



## ESID Briefing No. 16

# Politics and health service delivery: Insights from Ghana

### KEY FINDINGS:

- Ghana has a mixed record in terms of health outcomes. Despite some gains and a dramatic increase in the number of health facilities, healthcare – and particularly maternal healthcare – has not improved as much as it should. This is partly because the health sector has become politicised in ways that undermine the technical dimensions of policy formulation and implementation.
- Quantity is prioritised over quality: politicians are incentivised to make investments in visible aspects of the health sector, rather than the less visible, long-term factors that promote quality health outcomes.
- The inequitable allocation of resources and distribution of health workers is linked to deepening regional inequalities – politicians prefer to spread resources thinly to increase their influence on voters, rather than focus on more deprived areas.
- In the absence of system-wide drivers of improved performance, sub-national variations in the quality of maternal health services are strongly shaped by the capacity and commitment of regional and district health management teams in instituting and enforcing top-down accountability measures.

Ghana has a mixed record in terms of health outcomes. While there have been improvements in access to health services, with a dramatic increase in the number of health facilities, this is not reflected in progress on health indicators, which has been ‘worryingly slow’ (UNICEF, 2013). The sector is underfunded, with allocations declining from 16% of the overall national budget in 2006 to 7.6% in 2011. Wages dominate the government component of the budget, leaving limited resources for actual service delivery. In addition, there are frequent deviations between allocations and actual spending, as well as significant leakages at various levels.

“ While there have been improvements in access to health services ... this is not reflected in progress on health indicators. ”

Our research suggests that these outcomes reflect the character of politics in Ghana as well as the interaction of politics with the governance arrangements for the health sector. Ghana can be characterised as a ‘competitive clientelist’ type of political settlement, in which two political parties have consistently challenged each other in national elections and where patron-client forms of politics continue to prevail. In this context, the incentives of the ruling elites are loaded towards the use of public institutions in securing short-term political gains.

The health sector has a decentralised governance structure, at least on paper. The Ministry of Health oversees and provides guidance for the entire health sector, with regional and district health management teams responsible for medical matters at lower levels. Sub-district structures should be the main level for the provision of primary healthcare services, but their effectiveness is undermined, as they have little autonomy or resources of their own.

## FINDINGS

### The power of the political over the technical in policy-making

Competitive clientelist politics in Ghana create an environment in which public investment decisions are shaped more by political than technical or developmental considerations. Health reforms are directly shaped by electoral cycles, a key example being the introduction and evolution of the National Health Insurance Scheme (NHIS), which has been an electoral issue since the first competitive elections in December 2000. Appointments to the Scheme have been politicised, leading to electoral candidates taking over roles in the policy-making process traditionally played by technocrats, and the proposed NHIS law being rushed through parliament in advance of the 2004 election.

In the run-up to the 2008 election, the then President announced a free maternal healthcare initiative that would be implemented through the NHIS. The focus on the political, rather the technical, has continued as the current government has focused on increasing enrolment onto the NHIS, against technical advice that it should

“ Politicians prefer to spread resources thinly to increase voter reach, rather than focus on more deprived areas ”

be restricted to the most vulnerable. As a result, the financial sustainability of NHIS is now in crisis. Politicians prefer to spread resources thinly to increase voter reach, rather than focus on more deprived areas and recipients.

### Quantity versus quality

Politicians are incentivised to make investments in visible aspects of the health sector, rather than promoting quality health outcomes. The performance of health ministers is measured more by the quantity of Community-based Health Planning and Services (CHPS) compounds they construct, rather than their overall contribution to quality health outcomes.

“ Politicians are incentivised to make investments in visible aspects of the health sector ”

The number of CHPS compounds has increased from 39 in 2002 to 2,948 by 2014, but most CHPS compounds remain understaffed. A 2010 survey shows that 57% of CHPS compounds had no midwife, and many other health posts had only one midwife. The free maternal health policy introduced under NHIS has led to increased use of health services by pregnant women in ways that have increased pressure on existing human resources. This has negatively affected the quality of care.

