Reproductive health, NCDs, Malaria, HIV, TB and Mental health. It is envisioned that all allowed costs would be bundled into the PHC person-based payment (e.g. supplies, drugs, utilities, transport, small equipment, equipment maintenance, and other non-compensation costs). Claims management will be consolidated and simplified under PHC per capita payment. Claims are not submitted for payment; rather, payment is determined and paid prospectively to each eligible provider. It is calculated using the national yearly base payment rate determined in the budgeting process, provider actively and passively enrolled or catchment population, and provider data values for each payment adjustment. Quality assurance is performed by use of health monitoring indicators for PHC-sensitive conditions rather than a separate claims management system. Interoperable and efficient MOH and NHIA systems will avoid undue administrative burden on front-line PHC providers already grappling with substantial labor HR shortages.

In summary, PHC person-based payment with its certain and predictable payment amounts can push funding to the frontlines and enable PHC NoP and their health centre hubs to establish stable high-quality service capacity, perform the gatekeeper function, and develop and manage a strong foundation of front-line PHC services for the entire population. It is expected to serve as the glue linking health financing/purchasing and service delivery as shown in Figure 4.2 and increase access, equity, and efficiency on the road to UHC.

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[25] From WHO Policy Brief Direct Facility Financing: Concept and Role for UHC

5.2 Service provider autonomy, management, and accountability for the receipt, use and management of funds

Health care financing and management are two sides of a top-down and bottom-up process involving national institutions focused on policy, financing and purchasing health services, and service agencies and more autonomous service providers focused on receiving, using, and managing funds. Service providers deliver health services to the population consistent with their incentives and financial management systems and processes. Health service providers, including public and private hospitals and PHC providers, can function as businesses or management entities when they establish a basic financial management platform (differentiated from clinical service delivery) and take full advantage of robust financial management systems and processes.

Establishment of good financial management systems and processes at provider level enables facilities to diligently account for the inputs procured, report on the use of funds and provide an audit trail to facilitate financial accountability. The autonomy to directly receive funds paid for outputs and the flexibility to manage procurement of inputs to produce and deliver desired services must be underpinned by sound health facility financial management and accountability. [26] This key longstanding issue recognizes the different dynamics, activities and sequencing of provider payment and facility financial management as two separate but related elements of health purchasing or budget execution.

Strategy 2: enhance service provider autonomy, management, and accountability to receive, use and manage funds.

Activities are categorized by the UHC Roadmap and HFS priority of NoP with health centre hubs and all public and private service providers. To manage NHIS payments, sequencing of NoP financial management system and capacity development is vital. The first step is to improve health centre financial management and governance to prepare them for their role as NoP hubs, and the second step to establish and improve financial management, governance and coordination across the entire NoP. Three HFS activities listed and described below will realize this strategy:

- Strengthen health centre financial management and governance and prepare them for their role as NoP hubs.

[26] From WHO Policy Brief Direct Facility Financing: Concept and Role for UHC

- Establish, manage, govern, and coordinate NoPs nationwide including their health centre hub and surrounding PHC and community level spokes.
- Strengthen provider financial management and governance for all public and private service providers.

<u>Activity 1</u>: Strengthen health centre financial management and governance and prepare them for their role as NoP hubs.

This activity encompasses the autonomy health centres will require to receive funds directly, the nature of their response to financial incentives, and their financial management platform or how they manage funds including planning, budgeting, procurement, internal controls, accounting, financial reporting, and their facility governance and accountability. Strengthening health centre management and governance will enable them to play a leading role in establishing and managing NoPs to increase equity and efficiency and incentivize management of quality health service delivery.

A brief health centre situational analysis emerged from HFS TWG dialogue. Health centres have bank account (districts are also signatories) and can receive payment for services. Health centres are allowed to procure inputs (request and pay). Currently, procurement is primarily done by other government levels, but if provider payment evolves and health centres receive more funds directly, PFM procurement procedures could be adjusted. PFM systems for financial management including planning, budgeting, accounting, and reporting are not extended to health centre level but could be developed and implemented to enable health centres to better manage their own service delivery and serve as NoP hubs performing financial management functions. Drug payment and supply management needs to be extended and improved. This would include roles and drug procurement and management processes. Health centres have facility governance structures and functions. Currently, they primarily focus on citizen engagement, but their roles could be adjusted to enhance financial management including separation of functions.

Specific activities will strengthen health centre financial management and governance (see IP detail in Appendix 1). Financial management staffing for health centre hub of NoP will consist of at least one financial officer or accountant. PFM or financial management systems and processes will be designed or refined to extend to health centre level including planning, budgeting, accounting, reporting, together with data analysis to improve provider management decision-making. Health centre financial management procedures, manuals, common

management arrangements, and capacity building will be developed. Procurement systems, procedures, and processes will be designed, refined or extended to health centre level. Output-based payment delegates to facilities rights and accountability to determine and procure the best mix of inputs to produce, manage, and deliver service outputs to clients. What types and levels of inputs to be procured at health centre level will be determined in design of the PHC person-based payment system and the associated contracting mechanism.

Drug prescription, procurement and dispensing procedures will be improved and adapted to increased direct health centre financing/provider payment. Improvements or adaptations include refining facility and prescribing levels, changes in drug supply and procurement roles and corresponding rules enabling a mixture of national and facility level procurement and/or use of framework contracting (negotiate supplier or prime vendor contracts and facilities order through them to enable both facility involvement/transparency and management of drug volume, price and quality). Facility governance structure and function will be improved in the context of better separation of financial management functions, enhanced citizen engagement and participation in provider planning and budgeting.

<u>Activity 2:</u> Establish, manage, govern, and coordinate NoP health centre hubs and spokes to be accountable to PFM systems and rules, fiduciary obligations, and audit processes.

Establishing and developing NoPs requires clarity on all internal and external roles and relationships. Particularly important are financial management roles, relationships, responsibilities, rules, procedures, and processes for NoP receipt of funds and revenue sharing. One key financial management roles question is which NoP entities will receive funds directly and, therefore, be responsible for financial management? Options considered in the HFS development process were: 1) NoP health center hub will receive all funds and perform financial management functions for the entire NoP; and 2) one or more NoP spokes will be paid directly and will establish and maintain the required financial management systems.

Either option can work if financial management (i.e. PFM) systems and processes are well aligned to ensure good management, avoid financial compliance problems and establish good audit trails. If the highest priority is for each of the NoP "spokes" to function independently, then direct payment may best achieve this objective. If the highest priority is the NoP functions as a consolidated management entity, then health centres performing financial management functions may best achieve this objective. HFS dialogue selected a mixed model or hybrid to

recognize that NoP composition and roles should be flexible and responsive to the needs of its provider types, geographic and community environment. The reality that NoP health centre hub has the primary financial management role, NoP spokes will take time to develop, and financial management staffing will be limited in the early stages translates to an expectation that in most NoP health centres will receive and manage funds.

A second financial management roles and relationships question is how revenue received by NoP will be distributed within the network. What internal financial agreement will serve as the basis for revenue sharing? NoP implementation plans and guidelines should answer these questions and also incorporate internal financial agreements into contracts and financial management systems and processes to avoid confusion, conflict, contracting or fiduciary issues. It is assumed head of health centre hub reports to District Director for Health. NoP governance structures and organizational charts should make reporting relationships and audit responsibilities clear. Roles and relationships for private providers within NoP organizational and financial management may be complex and should be clearly managed.

In addition to clear financial management roles and relationships, the implementation plan in Appendix 1 will detail other activities contributing to NoP establishment, governance and management including funding to establish NoP; funding and management of administrative costs; details of NoP governance; financial incentives and procedures for NHIS enrollment and appropriate gatekeeping and referral processes; integration and management of vertical programs funded by domestic revenue or external assistance; and further development of an urban NoP model.

Activity 3: Strengthen provider financial management and governance for all public and private service providers.

This activity focuses on three questions or aspects of facility financial management and governance:

- Do public providers have the legal status, autonomy and flexible PFM systems and processes required to manage payments from NHIS purchasing of benefit package services?
- Do public service providers have the financial management systems they need to receive, use and manage funds?
- Do private providers have the access or interoperability to public systems to ensure efficient development and submission of required health and financial information?

More needs to be known about how national health and PFM policies, systems, rules, and processes filter down and impact day-to-day public service provider management. An assessment of health financing, purchasing, PFM, management, and governance from the bottom-up or service provider point of view would provide insight into public service provider autonomy and PFM. This includes planning, budgeting, procurement, internal controls, accounting and reporting for all funds flows (general revenue, donor, internally generated funds including NHIS, out-of-pocket, and other private). Specific areas of focus for this assessment include whether PFM systems, rules, procedures and processes hamper or support full implementation of NHIS purchasing of benefit package services through output-based payment, as well as the relationship between regulator licensing and accreditation and NHIA credentialing. Recommendations would be implemented to improve service provider management and governance.

Service provider financial management systems should be strengthened and extended to service provider level. In addition to Ghana Financial Management Information System (GIFMIS), performing national financial tracking and monitoring, robust facility-level systems and processes can be used by both hospitals and health centres as NoP hubs to manage their finances and service delivery. These systems should be interoperable between finance and health to the greatest extent possible and support improved planning, budgeting, procurement, claims management, accounting, financial reporting, and HR management. This activity also includes improving the structure and function of provider governing committees in the context of increased funding and procurement responsibilities requiring improved governance including separation of functions. One system could be used to account and report for all funds flows and also to report to all domestically- or externally- funded health programmes to increase efficiency, reduce service provider administrative burden and ensure one source of information is used for analysis to improve management and monitoring. Systems or processes for private provider claims submission, financial reporting or health statistics reporting could also be made simpler or more interoperable to reduce administrative burden.

