Moving toward UHC

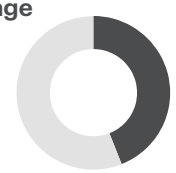
Ghana

NATIONAL INITIATIVES, KEY CHALLENGES, AND THE ROLE OF COLLABORATIVE ACTIVITIES

Ghana's snapshot

UHC Service Coverage Index *(SDG 3.8.1, 2015)*

44%



Catastrophic OOP health expenditure incidence at the 10% threshold *(SDG 3.8.2, 2005)*

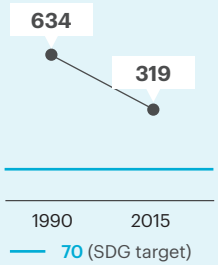
3.1% of households

Results of Joint External Evaluation of core capacities for pandemic preparedness *(JEE, 2017)*

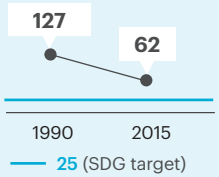
Score (for capacity)		# of indicators (out of 48)
5	Sustainable	0
4	Demonstrated	2
3	Developed	14
2	Limited	25
1	No capacity	7

Health results

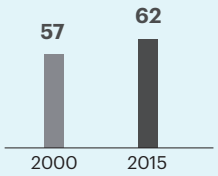
Maternal Mortality Ratio *(WHO)*
Per 100,000 Live Births



Under-Five Mortality Rate *(WHO)*
Per 1,000 Live Births



Life Expectancy at Birth *(WHO)*



Wealth Differential in Under-Five Mortality *(PHCPI, 2014)*

26.9

More deaths in lowest than highest wealth quintile per 1,000 live births

Performance of service delivery – selected indicators

(PHCPI, 2014-2015)

	Ghana	LMIC average
Care-seeking for symptoms of pneumonia	55.9%	61.5%
Dropout rate between 1st and 3rd DTP vaccination	9.3%	7.5%
Access barriers due to treatment costs	41.7%	47.4%
Access barriers due to distance	25.4%	35.8%
Treatment success rate for new TB cases	85%	80.1%
Provider absence rate	NO DATA	28.9%
Caseload per provider	NO DATA	9 per day
Diagnostic accuracy	NO DATA	47.9%
Adherence to clinical guidelines	NO DATA	33.6%

See page 8 for References and Definitions.

Existing national plans and policies to achieve universal health coverage (UHC)

SERVICE DELIVERY REFORMS

Community-based Health Planning and Services (CHPS) is a national strategy that delivers community-based care by bringing health services directly to communities. CHPS focuses on improving health in minimally resourced sub-districts; empowering people; encouraging community participation; and using task shifting to improve access to care. CHPS also uses a systems approach to increase the coverage of primary health care interventions critical to UHC. By 2016, CHPS services reached all 10 administrative regions, and 4,400 CHPS zones (67% of the total) were functional.

HEALTH FINANCING REFORMS

The National Health Insurance Scheme (NHIS), established in 2003, has been instrumental in increasing access to affordable health care. Approximately two-thirds of NHIS members are exempted from paying premiums, further reducing their financial burden. In addition, access to care has become more equitable: the ratio of NHIS coverage among women in the highest versus the lowest wealth quintile decreased from 1.6 in 2008 to approximately equal in 2014 (NHIS, 2017).

GOVERNANCE REFORMS

Achieving UHC is a key objective of the government; this agenda has been advanced by the establishment of both the CHPS and NHIS, yet several challenges remain. The government is also committed to implementing the International Health Regulations (IHR 2005) Joint External Evaluation (JEE) recommendations and continuing quality improvement, which will help progress toward quality UHC and health security.