Table 1: Recent selected maternal health indicators in Ghana, 2007-14

Year	Family planning acceptor rate	Skilled delivery rate	Proportion of mothers making 4 ante-natal care visits
2007	-	32.1	62.8
2008	-	42.2	60.9
2009	25.4	45.6	66.6
2010	23.7	48.2	66.6
2011	25.2	49.1	70.7
2012	24.9	55.0	72.3
2013	26.1	55.3	66.3
2014	-	-	67

Source: Compiled from MoH Annual Health Sector Review Reports, various years.

In response to poor performance on maternal health, the Ministry of Health developed the Ghana MDG (Millennium Development Goal) Acceleration Framework (MAF) to accelerate progress towards achieving MDGs 4 and 5. However, the MAF lacks dedicated funding in government budgets and after its implementation has been over-centralised. Although the aim was to prioritise investment in skilled attendance at birth, emergency obstetric care and family planning, the MAF initiative failed to overcome elite preference for visual impact. This exemplifies the policy incoherence that is characteristic of competitive clientelist political settlements. It also reflects the challenge that resource allocation is driven by the personal interests of dominant actors rather than policy objectives and population needs.

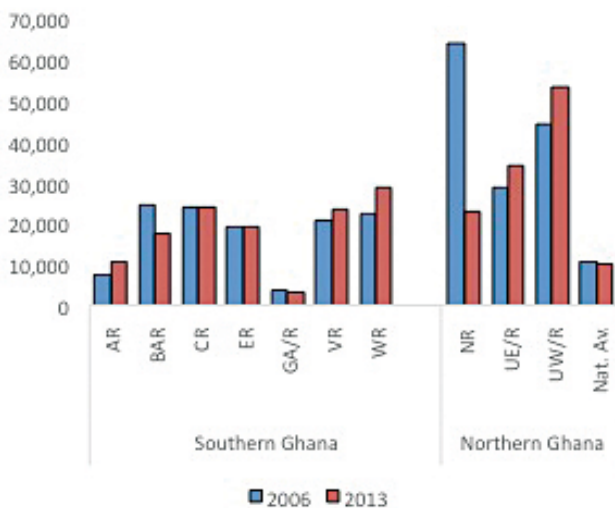
### Progress at regional level can be achieved with the enforcement of top-down accountability

There are three key factors that help explain differences in regional and district performance in quality healthcare delivery:

- Effective leadership in human resource capacity management;
- Presence or absence of top-down accountability mechanisms;
- Nature of multi-stakeholder governance arrangements.

There are national-level documents addressing inequalities, such as the Ghana Poverty Reduction Strategy (GPRS), which has the objective of 'bridging equity gaps in access to quality health and nutrition services' and the Ghana Health Service national staff posting guidelines. However, while there have been some improvements, for example in the Northern region, implementation varies, both across and within regions. The inequitable allocation of resources and health workers has persisted over a prolonged period of time and even worsened, particularly in the Upper East and Upper West regions (see Figure 1).

**Figure 1: Doctor to population ratios, 2006 and 2013**



Source: Author, based on MoH (2014).

**“ Weaknesses of accountability in the Ghanaian health sector are more of a political than a technical or cultural issue ”**

A study in 2001 by Canagarajah and Ye found allocation expenditure concentrated in higher-level health facilities, while lower-level facilities, which serve the vast majority of the population, were starved of investment. Although such investment strategies limit improvements in health outcomes, the authors predicted that the government was unlikely to re-allocate public funding from higher- to lower-level facilities, due primarily to political pressure to maintain levels of medical care in urban areas.

Weaknesses of accountability in the Ghanaian health sector are more of a political than a technical or cultural issue. This is evident in the significant variations between public and private health facilities, in terms of the functionality of accountability mechanisms and the ways these in turn shape health worker productivity. In the private sector, where absenteeism of health workers 'is typically sanctioned', health worker productivity tends to be higher. In the public sector, accountability and disciplinary measures are undermined by unclear lines of authority, and promotion is often based on patronage rather than performance. Centralisation of the payroll also contributes to a lack of monitoring and supervision at the local level.