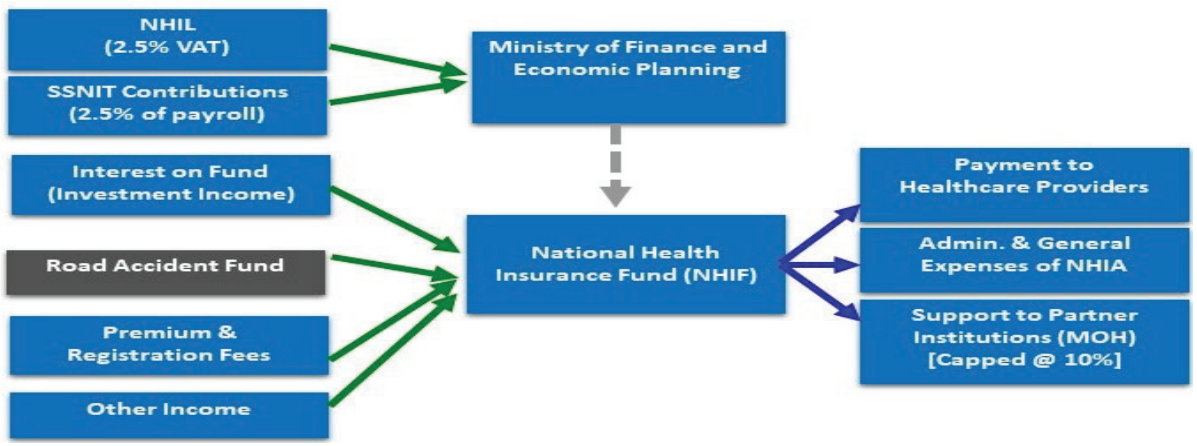
5.3 Address NHIS revenue issues including NHIL/SSNIT caps and transfer delays

NHIS revenue sources, administration and funds flows are shown in Figure 5.4 below.[27] Statutory funds come from three sources: National Health Insurance Levy (NHIL), which is

[27] PPT entitled Review of Health Financing Strategy by National Health Insurance Authority, April 2022

2.5% of domestic, and import value added tax (VAT), Social Security and National Insurance Trust (SSNIT), which is 2.5% of payroll tax, and National Insurance Commission Levy (NICL) or motor insurance premium/road accident fund. Domestic VAT is paid direct into the MOF Consolidated Fund and then transferred to the National Health Insurance Fund (NHIF) NHIL account at Bank of Ghana (BOG). Import VAT and SSNIT contributions go directly into the NHIL account at BOG. NICL is remitted directly into National Health Insurance Authority (NHIA) operations bank account. Non-statutory funds are paid directly into NHIA operational accounts and include investment income, premium and processing fees, donor funding, and other income. NHIS revenue source proportions of funding in 2021: levies income 93.99%, premium and processing fees 4.32%, investment income 1.52%, other income 0.16%, and bilateral donors 0.01%.

Figure 5.4: NHIS revenue sources, administration and funds flows



Strategy 3: Address NHIS revenue issues including NHIL/SSNIT caps and transfer delays.

The scale of the NHIS revenue problem is large and growing. Addressing NHIS revenue challenges will increase the amount, timeliness, certainty, predictability, and fairness of revenue forecast, collection, and transfer. Practically, the revenue challenges make it difficult to manage NHIS expenditures and pay providers for services delivered on a timely basis. Activities are categorized as policy and technical issues to improve NHIS revenue collection and a reform transition investment. While high and rising NHIS costs lead to increased revenue requirements, it is viewed as an expenditure management challenge and is discussed in the sections on health purchasing and key longstanding health financing issues. Sequencing

requires urgent work in parallel to implement activities. Three HFS activities listed and described below will realize this strategy:

- Verify, increase transparency, and advocate for management of Ghana's 25% earmark cap in a way that ensures full funding of statutory NHIL and SSNIT contribution
- Reduce delays in the reconciliation and release of NHIS funds from Government
- Premium increases and reform transition investment

<u>Activity 1</u>: Verify, increase transparency, and advocate for management of Ghana's 25% Earmark funding cap in a way that ensures full funding of statutory NHIL and SSNIT contribution. Caps are placed on NHIS NHIL (VAT tax) and SSNIT contribution based on the Earmarked Funds Capping and Realignment Bill, 2017.[28] Critical provisions of the law include:

- "The objects of this Act are to (a) free up public resources by placing a cap on the Earmarked Funds specified in the Schedule to ensure that tax revenue encumbered by those Funds as a result of allocations is twenty-five percent of tax revenue."
- "The Minister (MOF) shall ensure that the capped Earmarked Funds amount of twenty-five percent of tax revenue is allocated to the Earmarked Funds specified in the Schedule, each according to a weight which shall be approved by Parliament as part of the Annual Budget for each fiscal year and each Earmarked Fund shall be adjusted accordingly."
- "The Minister shall, in determining the weight to be applied to an Earmarked Fund for submission to Parliament for approval, be guided by (a) the allocation of budget revenue that the Earmarked Fund would have normally received if a cap was not placed on those Earmarked Funds, and (b) the corresponding weight that would have applied to the Earmarked Fund."
- "The identified Earmarked Funds specified in the Schedule and their weights for each fiscal year shall be appended to the Annual Budget."

Capping of NHIS funds from NHIL and SSNIT contribution has impacted NHIS revenue. The health sector falls under these fiscal rules; however, three HFS activities will verify, increase transparency and advocate for full funding of statutory NHIL and SSNIT contribution. First, HFS dialogue resulted in uncertainty about whether capping applied to SSNIT contributions,

[28] Earmarked Funds Capping and Realignment Bill, 2017

meaning health insurance, pensions and other contributions. Is a program, the size, scale and importance of all social security capped and/or is it an earmark tax or a mandatory withholding from employee salaries paid from non-earmarked sources? Secondly, although calculations and reports were initially provided on both budget estimates and actual revenue capping, they may no longer be provided and should be reinstituted to ensure transparency. Third, the health sector should advocate for management of 25% earmark budget cap in a way that ensures full funding of NHIL and SSNIT contribution as provided by law. At a minimum, this activity should ensure that NHIS revenue is not weighted in a manner that reduces its revenues proportionately more than other earmarked funds.

Activity 2: Reduce delays in the reconciliation and release of NHIS funds from Government.

One of the major challenges to NHIS revenue collection timeliness, certainty and predictability is delays in transfer of domestic VAT funds. "Since 2017, funds released to the NHIA for claims payments and other expenditure incurred in that particular year as a proportion of the budgeted releases for that year (excluding arrears payment) has reduced from 69.6% to 6.7% between 2017 and 2021."[29] This general revenue funding is at the heart of the progressive and internationally recognized NHIS architecture but trust of all stakeholders in NHIS functioning relies on the timely transfer of domestic VAT funds. To resolve this issue, HFS will proceed on two tracks: 1) develop and implement steps to speed up or fast track release of domestic VAT funds; and 2) amend Act 852 to enable direct transfer of 2.5% VAT (domestic and import) to NHIA, comparable to SSNIT contributions of employees which have been legislated to allow direct payment to SSNIT.

Activity 3: Premium increases and reform transition investment.

Health financing policy dialogue could consider increases in NHIS premiums for informal sector members, as they have remained fixed since inception almost 20 years ago. Success in achieving UHC and HFS goals and strategies depends on a reform transition investment sufficient to enable MOH, service delivery agencies and health purchaser transition to purchasing front-line PHC services from strengthened PHC structure, service provider level management and clinical practice. The investment could be in money, time, or both. The larger the reform transition investment, the less time it will take to establish PHC NoP structure;

[29] Health PER 2022

reduce NHIS transfer delays and clear arrears; shift to PHC person-based payment for 100% of actively and passively enrolled population; realign outpatient specialty and inpatient purchasing of NHIS benefit package services; create a better mix of compensation and non-compensation costs to support high quality service delivery; and harmonize and adapt pooling and purchasing arrangements for the non-compensation or service delivery costs of domestically and internationally funded MOH priority programmes. The critical challenge to address is the tsunami of rapidly worsening proportion of public funding for compensation and non-compensation costs undermining service delivery and increasing OOP payments. This tsunami is driven by increasing salaries, reduced NHIS proportion of total budget, and declining donor funds targeted at service delivery inputs.

On the service delivery side, the reform transition should invest in the costs of NoP establishment including capital equipment, finance and health systems, and capacity building. On the financing side, the reform transition should invest to enable NHIS to clear arrears, create a sub-pool to shift funds to PHC purchasing (person-based payment), realign outpatient specialty and inpatient purchasing giving providers time to adapt, and improve pooling arrangements for MOH priority programme non-compensation costs. For context, an estimate of the relationship between money and time is that without a reform transition investment, it could take 5-10 years to transition to new PHC structure and purchasing strategy and with a domestic and/or international reform transition investment; it could take 2-5 years to fully transition.

5.4 Mix of compensation and non-compensation operating costs

The proportion or mix of investment in compensation and non-compensation operating costs is a key longstanding health financing issue.[30] This mix and relationship has four interlinked problems that contribute to inefficiency, inequity, and poor service delivery. First is country health financing dynamics creating a tsunami that is rapidly expanding the scope and scale of the problem. “On average 80% of the public health expenditure is channeled through the MoH budget, which has more than doubled in nominal terms from GHC 3,927 million to GHC 8,776 million from 2015 to 2020. However, the NHIS budget as a percentage of public health

[30] Selected operating costs terminology (over other options such as recurrent costs) as relatively standard accounting terminology for non-capital fixed and variable costs of goods sold and operating expenses.

expenditure has declined over the same period from 24% to 12%."[31] Taken together, doubling the MOH health budget with approximately 90% going to compensation costs, halving the proportion of NHIS expenditure largely for non-compensation costs of service delivery, declining donor funding also tending to focus on service delivery costs, and the rapid shift in the mix of expenditures makes conditions ripe for increases in population out-of-pocket (OOP) costs which will undermine continued movement towards UHC. Strategies and activities addressing the first two key issues of PHC structure and purchasing, and service provider autonomy, management and accountability comprise reforms that will establish the conditions for more efficient and equitable investment in service delivery in the long-term. However, bottom-up reforms will not be sufficient and top-down rebalancing of compensation and non-compensation costs and HR rationalization will be required.

The second problem is fragmentation. Separate systems and processes for salary and non-salary operating costs funds flow, budgeting, and payment contribute to inefficiency and undermine planning, management, and coordination of health policy priorities. The third problem is the different and potentially conflicting incentives contained in the provider payment systems for civil servant health worker salaries and non-salary operating costs. MOF/MOH pays for health worker salaries using input-based payment and NHIS/NHIA pays for non-salary operating costs using output-based payment to purchase services (outputs) contained in the benefit package entitlement. Fourth, the top-down fund flows, budgeting and payments may not provide the appropriate mix or flexibility of inputs at the service provider level. If the proportion of payment for compensation vs. non-compensation costs is not optimal in each service provider including newly established NoP, it will be hard for the providers to manage delivery of high-quality health services to their patients and communities.

Strategy 3: Improve mix of compensation and non-compensation operating costs. Activities will improve both system-wide and service provider level mix of inputs, reduce fragmentation and improve incentives. As with all health financing issues and strategies, activities support overall health system strengthening and involve a relationship between health system functions. For this strategy, the key relationships are between health financing, human resources (HR), and service delivery. Concerning implementation sequencing, the first three activities are short-term, which means implementation will begin immediately after HFS

[31] Health Public Expenditure Review 2022

approval. The fourth is a longer-term activity with two phases: Phase I of study, design, and development, and Phase II of implementation (also see pooling and purchasing in health financing functions section). Four HFS activities listed and described below will realize this strategy.