Ghana is the only country in the world *to finance its national health insurance scheme with revenue from a value-added tax (VAT), which allows it to benefit from economic growth.*

Key challenges on the way to UHC

WEAKNESSES AND BOTTLENECKS IN SERVICE DELIVERY

Coverage of essential health services. Ghana has mixed results with respect to coverage of essential health services. The proportion of births attended by a skilled health professional has improved significantly, although there are large disparities across income groups. The use of contraceptives remains very low, only changing from 18.7% in 2003 to 22.2% in 2014 (World Bank, 2017). The proportion of fully immunized children increased in earlier years, but has recently plateaued. The proportion of children under five with fever who are taking anti-malarial drugs is lower now than in 2003. Access to mental health services is improving following the move toward community-based, as opposed to institutional, care, though more capacity needs to be built among health workers.

Quality of care. The share of private health facilities varies widely: ranging from 5.4% in the Northern region to 74.9% in the urban Greater Accra region. The 10 administrative regions of Ghana have a generally consistent distribution of public health workers; the Greater Accra, Upper East, and Upper West regions have slightly higher numbers. There is sparse information on the distribution of private health workers, which could affect access to care. Despite improvements in utilization of antenatal care and skilled birth attendance, maternal mortality and neonatal mortality remain high, raising concerns about quality of care.

Pandemic preparedness. The 2017 JEE assessment of core capacities identified limited or developed capacity in Ghana in most aspects of pandemic preparedness. Areas of readiness where Ghana currently has inadequate capacity are: various aspects of antimicrobial resistance; the capacity to activate emergency operations; and having systems in place for sending and receiving medical countermeasures and receiving health personnel during a public health emergency. Ghana's strongest aspects of preparedness are a fairly well developed immunization program and the presence of a field or applied epidemiology training program. In addition, almost all real-time surveillance capacities are developed, although more capacity needs to be built under the One Health approach and in events-based surveillance.

THE STATE OF HEALTH FINANCING

Overall funding for health. Ghana is the only country in the world to finance its national health insurance scheme with revenue from a value-added tax (VAT), which allows it to benefit from economic growth. On average, the National Health Fund has represented 3% of total public spending. From 2010 to 2012, public and external assistance declined, while the share of private expenditure (mostly out-of-pocket payments) has almost tripled, indicating increasing financial strain on people (World Bank, 2017).

Free and subsidized care. All residents of Ghana are eligible for NHIS coverage, and several people are exempted from paying premiums, including those under the age of 18, over the age of 70, indigent people, pregnant women, institutionalized persons, and beneficiaries of social protection programs. The NHIS covers 95% of common conditions

affecting the population and includes care delivered in outpatient, inpatient, and emergency settings. For conditions covered by the NHIS, beneficiaries do not have to pay out of pocket for services or pharmaceutical products.

Major financial protection schemes. The two-pronged approach to achieve UHC includes the NHIS, to eliminate financial barriers, and CHPS, to make services accessible and equitable. By 2013, 38% of the population was enrolled in NHIS. Utilization of health services (both inpatient and outpatient) increased from 0.46 per capita in 2005 to 3.3 per capita in 2012 (World Bank, 2017).

GOVERNANCE CHALLENGES

Health financing. While working toward UHC, the government of Ghana has faced public liabilities in the health sector. These include financial commitments to international organizations (e.g., co-financing for Gavi) and NHIS commitments to providers for claims reimbursements (estimated at US$181.8 million in early 2017) (NHIS, 2017). The NHIS deficit started in 2009 and has steadily increased since, necessitating urgent action to improve fiscal responsibility and address inherent challenges in the evolving health financing system. Rising costs and deficits will affect the government's ability to provide equitable, efficient, and sustainable health care for all.

Challenges with outbreak response. The country faced an unprecedented cholera outbreak in 2014 with about 29,000 cases and over 240 deaths reported. During the 2015–16 meningitis season, outbreaks of meningitis occurred in districts both in and out of the traditional meningitis belt. Over 2,400 cases were reported nationwide and the causative organisms included pathogens not typically responsible for outbreaks in the recent past. These incidents exposed the vulnerability of the health system to major outbreaks, including weaknesses in key areas such as laboratory diagnostic capacity.