The findings highlight the primacy of upward accountability within regional governance structures in determining health outcomes in Ghana. Weak supervision in the regional and district structures in Volta Region led to poor performance indicators, even though it is relatively well-resourced in terms of health facilities and personnel. On the other hand, in spite of its economically deprived status and relatively high population-per-doctor ratio, the Upper East Region has consistently performed well above the national average on a wide range of indicators relating to maternal and child health, due to strong leadership at the regional level.

The evidence also indicates that incentives for performance are generated by a hybrid form of accountability that combines top-down pressures from the regional health director with horizontal forms of accountability among various health facilities. Well-designed bottom-up accountability mechanisms that involve traditional leaders can also play a major role in improving performance and quality of service delivery.

This points to an important role for regional and district health management teams, and suggests that where developmental forms

**“ there is an important role for regional and district health management teams ”**

of leadership prevail at these levels, more power and resources should be decentralised to them. Where this is not the case, improved performance will require building higher levels of both top-down and bottom-up forms of oversight and accountability, as well as efforts to transfer policy learning from success stories such as the 'pocket of bureaucratic effectiveness' in Upper East.

## POLICY IMPLICATIONS

- If Ghana is to reverse poor outcomes in maternal mortality, political elites must extend their commitment and investment to improving healthcare beyond providing healthcare facilities, to equipping these facilities and ensuring the effective supervision of frontline health sector workers.
- Top-down accountability at all levels of the health sector is critical for improving the productivity of health professionals and an overall improvement in the quality of healthcare. This accountability mechanism should emphasise responsible leadership, human resource management, and supervision supported by appropriate incentives.
- However, even in the absence of strong top-down accountability pressures, hybrid forms of accountability and well-designed bottom-up mechanisms that involve traditional leaders can play a major role in driving up health worker performance and improving the quality of health service delivery.
- Standardised staff posting guidelines and performance contracts need to be adopted and enforced at all levels of the health service delivery chain, especially between district directors and district health management teams.
- External maternal mortality audits are required, rather than self-audits.

## ABOUT THIS BRIEFING

This briefing was produced from an ESID project investigating the implementation of health reforms in Ghana, particularly the slow progress in reducing maternal mortality. It draws on research framing by ESID researchers Professors Brian Levy (University of Cape Town) and Michael Walton (Harvard University). It was drafted by Kate Pruce, adapted from a forthcoming ESID Working Paper, with inputs from Professor Sam Hickey (ESID Research Director, The University of Manchester). The research was undertaken by Dr Abdul-Gafaru Abdulai (University of Ghana Business School), coordinated by Professor Sam Hickey.

## FURTHER READING

ESID Working Paper (2016 forthcoming). 'Health service delivery in clientelist political settlements: Insights from Ghana', by Abdul-Gafaru Abdulai.

ESID Working Paper 18 (2013). 'Institutions, provision and service delivery: Bringing politics back in', by Brian Levy and Michael Walton.

ESID Briefing Paper No. 8: 'Researching the politics of service provision: A new conceptual and methodological approach (November 2018).

All available at: [www.effective-states.org](http://www.effective-states.org)

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Booth, D., and Therkildsen, O. (2012). 'The political economy of development in Africa: A joint statement from five research programmes'. April.

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DW3095.03.16



The **Effective States and Inclusive Development Research Centre** (ESID) is an international partnership of research and policy institutes led from the Global Development Institute (GDI) at The University of Manchester. ESID is funded by the UK Government.

ESID researchers are based in Bangladesh, Cambodia, Ghana, India, Malawi, Peru, Rwanda, South Africa, Uganda, UK, USA, Zambia and elsewhere.

ESID is led by David Hulme, Chief Executive Officer; Samuel Hickey and Kunal Sen are Research Directors; Julia Brunt is the Programme Manager; and Pablo Yanguas is Research Associate.

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**Effective States and Inclusive Development Research Centre**

Global Development Institute  
School of Environment, Education and Development  
The University of Manchester  
Oxford Road  
Manchester  
M13 9PL  
UK

email: [esid@manchester.ac.uk](mailto:esid@manchester.ac.uk)

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March 2016.

This document is an output from a project funded by the UK Aid from UK Government for the benefit of developing countries. However, the views expressed and information contained in it are not necessarily those of or endorsed by the UK Government, which can accept no responsibility for such views or information or for any reliance placed on them.