- Introduce simulation model to support HR rationalization, distribution and redistribution according to facility utilization and need
- Extend planning and budgeting to facility level and introduce managerial accounting and capacity building to improve management, transparency and facility level proportion of compensation and non-compensation costs
- Coordinate with HR function to enforce HR management, improve HR recruiting, and implement financial and non-financial incentives to performance and improve staffing in underserved areas
- Engage in dialogue and develop long-term plans to improve pooling and corresponding purchasing arrangements for both compensation and non-compensation costs

Activity 1: Introduce simulation model to support HR rationalization, distribution and redistribution according to facility utilization and need.

This HFS activity will develop and implement a simulation model for staff allocation to health facility level to enable national government, local government, and health facilities to support HR rationalization, distribution and redistribution. The simulation model will document exact location of current staff and will simulate and analyze options for future HR allocation based on actual health facility utilization and need. Specifically, it will develop and use evidence-based information to: 1) analyze options and mechanisms to allocate public health facilities the necessary staff and salary costs (and conversely not allocate unnecessary staff); 2) analyze the impact of changes in HR and salary cost allocation across geography/regions, levels of care, types of facilities, and other parameters important to efficiency, equity, and service delivery; 3) support establishment of a better proportion of compensation and non-compensation costs and also assess the relationship between salary and allowances; and 4) analyze facility staff across types of facility ownership (public, private, faith-based) including how the mix of compensation and non-compensation is affected by contracting with private providers. Allocation and distribution of health workforce and their compensation costs is critical to health financing and moving towards UHC. Consistent with the UHC roadmap, prioritize analysis and improvement in health centre and NoP staff and salary cost allocation and distribution.

Activity 2: Extend planning and budgeting to facility level and introduce managerial accounting and capacity building to improve management, transparency and facility level proportion of compensation and non-compensation costs.

Refining existing or introducing new systems to extend annual planning and budgeting to health facility level is consistent with better HR management, improved planning and budgeting, shift to output-based payment, and provider autonomy, management and accountability. Service providers who perform planning and budgeting within parameters set by finance authorities, service delivery agencies and higher government levels will have the information and capacity to better implement plans and budgets and receive, use and manage their funds. It also establishes a mechanism to analyze and enforce an acceptable mix of compensation and non-compensation costs in each health facility thus establishing the conditions to improve service delivery, increase efficiency, and move towards UHC by increasing financial risk protection and reducing OOP payments.

Activity 3: Coordinate with HR function to enforce HR management, improve HR recruiting, and implement financial and non-financial incentives for performance and staffing in underserved areas.

A focus of enforcement is following the rules of HR posting, programs requiring or assigning staff to underserved areas for a certain period of time, transfers, staff supervision and support, and performance review. It could also include other small regulatory improvements in wage classification, allowances or other HR procedures to address financing and management issues hampering provider-level service delivery.

Improving HR recruitment and management is not a primary role of the health financing function. However, better matching HR budgeting and payment to priority health services, purchasing of NHIS benefit package services, and motivated staff driving provider service delivery management is critical to achieving the UHC Roadmap and related objectives of efficiency, equity, and high-quality services. HFS activities focus on coordinating activities with all responsible HR institutions, departments, or units to strengthen HR recruitment. This includes recruit according to regional need and from underserved areas, delegate tasks or increase involvement of local governments and health facilities in recruitment systems and processes, and HR recruitment and application portal that allows candidates to choose region and facility level vacancies rather than being assigned. This activity links to current studies in process and scaling up current strategies and links to management accounting processes above.

For incentives especially in underserved areas, the HFS priority will be non-financial incentives. Examples include transparent promotion processes, performance recognition, better working conditions, continuing medical education (facility level allowed costs), and improvement of internships or residencies in underserved areas. There has been mixed results and limited success with financial incentives for staff in underserved areas. Nevertheless, it is important to develop innovative ideas to make it easier for staff to commit to NoP or work in underserved areas including performance bonuses or district assembly allocation of funds or in-kind support including housing or transport.

<u>Activity 4</u>: Engage in dialogue and develop long-term plans to improve pooling and corresponding purchasing arrangements for both compensation and non-compensation costs.

In concert with the first key issue of PHC purchasing and fifth key issue of allocation across types of health services, policies on pooling of non-compensation service delivery costs need to be developed and implemented (see also pooling health financing function). In addition to proportionately declining revenue problem, fragmented funds flows for non-compensation (service delivery) costs across MOH EHSP/priority programme and NHIS benefit package reduces efficiency and creates conflicting financial incentives (input-based vs output-based payment). Pooling could be increased by NHIS transfers or unified provider payment systems could use purchasing to mitigate pooling issues for all facility level non-compensation or service delivery costs. Regardless of the option selected, it is clear both implementing the core PHC structure and purchasing strategy and ensuring efficient use of limited funding require improving non-compensation pooling arrangements.

In the long-term, pooling compensation costs and incorporating them into comprehensive purchasing of benefit package services can be considered. This intervention will have activities in two phases. Phase I in the first 1-2 years of HFS implementation is more extensive analysis and development of options for incorporating salary costs into NHIA provider payments purchasing NHIS benefit package services. Three options for analysis and consideration:

- Further strengthen simulation model for staff allocation to facility level to better link payment of HR and finance (money) budgeting and payment
- Use planning, budgeting, accounting and reporting systems extended to facility level to develop HR/salary cost allocation for each health facility (incorporate salaries on paper).

- Incorporate salary funds into NHIS provider payment purchasing of benefit package services (complete incorporation as money funding salary costs enters funds flow and cash payments)

Phase II will consist of realization of the selected option in the last 3 years of HFS implementation. Plans will be developed after selecting the preferred option. Given the priority of strengthening PHC in UHC Roadmap, HFS and other health policy documents, it is expected that a focus of this intervention will be incorporating salaries into PHC person-based budgeting and payment for health centres and NoP.

5.5 Prioritization and investment across types of health services

Investments in population-based, public health services underpinning both UHC and health security need to be balanced with the need for high-quality individual health services. This requires optimizing, aligning, and prioritizing financing levels and levers based on the type of services to be provided. This HFS lays out strategies to realign and de-fragment funds flows to improve efficiency and enable service delivery objectives, while also ensuring PFM enables both prioritization and realignment.

Strategy 5: Improve the prioritization and investment across types of health services. There are two aspects of this strategy. First, the current programme-budget structure does not give sufficient visibility to population-based, public health services. This includes population-based promotion and prevention activities, essential water and sanitation, and functions that are necessary for pandemic preparedness and response (e.g. disease surveillance systems). Second, beyond the organization of the programme budget, the persistence of input-based budget formation and execution modality does not enable cross-programme collaboration or integration, which constrains efficiency.[32] This structure can also act as a constraint to effective donor transition planning, whereby fragmented fund flows are locked into health programme budget categories and do not give sufficient visibility to the source of revenues. It can also obfuscate the distinction between individual and population-based services within specific health programmes. Generally, fragmentation across fund flows and types of service inputs hampers prioritization, resource allocation and budget formulation processes. Two HFS

[32] Ghana 2017 CPEA Study

activities listed and described below and in the implementation plan in Appendix 1 will realize this strategy.

<u>Activity 1:</u> Improve programme budgeting to help ensure sufficient funding, prioritization, and budget visibility for population-based public health services, including pandemic preparedness.

This activity involves a re-evaluation of the current programme-budget structure, including sub-programmes, to better align budget formation and inputs with types of service priorities and related institutions. Making these population-based, public health services and priorities more visible in the budget can enable advocacy and protection of funding as well as alignment of individual service funding towards payment for front-line PHC services. The MOH budget programme structure is well developed, but is a mixture of input- and output-based with plans and budgets for public health programmes existing in two or more places. For example, drugs for health services are under Management and Administration rather than the Health Service Delivery budget programme, such that the link to services delivered is less clear and the impact of declining donor funds is less visible. Enhancing budget formation to explicitly portray population-based, public health will enable better prioritization and clear identification of funding needs to support advocacy for increased health revenue allocation.

<u>Activity 2:</u> Develop concrete plans, including timelines, for external assistance for individual services in MOH priority programmes to transition to NHIS benefit package and purchasing.

Harmonizing, increasing transparency, and improving coordination of MOH EHSP/priority programmes and NHIS benefit package processes[33] is needed to enable sustainable and efficient coverage of services and mitigate the risk of declining donor funding. Shifting services to the NHIS benefit package and increasing the health budget will likely both be needed as part of a sustainable transition process. The first step in this process will be to consider which individual services now funded through the MOH budget should be identified in the context of establishing and purchasing universal PHC benefits. The relationship between the MOH-funded services/programmes and NHIS benefit package should continuously evolve consistent with health policy, strategy, and plans (see health purchasing function section). As a key issue, it should also consider the lessons from COVID-19 on building a strong, prepared, and resilient

[33] Including budget formation, resource allocation, funds flows, provider payment, financial management)

health system. Matching funding to the UHC Roadmap priorities requires explicit determination of the proportion of NHIS funding allocated or pooled for different types of benefit package services. This activity will also clearly lay out the services, commodities and activities that donors are currently funding enabling the realignment of functions and funds flows supporting the vision laid out in the UHC Roadmap and to ensure sustainable coverage for the population.

CHAPTER SIX

Health Financing Strategies by Function

Figure 4.2 portrays the overall health financing strategy as a two-pronged approach to achieve the UHC Roadmap by creating synergies between resolving key longstanding health financing issues and comprehensively strengthening health financing. This second aspect of the two-pronged approach is organized by health financing function together with governance at both the front end (e.g., legal and policy) and the back end (e.g., M&E) of a continuous improvement cycle.

As with strategies intended to resolve key longstanding issues, the health financing strategies described below are informed by the Review of Ghana's National HFS 2019.[34] Largely the same structure as Ghana HFS 2015 is used in the health financing function element of the two-pronged HFS approach. The comparable strategies are intended to maintain consistent direction in the next generation of strengthening health financing. Specific strategies and major activities are described in the subsections below categorized by governance including policy and legal and regulatory framework, revenue collection, pooling of funds, health purchasing, and M&E and communication. Health financing strategies by function comprise six strategies and when combined with five key longstanding issue strategies, it represents a total of 11 strategies.

6.1 Health Governance Including Policy and Legal and Regulatory Framework

Strategy 6: Strengthen health governance including health financing policy and legal and regulatory framework.

The specific objectives or aims of policy development and legal and regulatory framework are improved policy, increased stakeholder participation, clear and executed laws and regulations, and public accountability. Health financing policy will be consistent with Ghana country development strategies, UHC Roadmap, HSMTDP, and other GOG and Ministry of Health (MOH) strategies and plans. The process-oriented aspects of health financing policy, legal and regulatory framework will continue to be a priority (e.g. participatory policy dialogue) and the legal and regulatory framework will be amended as required by evolving policy and operational experience. Other governance priorities include realigning roles and relationships and better use of information.