Collaborative efforts to accelerate progress toward UHC

EXISTING INITIATIVES SUPPORTED BY EXTERNAL PARTNERS

External partners are engaged in Ghana to build national capacity and strengthen the health system, including by conducting a situation analysis and updating and costing the National Action Plan for Health Security. The Tokyo Joint UHC Initiative, supported by the government of Japan and led by the World Bank (WB), in collaboration with the Japan International Cooperation Agency (JICA), United Nations Children's Fund (UNICEF), and the World Health Organization (WHO), is supporting the government of Ghana and strives to accelerate progress toward UHC. This support will enable strengthening of nationally-led strategic health systems to achieve UHC, as well as pandemic preparedness.

Through budgetary support and technical cooperation, the WB, U.K. Department for International Development (DFID), and JICA have jointly supported and monitored CHPS implementation. UNICEF is also working with government agencies (the Ghana Health Service and the National Health Insurance Scheme) to demonstrate quality improvement models for maternal, newborn, and child health services.

95% of common conditions are covered by the NHIS.

PLANS FOR FUTURE COLLABORATIVE WORK

Policy and Human Resources Development (PHRD)-funded advisory support

The work under the Tokyo Joint UHC Initiative falls within two major objectives: supporting equitable, efficient, and sustainable health financing for primary care/community-based health planning and services (CHPS) and strengthening pandemic preparedness. Key components of the first objective are technical support for the NHIS reform strategy and policy development, and technical support for refining mechanisms of paying for primary care. Activities in support of the second objective entail: providing technical assistance to strengthen capacity for preparedness and response to public health events and hazards including emergency operations; conducting a systems audit; mapping existing stakeholders and coordination mechanisms and developing an engagement protocol; and developing an epidemiology information architecture, a technology gap analysis, and a business and administration requirement document. Furthermore, the Tokyo Joint UHC Initiative will closely cooperate with other investments in health, such as those by the Global Fund and Gavi, to contribute to health system strengthening. CConsidering that other sectors, such as nutrition and water and sanitation, compose the foundations of heath for all, challenges in these fields also will be considered under the joint work. Future efforts can further PHRD-funded pilot activities to generate evidence for mobilizing resources under IDA18 to better support the UHC agenda.

References & Definitions (page 1 indicators)

UHC Service Coverage Index (2015) – WHO/World Bank index that combines 16 tracer indicators into a single, composite metric of the coverage of essential health services. For more information: WHO/World Bank (2017). Tracking UHC: Second Global Monitoring Report.

Catastrophic out-of-pocket (OOP) health expenditure incidence at the 10% threshold (Single data point, year varies by country) – WHO/World Bank data from Tracking UHC: Second Global Monitoring Report (2017). Catastrophic expenditure defined as annual household health expenditures greater than 10% of annual household total expenditures.

Results of the Joint External Evaluation of core capacities for pandemic preparedness (2016/17, year varies by country) – A voluntary, collaborative assessment of capacities to prevent, detect, and respond to public health threats under the International Health Regulations (2005) and the Global Health Security Agenda. 48 indicators of pandemic preparedness are scored using five levels (1 is no capacity, 5 is sustainable capacity). https://www.ghsagenda.org/assessments

Life Expectancy at Birth (2000-2015), Maternal Mortality Ratio (1990-2015), Under-five Mortality Rate (1990-2015) – WHO Global Health Observatory: http://apps.who.int/gho/data/node.home

Wealth Differential in Under-five Mortality (Single data point, year varies by country) – Indicator used by the Primary Health Care Performance Initiative (PHCPI) to reflect equity in health outcomes. For more information: https://phcperformanceinitiative.org/indicator/equity-under-five-mortality-wealth-differential

Performance of service delivery – selected indicators (Single data points, years vary by country) – Indicators used by the Primary Health Care Performance Initiative (PHCPI) to capture various aspects of service delivery performance. PHCPI synthesizes new and existing data from validated and internationally comparable sources. For definitions of individual indicators: https://phcperformanceinitiative.org/about-us/our-indicators#/

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