[34] Review of Ghana National HFS 2019

Major governance, health policy and legal and regulatory framework activities include:

- Strengthen health financing policy dialogue processes to ensure open, transparent and participatory dialogue. Mechanisms will include all relevant country institutions, Health Financing Steering Committee and National Health Financing TWG.
- Policy dialogue, decisions and refinements on major policy issues. Focal points will be the five key health financing issues, shrinking fiscal space and related emphasis on both resource mobilization and efficiency gains, and ramifications of middle-income status (e.g. declining donor and concessionary funds, short-term fiscal and cash management issues). Feedback from M&E will be incorporated into policy dialogue.
- Amend and implement legal and regulatory framework and guidelines to codify health financing policy decisions. Examples include GHS NoP guidelines and implementation plans, NHIS refinement of provider payment systems, refining and enforcing HR management procedures including allocation, recruitment and transfers.
- Strengthen and realign institutional structure, roles and relationships. Specific priorities are Public Health Act functional review, enhancing MOH stewardship, reforms to address key health financing issues (e.g. establishing NoP as one entity, core relationship between PHC purchasing and health centre/NoP provider structure and management), harmonizing HeFRA and NHIA licensing, accreditation and credentialing including facility levels and staffing, public service provider autonomy, and role of private providers including in NoP.

6.2 Revenue Collection and Resource Mobilization

Revenue collection strategies are intended to ensure sustainable financing in moving towards UHC. Reliably delivering well-managed and high-quality health services requires sufficient and predictable funding. Objectives or aims of revenue collection and resource mobilization are stable and predictable revenue together with gradual increases in revenues, as the health sector should at least benefit proportionally from any GOG revenue increases. The two strategies consist of addressing NHIS revenue issues (see key issue section) and broader MOH and health sector increases in revenue and resource mobilization. As discussed throughout HFS, financing is a major challenge, Ghana fiscal space is tight, and revenue and coverage are expected to be expanded by optimizing use of funds and efficiency gains including those obtained by resolution of key longstanding health financing issues.

Strategy 7: Gradually increase revenue and mobilize resources for MOH services and programs, particularly in the context of declining external donor funding for public health, disease prevention and promotion programs.

Major revenue collection and resource mobilization activities include:

- Develop evidence and make a business case for increased general revenue allocation to health in a tight fiscal space environment
- Strengthen public-private partnerships (e.g. business investment)
- Pursue a variety of resource mobilization opportunities including corporate social responsibility, district assembly health allocations, and local drug/vaccine production

As stated in the UHC Roadmap, 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 PHC and seek additional sources of financing. Increasing health (sin) taxes or establishing other earmarked funds was not considered to be a viable option due to the Earmarked Funds Capping and Realignment Bill, 2017 and its impact on the more substantial and efficient NHIL (VAT) and SSNIT.

During HFS development, how to increase revenue from the private sector was the subject of extensive dialogue including both business investment and philanthropic (corporate social responsibility). Both types of private sources and public-private partnerships will require realistic assessment and development of a business case. The UHC Roadmap envisions developing 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. A deliberate effort will be made to crowd in additional financial and management resources through increased public-private partnerships and investments in this area. District assembly health allocations are small but could have an impact if coordinated and well-targeted at complementary health services or HR support. Domestic production of vaccines or drugs is under consideration, but no decisions have been made.

6.3 Pooling of Funds

Pooling of funds has been strength of Ghana health financing. General revenue is allocated to the MOH through the health budget. The funds are pooled at the national level and distributed to health facilities at all administrative levels through MOH programs. NHIA revenue from VAT, SSNIT, any GoG annual budgetary allocations, premiums, investment income, grants,

gifts and donations made to NHIF are pooled at the national level before distribution to health facilities. However, problems with pooling have arisen or been aggravated during HFS 2015, underlay most of the key longstanding health financing issues and should an emphasis in HFS 2022. Specifically, pooling is the structural health financing function at the core of the critical and growing threat to service delivery and UHC of the disproportionate mix of compensation and non-compensation costs (see key health financing issue).

Strategy 8: identify and implement improvements in pooling of funds. Improving pooling of funds will strengthen the general heath financing foundation, enable improvement in purchasing arrangements, and contribute to resolving all key longstanding health financing issues. Pooling is complex hence sequencing will involve two phases: Phase I in HFS Years 1-2 comprising more in-depth analysis, dialogue, policy decisions and development of plans, and Phase II to implement the plans in Years 3-5. Major pooling of funds activities include:

- Continue to engage in dialogue on functional specification in health defined by central pooling and purchasing arrangements and decentralized service provider autonomy and management
- Develop and implement plans to reduce fragmentation in pooling and purchasing arrangements for non-compensation costs in the short-term and compensation costs in the long-term

On horizontal pooling or fragmentation across levels of government, HFS will engage in dialogue and increase awareness of Parliament, Government and other stakeholders on the unique aspects of functional specification and decentralization in the health sector including pooling of funds, insurance, financial risk protection, and UHC. On vertical pooling or pooling across programmes, funds flows or types of inputs to service delivery, short-term policy dialogue, design and development of options is necessary including consideration of transfer of MOH programme and donor funds to NHIS/NHIA to mitigate the proportionate reduction in non-compensation or service delivery operating costs driving increases in OOP payments. Pooling of compensation and non-compensation costs is a long-term option to consider to ensure the stable and sustainable mix of type of service delivery cost inputs vital to UHC, level the playing field in contracting with public and private providers, and improve purchasing arrangements to avoid conflicting financial incentives and increase HR productivity.

6.4 Health Purchasing

6.4.1 What to Purchase: Services and Benefits

Strategy 9: Better define what to purchase or benefit packages. Major benefit and services activities include:

- Implement MOH essential health services package (EHSP)
- Continuously refine NHIS benefit package
- Coordinate EHSP and NHIS benefits package

MOH Essential Health Service Package (EHSP) is in its final design stages.[35] Health and finance authorities and other stakeholders will support completing specification, approval, and implementation of MOH EHSP as the overarching policy on what benefits and services to purchase for the population. The purpose of EHSP is to elaborate the set of priority essential services and interventions to be made universally accessible to all persons living in Ghana by 2030 within the framework of UHC. It is meant to help address critical gaps in health equity across the country and to better use existing resources and increase efficiency. The EHSP consists of high impact, cost effective services and interventions, which will contribute to a strengthened health system, reduction of morbidity and mortality, as well as ensuring a health population with equitable access to quality health services. The EHSP has five domains as follows:[36]

- Family and reproductive health
- Prevention, control, and management of priority communicable diseases
- Prevention, control, and management of the major non-communicable diseases and their risk factors, as well as mental health
- Prevention and management of clinical (medical and surgical) and public health emergencies
- Rehabilitation, palliation, quality assurance

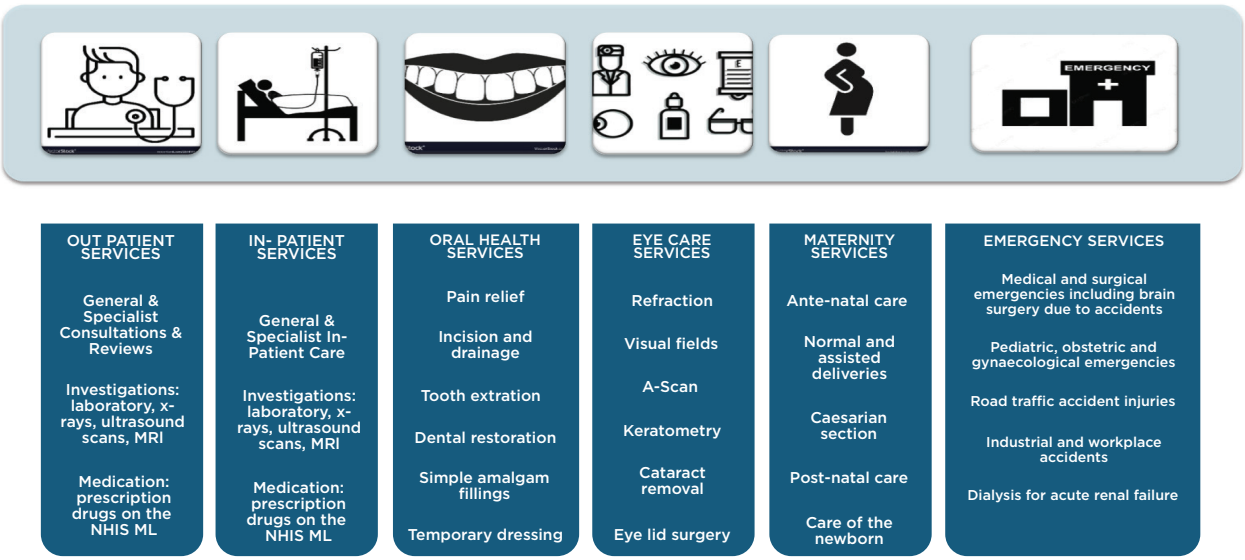
The NHIS benefit package from Act 852 is the service package to be rendered to NHIS members by credentialed providers. NHIS will continue to use their established process to periodically review, refine and expand the benefit package. Figure 6.1 shows the benefit package main service categories. It does not have an explicit inclusion list and the exclusion

[35] MOH PPT at HFS TWG meeting 3

[36] A request to incorporate mental health in HFS was received during stakeholder dialogue, explicit mention of mental health in the EHSP domains is responsive to request and should enable inclusion in health purchasing

list is defined in legal and regulatory documents. The benefit package is expanded periodically with recent expansions including childhood cancers and clinical family planning services. NHIS operationalizes the inclusion list through service and medicine lists. The NHIS Medicines List is a list of drug formulations derived from the MOH national Essential Medicines List (EML) and used to manage diseases and conditions covered by NHIS. Generic names of drugs are used on the NHIS Medicines List as directed by NHI Act 852 Section 33 (2012). The current Medicines List has 532 formulations (April 2021). Inclusion or exclusion of medicines is based on evaluation of evidence on efficacy, safety and cost effectiveness. The NHIS Medicines List is reviewed periodically to conform to current recommended treatment guidelines and economic conditions.

Figure 6.1: NHIS Benefit package main services categories



The third activity will be active coordination of MOH EHSP and NHIS benefit package with an eye to including in NHIS benefit package the MOH programmes, services, or inputs (e.g. drugs) where either development partner funding is declining and MOH budget cannot fill the gap, or the services are most efficiently and effectively purchased through a standard and comprehensive NHIS benefit package. An example of active transition from donor-funded commodities to country-funded services and commodities is reproductive health. NHIS pays for clinical services with commodities still being provided by the MOH and largely donor-funded through GHS. However, in the future, reproductive health commodities should be included in purchasing of NHIS benefit package. HIV, TB and Malaria are also examples of individual health services requiring benefits coordination given transition to domestic funding

responsibility. In addition, both EHSP and NHIS benefits package will further define integrated first point of contact or front-line PHC services and/or categorize them separately from outpatient specialty to enable prioritization and better matching provider payment to these PHC services.

6.4.2 How to Purchase: Provider Payment Systems

An objective of MOH EHSP is to assist the Government of Ghana to derive the best value-for-money by allocating resources based upon the most pressing needs (diseases with high morbidity, disability, and mortality) and cost effectiveness. However, this does not happen in isolation or based solely on the specification or costing of EHSP or NHIS benefit package, how services are purchased and what provider payment systems are used matters.

Strategy 10: Improve purchasing of all health services and programmes including operating systems.

Core aspects of health purchasing and provider payment systems are contained in the key health financing issue section. To use resources more efficiently, better match payment and incentives to priority services, and improve management, transparency and accountability, major health purchasing activities are:

- Refine NHIS inpatient and outpatient specialty payment systems and their claims management systems and realign around strengthened PHC purchasing
- Improve purchasing or budget execution of MOH programmes (e.g. population-based public health, health professions education and training, science and research)
- Improve capital planning, purchasing and management
- Strengthen public finance management (PFM) systems and interoperability of PFM, health information and claims management systems at all levels including service providers.

Focal points of activities to refine NHIS inpatient and outpatient specialty payment systems and their claims management systems will be further shift flat fees towards budget neutral formula-based systems, improve drug payment in concert with drug supply management, and realign systems around the strengthened front-line PHC person-based payment system (see key longstanding issues). NHIA will assess hospital and outpatient specialty payment systems and consider moving from payment of flat fees towards budget neutral formula-based payment systems. Formula-based payment systems can help ensure total payments stay within the available resource envelop by setting the base payment rate consistent with budget and

expected utilization. They can also add payment adjustors to increase the fairness of payment for individual cases and be consistent with policy objectives for many factors including need, equity and performance.

Claims management system improvements will include adjusting Ghana Diagnosis-Related Groups (G-DRG) to classify cases and determine payment through a grouper based on clinical information rather than submitted claims (invoices) and increase automation and efficiency by making claims management and health information systems interoperable at all levels including service providers. Refinement of hospital and outpatient specialty provider payment activities will include assessment and refinement of provider payment to further bundle drugs into the hospital and outpatient specialty unit of service (one payment per unit of service including all costs). Hospital and outpatient specialty payment should both realign as establishment of strengthened PHC structure (NoP and health centre management) and PHC purchasing takes hold and begins to improve front-line PHC services and increase their utilization and gatekeeper function. As discussed throughout HFS, a reform transition investment will buy time to enable this realignment to occur in a well-planned and transparent way (clear arrears, shift funding to PHC, and refine hospital and outpatient specialty payment systems).

HFS envisions increasing efficiency and expanding coverage by reducing funds flow fragmentation and conflicting financial incentives to all service providers but particularly health centre and NoP by either enhancing pooling or unifying provider payment for NHIS, MOH budget, donor, and any other funds flows to provider level. If service providers face the same financial incentives to deliver the same services to populations with largely the same characteristics, it will increase equity and move towards UHC. This second Strategy 8 activity also improves budget execution or purchasing of MOH programmes that are not contained in the NHIS benefit package. It is the budget execution side of improving population-based public health and MOH priority programme budget formation in the key longstanding issues section. It should also encompass appropriate budget execution and payment for other programmes such as health professions education and training and research and science.

Strategy 10 will improve capital planning, purchasing and management. Improving facility infrastructure and equipment is vital to address UHC Roadmap challenges. It is envisioned that planning and investment decisions for capital investments including facility infrastructure and major equipment purchases will continue to be nationally managed directly by the MOH as health facilities are generally unable to fund these investments and planning of capital

investment is an important aspect of cost containment. HFS activities will assess national capital regulations and develop and implement recommendations for improvement in determination of need, prioritization, planning, design, funding, procurement of both infrastructure and equipment, inventory, accounting and depreciation, maintenance, and replacement planning and costing. Through their provider payments and management autonomy, health facilities will fund small capital investments consistent with procurement law thresholds, capital maintenance and all recurrent costs of operating equipment.

Public finance management (PFM) systems, rules, procedures and processes are a vital element of the health purchasing and management-operating platform. Interoperability of PFM, claims management, and health information systems across all funds flows and levels of government including service providers will reduce the negative impacts of fragmentation, improve operations, increase efficiency and transparency, and ensure consistent and standard information feeds analysis and policy decisions. Extension of PFM and health information systems to service provider level will enable them to function as management entities and improve budget formation, budget execution/ provider payment, procurement, internal controls, accounting, financial reporting, and internal and external audit. Strengthening the regulatory framework and operational procedures to receive standardized information from private providers will improve health sector information for decision-making and enable private providers to receive public funds and contract to deliver health services.

6.5 Monitoring and Evaluation and Communication

Strategy 11: monitor and evaluate HFS implementation and strengthen communication.
Major monitoring and evaluation (M&E) and communication activities are:

- Design of HFS comprehensive monitoring framework and indicators
- Develop and implement HFS M&E system
- Develop and implement a communications strategy to inform and educate stakeholders, promote health sector results and advocate for resource mobilization, financial risk protection, efficiency gains and quality improvement.

HFS M&E is critical to guide continuous refinement of activities and increase ownership at all levels of the system. A performance framework and monitoring indicators will be developed for routine HFS monitoring. Indicator selection will be informed by and synchronized with indicators from Performance for Results (P4R) and health financing progress matrices. Its regular review will be incorporated into Health Summits reviewing all health sector indicators.

Regular reviews of health expenditure will be strengthened and incorporate various tools including public expenditure reviews and national health accounts. In addition to routine monitoring, periodic operations research studies and evaluations will strengthen policy analysis and contribute to continuous refinement of health financing mechanisms. M&E will be institutionalized at all levels of the system and information fed back into next generation policy dialogue improving transparency, promoting results and increasing sustainability as the feedback loop begins to function on its own indicative of a more responsive health system.

The third activity in this strategy will develop or refine and implement a communications strategy. The purpose of the communications strategy is to inform and educate stakeholders, promote health sector results and advocate for resource mobilization, financial risk protection, efficiency gains and quality improvement. A priority will be increasing awareness and support to resolve key longstanding health financing issues. Rationale and impact of policy decisions and consequences of decisions will be communicated to all stakeholders. Positive health sector results will be promoted to policy-makers, health providers and the population. Capacity will be increased enabling the health sector to effectively advocate for resource mobilization, health system barrier removal, efficiency gains, management and service delivery improvements and increased population involvement in their own health.

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10. Ghana Health Service Network of Practice Presentation to HFS TWG meeting
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12. Earmarked Funds Capping and Realignment Bill (2017)
13. Ghana CPEA Study (2017)

APPENDIXES

Appendix 1: Ghana National Health Financing Strategy Implementation Plan (2023- 2030)

Notes: first three years planned by half-year (S=semester), last four years planned by year. Timeframe blocks: 2023: S1-S2, 2024: S3-S4, 2025: S5-S6, then 2026: Y1, 2027: Y2, 2028: Y3, and 2029: Y4. Table structured by strategy, major activity. Primary party is listed first in Responsible Parties, LG=local government, prov=public and private provider, civil society and private=CSO, other sector=OS. Complete indicator column after M&E framework and indicators are finalized.

Specific Activities	Responsible Parties	S1	S2	S3	S4	S5	S6	Y1	Y2	Y3	Y4	Indicator
HFS Section 5: Strategies to Address Key Health Financing Issues												
Strategy 1 is strengthening purchasing of PHC services												
Sequencing of this key strategy determines sequencing for both its major activities and the activities of other strategies. The general sequencing is below.												
Preparation of both PHC structure and PHC purchasing	All	X	X									
Phase I entry of NoP/health centre hub into PHC person-based payment	All			X								
Refinements of systems and methodologies based on Phase I	All			X	X							
Phase II entry of NoP/health centre hub into PHC person-based payment	All				X							
Phase III entry of NoP/health centre hub into PHC person-based payment	All					X						
Phase IV entry of NoP/health centre hub into PHC person-based payment	All						X					
Continuously strengthen NoP/health centre hub and PHC structure, PHC person-based payment, financial management, and service delivery	All							X	X	X	X	
Strategy 1 Activity 1: Coordinate NoP establishment/management and financing to purchase their services												

Specific Activities	Responsible Parties	S1	S2	S3	S4	S5	S6	Y1	Y2	Y3	Y4	Indicator
Engage in dialogue on contracting (payment) terms for PHC purchasing	NHIA, MOH, MOF, GHS, prov, DP	X										
Develop standard PHC person-based payment contracts and terms	NHIA, MOH, GHS, prov, DP		X									
Finalize NoP implementation plan and guidelines to set up networks	GHS, MOH, NHIA, DP	X										
Disseminate and coordinate NoP implementation plan and guidelines	GHS, MOH, NHIA, LG, prov, CSO, DP		X									
Engage in dialogue on technical NoP establishment topics including harmonizing licensing, accreditation, and credentialing; ensuring right types, levels, and staffing in NoP; recognize NoP as one entity.	MOH, GHS, HFRA, NHIA, MOF, OS, LG, prov, CSO, DP	X										
Develop methodologies and documentation on NoP establishment topics	GHS, HFRA, MOH, NHIA, LG, prov, DP		X									
Coordinate NoP establishment with Strategy 2 provider management	MOH, GHS, NHIA, LG, prov, DP	X	X	X	X	X	X					
Dialogue and design of bottom-up participatory NoP formation process	GHS, MOH, NHIA, LG, prov, CSO, DP	X	X									
Phase I bottom-up NoP process and technical NoP establishment tasks	GHS, MOH, LG, prov, CSO, DP			X								
Refine bottom-up NoP process and NoP regulations and methodologies	GHS, MOH, NHIA, LG, prov, CSO, DP			X	X							
Phase II bottom-up NoP process and technical NoP establishment tasks	GHS, MOH, LG, prov, CSO, DP				X							
Phase III bottom-up NoP process and technical NoP establishment tasks	GHS, MOH, LG, prov, CSO, DP					X						

Specific Activities	Responsible Parties	S1	S2	S3	S4	S5	S6	Y1	Y2	Y3	Y4	Indicator
Phase IV bottom-up NoP process and technical NoP establishment tasks	GHS, MOH, LG, prov, CSO, DP						X					
Continuously strengthen NoP health centre hubs and spokes	GHS, MOH, NHIA, LG, prov, CSO, DP							X	X	X	X	
Strategy 1 Activity 2: Differentiate front-line PHC services and outpatient specialty and payment systems to providers or management entities delivering them.												
Dialogue on differentiating frontline PHC and outpatient specialty (OS)	NHIA, MOH, GHS, DP	X										
Decision on differentiating frontline PHC and OP services	NHIA, MOH, GHS, DP	X										
Change benefit package regulation to differentiate to match payment	NHIA, MOH, GHS, DP		X									
Refine benefit package regulation to differentiate frontline PHC and OS	NHIA, MOH, GHS, DP			X	X	X	X	X	X	X	X	
Strategy 1 Activity 3: Active or passive enrolment for 100% of population for entitled front-line PHC services												
Dialogue to define enrolment policy specifics and any regulatory changes	NHIA, MOH, GHS, DP	X										
Make regulatory changes for combined active and passive enrolment	NHIA, MOH, GHS, DP	X	X									
Design and develop info systems for active and passive enrolment	NHIA, MOH, GHS, LG, prov, DP		X	X								
Implement info systems for active and passive enrolment	NHIA, MOH, GHS, LG, prov, DP			X	X	X	X					
Refine info systems and accelerate active enrolment	NHIA, MOH, GHS, LG, prov, DP							X	X	X	X	

Specific Activities	Responsible Parties	S1	S2	S3	S4	S5	S6	Y1	Y2	Y3	Y4	Indicator
Include active enrolment in NoP formation and PHC payment design	NHIA, MOH, GHS, LG, prov, CSO, DP			X	X	X	X					
Promote active enrolment and improved NoP gatekeeping/referral	NHIA, MOH, GHS, LG, prov, CSO, DP						X	X	X	X	X	
Strategy 1 Activity 4: PHC person-based payment purchases PHC services and shifts financing to lower levels of health system delivering front-line PHC services.												
Dialogue on formula-based PHC person-based payment system	NHIA, MOH, GHS, MOF, OS, LG, prov, CSO, DP	X										
Technical specification of PHC person-based payment system	NHIA, MOH, DP	X	X									
Determine allowed costs in payment rate (all non-comp, drugs, etc.)	NHIA, MOH, DP	X										
Payment adjustor decisions (need, equity, perf), collect and analyze data	NHIA, MOH, GHS, LG, prov, CSO, DP	X	X									
Develop and implement simulation model showing PHC payment impact	NHIA, MOH, GHS, LG, prov, CSO, DP	X	X	X	X	X	X	X	X	X	X	
Set PHC sub-pool or budget ceiling and calculate base payment rate	NHIA, MOH, prov, DP		X									
Simplify and consolidate claims management for PHC payment	NHIA, MOH, prov, DP		X	X	X							
Link monitoring and QA to HIS indicators for PHC-sensitive conditions	NHIA, MOH, prov, DP		X	X	X							
Phase I entry of NoP/health centre hub into PHC person-based payment	NHIA, MOH, GHS, LG, prov, CSO, DP			X								

Specific Activities	Responsible Parties	S1	S2	S3	S4	S5	S6	Y1	Y2	Y3	Y4	Indicator
Refinements of systems and methodologies based on Phase I	NHIA, MOH, GHS, LG, prov, CSO, DP			X	X							
Phase II entry of NoP/health centre hub into PHC person-based payment	NHIA, MOH, GHS, LG, prov, CSO, DP				X							
Phase III entry of NoP/health centre hub into PHC person-based payment	NHIA, MOH, GHS, LG, prov, CSO, DP					X						
Phase IV entry of NoP/health centre hub into PHC person-based payment	NHIA, MOH, GHS, LG, prov, CSO, DP						X					
Continuously strengthen PHC person-based payment and info system	NHIA, MOH, GHS, LG, prov, CSO, DP							X	X	X	X	
Strategy 2: enhance service provider autonomy, management, and accountability to receive, use and manage funds.												
Strategy 2 Activity 1: Strengthen health centre financial management and governance and prepare them for their role as NoP hubs.												
Define health centre (HC) autonomy to receive, use, manage funds	GHS, MOH, NHIA, LG, prov, DP	X										
Grant HC autonomy to receive funds and serve as NoP hub	GHS, MOH, LG	X	X									
Dialogue and design of health centre (HC) financial management (FM) systems including bank account/receive funds, plan, budget, procure, internal controls, account, financial reports, internal and external audit	GHS, MOH, NHIA, MOF, LG, prov, DP	X	X									
Develop HC FM systems to manage and be accountable	GHS, MOH, NHIA, MOF, LG, prov, DP		X	X	X							
Implement and refine HC FM systems to manage and be accountable	GHS, MOH, NHIA, MOF, LG, prov, DP			X	X	X	X	X	X	X	X	

Specific Activities	Responsible Parties	S1	S2	S3	S4	S5	S6	Y1	Y2	Y3	Y4	Indicator
Allocate minimum 1 financial officer (FO) or accountant to HC/NoP FM	GHS, MOH, LG, prov, DP		X	X	X	X	X					
Build capacity of HC FO to use systems and data to improve FM	GHS, MOH, NHIA, MOF, LG, prov, DP			X	X	X	X	X	X	X	X	
Define HC/NoP role in drug procurement, management	GHS, MOH, CMS, NHIA, LG, prov, DP	X	X									
Implement and refine HC/NoP role in drug procurement, management	GHS, MOH, CMS, NHIA, LG, prov, DP			X	X	X	X	X	X	X	X	
Decide how to enhance HC governance structure, roles and capacity	GHS, MOH, NHIA, MOF, LG, prov, CSO, DP	X	X									
Establish and support new HC governance structure, roles and capacity	GHS, MOH, NHIA, MOF, LG, prov, CSO, DP			X	X	X	X	X	X	X	X	
Strategy 2 Activity 2: Establish, manage, govern, and coordinate NoP health centre hubs and spokes to be accountable to PFM systems and rules, fiduciary obligations, and audit processes.												
Determine all NoP internal and external roles and relationships (R&R)	MOH, MOF, GHS, NHIA, OS, LG, NoP, CSO, DP	X										
Determine how NoP reports within government levels and structure	MOH, GHS, LG, DP	X										
Determine who receives funds directly in each NoP (hybrid approach)	MOH, MOF, GHS, NHIA, LG, NoP, DP	X										
Decide NoP revenue sharing process for formation and NHIA contract	MOH, MOF, GHS, NHIA, LG, NoP, CSO, DP	X										
Develop mechanisms to include private providers in NoP	MOH, MOF, GHS, NHIA, LG, NoP, CSO, DP	X										
Develop NoP formation sequencing especially for urban and private	MOH, GHS, NHIA, LG, NoP, CSO, DP	X	X									

Specific Activities	Responsible Parties	S1	S2	S3	S4	S5	S6	Y1	Y2	Y3	Y4	Indicator
Each Phase NoP formation, implement R&R, FM, rev sharing, sequencing	MOH, MOF, GHS, NHIA, OS, LG, NoP, CSO, DP		X	X	X	X	X					
Determine NoP governance structure and internal representation	MOH, GHS, NHIA, LG, NoP, CSO, DP	X	X									
Implement and continuously build capacity of NoP governance structure	MOH, GHS, NHIA, LG, NoP, CSO, DP			X	X	X	X	X	X	X	X	
Strategy 2 Activity 3: Strengthen provider financial management and governance for all public and private service providers.												
Bottom-up assessment of service provider autonomy and accountability	MOH, GHS, NHIA, MOF, LG, prov, CSO, DP	X	X									
Develop recommendations to increase public provider autonomy	MOH, GHS, NHIA, MOF, LG, prov, CSO, DP		X	X								
Implement recommendations to increase public provider autonomy	MOH, GHS, NHIA, MOF, LG, prov, CSO, DP				X	X	X	X	X	X	X	
Develop plans to improve provider FM systems, be interoperable GFMIS	MOH, GHS, NHIA, MOF, LG, prov, CSO, DP	X	X									
Design and develop improved public provider FM systems	MOH, GHS, NHIA, MOF, LG, prov, CSO, DP		X	X	X							
Implement improved public provider FM systems	MOH, GHS, NHIA, MOF, LG, prov, CSO, DP				X	X	X	X	X	X	X	
Develop plans to improve structure and function of provider governing committees (GC) given increased funding and separation of functions	MOH, GHS, NHIA, MOF, LG, prov, CSO, DP	X	X	X								
Implement and continuously build capacity of provider GC	MOH, GHS, NHIA, MOF, LG, prov, CSO, DP			X	X	X	X	X	X	X	X	

Specific Activities	Responsible Parties	S1	S2	S3	S4	S5	S6	Y1	Y2	Y3	Y4	Indicator
Improve systems or processes for private provider claims submission, financial reporting and health statistics reporting	MOH, GHS, NHIA, prov, CSO, DP	X	X	X								
Implement and continuously improve private provider systems/processes	MOH, GHS, NHIA, prov, CSO, DP			X	X	X	X	X	X	X	X	
Strategy 3: address NHIS revenue issues including NHIL/SSNIT caps and transfer delays.												
Strategy 3 Activity 1: verify, increase transparency, and advocate for management of Ghana's 25% earmark cap in a way that ensures full funding of statutory NHIL and SSNIT contribution.												
Verify whether earmark capping applies to NHIS SSNIT contributions	NHIA, MOH, MOF, Govt, Parliament, OS	X	X									
Engage in dialogue to reinstitute receipt of capping calculations, reports	NHIA, MOH, MOF	X	X	X	X							
Receive and analyze capping calculations and reports	NHIA, MOH, MOF, DP				X	X	X	X	X	X	X	
Develop a strategy to advocate for full funding of NHIL, SSNIT per law	NHIA, MOH, OS, LG, prov, CSO, DP	X	X	X	X							
Implement strategy to advocate for full funding of NHIL, SSNIT per law	NHIA, MOH, OS, LG, prov, CSO, DP				X	X	X	X	X	X	X	
Strategy 3 Activity 2: reduce delays in the reconciliation and release of NHIS funds from Government.												
Develop steps to speed up reconciliation and release of VAT funds	NHIA, MOH, MOF, Govt, OS, DP	X	X	X								
Implement steps to speed up reconciliation and release of VAT funds	NHIA, MOH, MOF, Govt, OS, DP				X	X	X					
Dialogue on amending Act 852 for direct transfer of VAT (like SSNIT)	NHIA, MOH, MOF, Govt, Parliament, OS, DP	X	X	X								
Amend Act 852 or consider other steps to speed up release of VAT funds	NHIA, MOH, MOF, Govt, Parliament, OS, DP				X	X	X	X	X	X	X	

Specific Activities	Responsible Parties	S1	S2	S3	S4	S5	S6	Y1	Y2	Y3	Y4	Indicator
Strategy 3 Activity 3: premium increases and reform transition investment												
Dialogue on increasing NHIS informal sector premiums (fixed 20 years)	NHIA, MOH, MOF, Govt, Parl, OS, CSO, DP	X	X									
Develop and approve NHIS informal sector premium option	NHIA, MOH, MOF, Govt, Parl, OS, DP			X	X							
Implement NHIS informal sector premium option	NHIA, MOH, MOF, Govt, Parl, OS, CSO, DP					X	X					
Dialogue, develop options on reform transition investment to shift to PHC: form NoP, clear arrears, establish PHC pool, realign inpatient and outpatient specialty	MOH, NHIA, GHS, MOF, Govt, Parl, OS, LG, prov, CSO, DP	X	X	X								
Allocate domestic and external funds to reform transition investment (Phase I)	MOH, NHIA, MOF, Govt, Parl, DP			X	X	X	X					
Implement transition	MOH, NHIA, GHS, MOF, LG, prov, CSO, DP			X	X	X	X					
Long-term sustainable financing by efficiency gains and increase revenue	MOH, NHIA, GHS, MOF, LG, prov, CSO, DP							X	X	X	X	
Strategy 4: improve mix of compensation and non-compensation operating costs.												
Strategy 4 Activity 1: Introduce simulation model to support HR rationalization, distribution and redistribution according to facility utilization and need.												
Dialogue on mechanisms and methods to allocate HR based on need	MOH, GHS, NHIA, MOF, OS, LG, prov, CSO, DP	X	X									
Develop simulation model to support HR distribution and rationalization	MOH, GHS, NHIA, LG, prov, DP		X	X								
Simulation model extended to provider level documents HR location	MOH, GHS, NHIA, LG, prov, DP			X	X							

Specific Activities	Responsible Parties	S1	S2	S3	S4	S5	S6	Y1	Y2	Y3	Y4	Indicator
Analyze options for staff/salary distribution and rationalization across regions, facility type, level and ownership (public vs. private) to improve HR allocation and ratio of compensation vs. non-compensation costs.	MOH, GHS, NHIA, MOF, OS, LG, prov, CSO, DP				X	X						
Develop plans for better HR distribution and rationalization	MOH, GHS, NHIA, MOF, OS, LG, prov, CSO, DP					X	X					
Implement and refine plans for better HR distribution and rationalization	MOH, GHS, NHIA, MOF, OS, LG, prov, CSO, DP						X	X	X	X	X	
Strategy 4 Activity 2: Extend planning and budgeting to facility level and introduce managerial accounting and capacity building to improve management, transparency and facility level proportion of compensation and non-compensation costs.												
Dialogue on extending planning and budgeting systems to facility level	GHS, MOH, NHIA, MOF, LG, prov, CSO, DP	X	X									
Develop systems to extend planning and budgeting to facility level	GHS, MOH, NHIA, MOF, LG, prov, CSO, DP		X	X								
Implement and refine planning and budgeting system at facility level	GHS, MOH, NHIA, MOF, LG, prov, CSO, DP			X	X	X	X	X	X	X	X	
Develop and introduce management accounting to use data to enhance system and facility level HR decisions and management	GHS, MOH, NHIA, MOF, LG, prov, CSO, DP			X	X	X	X	X	X	X	X	
Monitor facility level mix of compensation and non-compensation costs	GHS, MOH, NHIA			X	X	X	X	X	X	X	X	
Strategy 4 Activity 3: Coordinate with HR function to enforce HR management, improve HR recruiting, and implement financial and non-financial incentives for performance and staffing in underserved areas.												
Develop plans to enforce HR rules including posting to underserved areas, transfers, staff supervision, support and performance review	MOH, GHS, LG, prov, DP	X	X	X	X							
Implement plans to enforce HR rules	MOH, GHS, LG, prov, DP				X	X	X	X	X	X	X	

Specific Activities	Responsible Parties	S1	S2	S3	S4	S5	S6	Y1	Y2	Y3	Y4	Indicator
Assess improvements to wage classification, allowances or other regs	MOH, MOF, MOL, OS, Govt	X	X	X	X							
Implement improvements to HR regulations	MOH, MOF, MOL, OS, Govt				X	X	X	X	X	X	X	
Develop plans to strengthen HR recruitment to better match HR budget and salary costs to priority services including applicant choice of posting location, recruit from underserved areas, delegate tasks to local govt	MOH, GHS, NHIA, MOF, LG, prov, DP	X	X	X	X							
Implement plans to strengthen HR recruitment	MOH, GHS, NHIA, MOF, LG, prov, DP				X	X	X	X	X	X	X	
Dialogue, develop underserved area financial and non-financial incentives	MOH, GHS, NHIA, MOF, LG, prov, CSO, DP	X	X	X	X							
Implement HR underserved area financial and non-financial incentives	MOH, GHS, NHIA, MOF, LG, prov, CSO, DP				X	X	X	X	X	X	X	
Strategy 4 Activity 4: Engage in dialogue and develop long-term plans to improve pooling and corresponding purchasing arrangements for both compensation and non-compensation costs.												
Dialogue on pooling domestic and external non-compensation costs in fragmented MOH EHSP/ priority programmes and NHIS BP to address key issues including mix of costs and PHC purchasing (see pooling function).	MOH, NHIA, GHS, MOF, Govt	X	X									
Develop mechanisms to improve pooling of non-compensation costs	MOH, NHIA, GHS, MOF		X	X								
Implement pooling improvements for non-compensation costs	MOH, NHIA, GHS, MOF			X	X	X	X	X	X			
Phase I analysis and options development for pooling compensation costs including use simulation model and	MOH, NHIA, GHS, MOF	X	X	X	X	X	X					

Specific Activities	Responsible Parties	S1	S2	S3	S4	S5	S6	Y1	Y2	Y3	Y4	Indicator
facility level planning and budgeting to do a paper analysis of including salaries in NHIS provider payment												
Dialogue on pooling options and make policy decisions	MOH, NHIA, GHS, MOF, MOL, Govt, Parl					X	X	X	X			
Phase II implementation of pooling or reduced fragmentation to improve proportion of compensation and non-compensation costs	MOH, NHIA, GHS, MOF								X	X	X	
Strategy 5: improve the prioritization and investment across types of health services.												
Strategy 5 Activity 1: improve programme budgeting to help ensure sufficient funding, prioritization, and budget visibility for population-based public health services, including pandemic preparedness.												
Assess programme-budget structure including input vs. output-based	MOH, MOF, DP	X	X	X								
Develop recommendations to shift to output-based structure and better align to service priorities especially population-based public health	MOH, MOF, OS, DP		X	X	X							
Implement recommendations to improve programme-based budgeting	MOH, MOF, OS, DP				X	X	X	X	X	X	X	
Align donor funding and transition planning to new programme structure	MOH, MOF, OS, DP				X	X	X	X	X	X	X	
Increase visibility and promote new programme-budget structure to increase multi-sectoral and cross-programme collaboration/integration	MOH, MOF, OS, DP						X	X	X	X	X	
Develop and implement other budget formation improvements	MOH, MOF, OS, DP						X	X	X	X	X	
Strategy 5: Activity 2 improve the prioritization and investment across types of health services.												

Specific Activities	Responsible Parties	S1	S2	S3	S4	S5	S6	Y1	Y2	Y3	Y4	Indicator
Prioritize MOH EHSP/NHIS benefit package (BP) type and level of services	MOH, NHIS, DP	X	X									
Determine MOH programmes to shift to NHIS BP/purchase PHC services	MOH, NHIS, DP		X	X								
Shift domestic and external priority programme funding to NHIS BP	MOH, NHIS, MOF, DP			X	X	X	X	X	X			
Continuous design, development and implementation of mechanisms and methods to prioritize and invest across types of health services	MOH, NHIS, GHS, MOF, LG, CSO, DP					X	X	X	X	X	X	
HFS Section 6: Health Financing Strategies by Function												
Strategy 6: strengthen health governance including health financing policy and legal and regulatory framework.												
Develop detailed plans for Strategy 6	MOH, NHIA, GHS, OS, LG, CSO, DP	X	X									
Establish processes for Health Financing Steering Committee (HFSC) and National Health Financing TWG (HFTWG)	MOH, HFSC, HFTWG	X										
Hold HFSC and HFTWG meetings and perform follow-up steps	HFSC, HFTWG, MOH		X	X	X	X	X	X	X	X	X	
Develop, strengthen other health financing policy dialogue processes	MOH, NHIA, GHS, MOF, OS, LG, prov, CSO, DP			X	X	X	X	X	X	X	X	
Policy dialogue and decisions on five key health financing issues	MOH, NHIA, GHS, MOF, OS, LG, prov, CSO, DP	X	X	X	X							
Develop, approve and implement legal and regulatory changes	MOH, NHIA, GHS, MOF, OS, LG, DP			X	X	X	X					
Engage in policy dialogue on all health financing functions	MOH, NHIA, GHS, MOF, OS, LG, prov, CSO, DP					X	X	X	X	X	X	

Specific Activities	Responsible Parties	S1	S2	S3	S4	S5	S6	Y1	Y2	Y3	Y4	Indicator
Develop, approve, and implement legal and regulatory changes	MOH, NHIA, GHS, MOF, OS, LG, DP					X	X	X	X	X	X	
Envision changes in institutional roles and relations (e.g. provider autonomy)	MOH, NHIA, GHS, MOF, OS, LG, prov, CSO, DP	X	X									
Implement changes in institutional roles and relations and build capacity	MOH, NHIA, GHS, MOF, OS, LG, prov, CSO, DP		X	X	X	X	X	X	X	X	X	
Strategy 7: gradually increase revenue and mobilize resources for MOH services and programs, particularly in the context of declining external donor funding for public health, disease prevention and promotion programs.												
Develop evidence and a business case for increased general revenue	MOH, NHIA, GHS, LG, prov, CSO, DP	X	X	X								
Promote the business case for increased general revenue	MOH, NHIA, GHS, LG, prov, CSO, DP			X	X	X	X	X	X	X	X	
Refine definition and categorization of public-private partnerships	MOH, GHS, prov, CSO, other private, DP	X	X	X								
Develop and implement public-private partnerships	MOH, GHS, prov, CSO, other private, DP			X	X	X	X	X	X	X	X	
Dialogue on resource mobilization opportunities	MOH, GHS, NHIA, MOF, LG, prov, CSO, DP	X	X	X								
Develop and implement resource mobilization activities	MOH, GHS, NHIA, MOF, LG, prov, CSO, DP			X	X	X	X	X	X	X	X	
Strategy 8: identify and implement improvements in pooling of funds												
Perform assessment of horizontal pooling issues (fragmentation across levels of government) and vertical pooling (across programs, inputs)	MOH, NHIA, MOF, Govt, OS, LG, DP	X	X	X	X							

Specific Activities	Responsible Parties	S1	S2	S3	S4	S5	S6	Y1	Y2	Y3	Y4	Indicator
Develop detailed plans for Phase I/Yr1-2 of more in-depth analysis, dialogue, policy decisions, develop mechanisms, and Phase II/Yr3-5 to implement the plans	MOH, NHIA, MOF, Govt, OS, LG, DP				X	X	X					
Dialogue on functional specification in health of central pooling and purchasing arrangements and decentralized service provider autonomy and management	MOH, NHIA, GHS, MOF, Govt, Parliament, OS, LG, prov, CSO, DP	X	X	X	X							
Phase I dialogue, analysis, awareness of decentralization and unique aspects of health including pooling, insurance, risk protection, UHC	MOH, NHIA, GHS, MOF, Govt, Parliament, OS, LG, prov, CSO, DP	X	X	X	X							
Phase II implement horizontal pooling/decentralization decisions/plans	MOH, NHIA, GHS, MOF, LG, prov, DP				X	X	X	X	X	X	X	
Phase I dialogue, analysis, awareness of vertical pooling across programmes, funds flows or types of inputs to service delivery	MOH, NHIA, GHS, MOF, Govt, Parliament, OS, LG, prov, CSO, DP	X	X	X	X							
Phase II implement vertical pooling policy decisions and plans	MOH, NHIA, GHS, MOF, LG, prov, DP				X	X	X	X	X	X	X	
Strategy 9: better define what to purchase or benefit packages.												
Finalize design, specification and approval of EHSP	MOH, GHS, DP	X	X	X								
Implement EHSP as overarching policy on population benefits/services	MOH, GHS, DP			X	X	X	X	X	X	X		
Assess and refine BP for declining donor funds services	NHIA, MOH, GHS, DP	X	X	X	X	X	X	X				
Periodically review, refine, and expand NHIS benefit package (BP)	NHIA, MOH, GHS, DP	X	X	X	X	X	X	X	X	X	X	
Assess changes in NHIS ML required to bundle into service payment	NHIA, MOH, GHS, DP	X	X	X	X	X	X	X				

Specific Activities	Responsible Parties	S1	S2	S3	S4	S5	S6	Y1	Y2	Y3	Y4	Indicator
Periodically review and refine NHIS medicines list (ML)	NHIA, MOH, GHS, DP	X	X	X	X	X	X	X	X	X	X	
Dialogue and develop mechanisms to coordinate EHSP and NHIS BP	MOH, NHIS, GHS, DP	X	X	X	X							
Implement mechanisms to coordinate EHSP and NHIS BP	MOH, NHIS, GHS, DP			X	X	X	X	X	X	X	X	
Strategy 10: improve purchasing of all health services and programmes including operating systems.												
Design refined inpatient and outpatient specialty (OS) payment systems	NHIA, MOH, GHS, LG, prov, DP	X	X	X								
Develop refined inpatient and OS payment and claims management (CM) systems	NHIA, MOH, DP			X	X	X						
Implement refined inpatient and OS payment and CM systems	NHIA, MOH, GHS, LG, prov, DP					X	X	X	X	X	X	
Develop methodologies to improve purchasing of MOH programmes	MOH, MOF, prov, DP	X	X	X	X							
Implement improved purchasing for MOH programmes	MOH, MOF, GHS, NHIA, LG, prov, DP				X	X	X	X	X	X	X	
Review and recommend improvements to capital planning and procurement	MOH, GHS, MOF, LG, prov, DP	X	X	X								
Implement improved capital planning and procurement	MOH, GHS, MOF, LG, prov, DP			X	X	X						
Refine and implement capital inventory and replacement processes	MOH, GHS, MOF, LG, prov, DP					X	X	X	X	X	X	
Design, develop more interoperable PFM and health info systems (HIS)	MOH, MOF, NHIA, GHS, LG, prov, DP	X	X	X	X							

Specific Activities	Responsible Parties	S1	S2	S3	S4	S5	S6	Y1	Y2	Y3	Y4	Indicator
Implement interoperable PFM and HIS, use data to improve management	MOH, MOF, NHIA, GHS, LG, prov, DP				X	X	X	X	X	X	X	
Strategy 11: monitor and evaluate HFS implementation and strengthen communication.												
Design an HFS comprehensive monitoring framework and indicators	MOH, GHS, NHIA, DP	X	X									
Synchronize indicators with P4R and health financing progress matrices	MOH, DP	X	X									
Develop HFS M&E system	MOH, GHS, NHIA, LG, prov, CSO, DP		X	X								
Implement HFS M&E system	MOH, GHS, NHIA, LG, prov, CSO, DP			X	X	X	X	X	X	X	X	
Incorporate into Health Summit reviews, link to PER and NHA	MOH, GHS, NHIA, LG, prov, CSO, DP			X	X	X	X	X	X	X	X	
Institutionalize M&E at all levels and feedback info into policy dialogue	MOH, GHS, NHIA, LG, prov, CSO, DP					X	X	X	X	X	X	
Develop communications strategy to inform stakeholders and promote results	MOH, GHS, NHIA, DP	X	X	X								
Implement communications strategy	MOH, GHS, NHIA, LG, prov, CSO, DP			X	X	X	X	X	X	X	X	

Appendix 2: Monitoring and Evaluation Plan

The M&E plan aims to track and assess the progress of the strategies and activities outlined in the 2023 Health Financing Strategy (HFS) for addressing the key longstanding health financing issues in Ghana. The M&E framework will provide the means to monitor and assess consistently how the strategies and activities are operating, and generate information to assess implementation. Such monitoring would ideally lead to the identification of bottlenecks in programme operation, and suggest areas for improvement.

Overall, the plan has short to long term targets that culminates into the achievement of the Sustainable Development Goals (SDGs) alongside reaching Universal Health Coverage in Ghana. The plan is thus, an embodiment of the key health financing strategies and UHC plan Ghana is implementing.

Indicator Framework

The overall health financing system of Ghana will be monitored and evaluated with the following underlisted indicators which captures the health financing functions, Public Financial Management, and Universal Health Coverage. These are overarching indicators that measure the status and strength of health financing in Ghana.

Indicators	Baseline (2020)	Short term				Medium term		Long term			Frequency	Responsible entity
		2022	2023	2024	2025	2026	2027	2028	2029	2030		
Current Health Expenditure (CHE) as % Gross Domestic Product (GDP)	4[1]	4	4	4.5	5	5.5	6	6.5	7	7.5	Annually	MoH
Current health expenditure per capita ($) in a year	85[1]	85	90	95	100	110	120	130	140	150	Annually	MoH
Domestic General Government Health Expenditure (GGHE-D) as % Gross Domestic Product (GDP)	2[1]	2.3	2.3	3.2	3.5	3.8	4	4.5	5.2	6	Annually	MoH
Domestic Health Expenditure (DOM) as % of Current Health Expenditure (CHE)	91[1]	91.2	91.3	91.9	92.5	93	93.5	94	94.5	95	Annually	MoH
Domestic General Government Health Expenditure (GGHE-D) as % Gross Domestic Product (GDP)	2.3[2]	2.3	2.3	2.5	2.7	3.0	3.3	3.5	3.8	4	Annually	MoH
Domestic Health Expenditure (DOM) as % of Current Health Expenditure (CHE)	91[1]	91.2	91.3	91.9	92.5	92.8	93	93.5	94.2	95	Annually	MoH
Domestic General Government Health Expenditure (GGHE-D) as % Current Health Expenditure (CHE)	50[1]	52	54	56	58	60	62	65	67	70	Annually	MoH
Domestic general Government health expenditure per capita (US$)	49.73[1]	52	53	54	55	60	70	76	80	86	Annually	MoH
Domestic general government health expenditure (% of general government expenditure)	7.6[2] (2022)	7.6	8	9	10	11	12	13	14	15	Annually	MoH

Indicators	Baseline (2020)	Short term				Medium term		Long term			Frequency	Responsible entity
		2022	2023	2024	2025	2026	2027	2028	2029	2030		
Domestic Private Health Expenditure (PVT-D) as % Current Health Expenditure (CHE)	41[1]	41	40	39	38	36	35	33	31	30	Annually	MoH
PHC as a % of total NHIS expenditure	21[3]	21	22	25	28	33	38	43	47	50	Annually	MoH
Percentage of current Health expenditure devoted to PHC	83[1]	83	83.5	84	85	86	88	90	93	95	Annually	MoH
Out-of-pocket expenditure (% of current health expenditure)	31[1]	30	28	27	25	23	21	19	17	15	Annually	MoH
Out-of-pocket expenditure per capita (US$)	26[1]	26	25	24	23	22	20	18	16	15	Annually	MoH
Voluntary Prepayments as % of Current Health Expenditure (CHE)	1[1]	1	1.5	2	2.5	3	3.5	4	4.5	5	Annually	MoH/NHIA
External Health Expenditure (EXT) as % of Current Health Expenditure (CHE)	9[1]	9	8	7	6	5	4.5	4	3.8	3.5	Annually	MoH
External health expenditure per capita (US$)	7.81[1]	7.8	7.5	7	6.5	6	5.5	5	4	16	Annually	MoH
Percentage of the population with active NHIS coverage	55[4] (2022)	55	57	58	60	62	65	70	75	80	Annually	NHIA
Average time of NHIS Claims Settlement (Months)	6[2]	3	3	3	3	3	3	3	3	3	Quarterly	NHIA, MoH, Providers
Proportion of NHIF receivable funds released to NHIA by MOF (%) in a fiscal year	100[2]	100	100	100	100	100	100	100	100	100	Biannually	NHIA, MoH, MoF
Execution rate of Goods & Services budget	89.42%[5]	100	100	100	100	100	100	100	100	100	Annually	MoH
% of budget explicitly allocated for IHR	Not readily available	0.5	0.5	0.5	0.5	0.6	0.7	0.8	0.9	1	Annually	MoH
% of health care facilities enrolled on GIFMIS	Not readily available	-	40	45	50	55	60	65	70	75	Annually	MoH

Indicators	Baseline (2020)	Short term				Medium term		Long term			Frequency	Responsible entity
		2022	2023	2024	2025	2026	2027	2028	2029	2030		
% of health care facilities using GIFMIS for transactions, tracking and reporting of resources.	Not readily available	-	40	45	50	55	60	65	70	75	Annually	MoH
Percentage of resources mobilized from the Private Sector***	Not readily available	-	10	11	12	14	16	17.5	19	20	Annually	MoH
Proportion of total health budget allocated to health research activities (%)	0	0	0.5	0.5	0.5	0.6	0.7	0.8	0.9	1	Annually	MoH
UHC effective coverage index (%)	49.1[6]	51	52	53	55	57	60	63	66	70	Annually	MoH
% of PHC NoPs covering essential health services	Not readily available	50	50	50	50	60	65	70	80	90	Annually	GHS
No. of NoPs established	-	-	50	250	300	400	500	700	850	1000	Annually	GHS
# of NoPs that are autonomous, and able to manage, and account for received funds	-	-	50	250	300	400	500	700	850	1000	Annually	GHS
% of private providers included in each NoP	-	-	10	30	50	60	70	80	90	95	Annually	GHS
% of NHIL contributions subject to earmark capping in accordance with relevant regulations and guidelines	***	***									Biannually	NHIA, MoH, MoF

1. World Health Organization (2023). Global Health Expenditure Database. available at https://apps.who.int/nha/database/Select/Indicators/en
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GHANA HEALTH FINANCING STRATEGY
2023-2030