HEART
HEALTH & EDUCATION ADVICE & RESOURCE TEAM

UKaid
from the British people

# GHANA HEALTH SECTOR SUPPORT PROGRAMME: SCENARIO PLANNING AND RISK MANAGEMENT

DRAFT REPORT 21 October 2014

Authors: Jeremy Clarke and Stewart Tyson

# Table of contents

# List of abbreviations

| | |
|---|---|
| CAGD | Controller & Accountant General's Department |
| CHAG | Christian Health Association of Ghana |
| CHPS | Community-based Health Planning and Services |
| CSO | Civil Society Organisation |
| DFIDG | Department for International Development Ghana |
| DHS | Demographic and Health Survey |
| GHS | Ghana Health Service/Ghanaian New Cedi |
| GIFMIS | Ghana Integrated Financial Management System |
| GOG | Government of Ghana |
| HFS | Health Financing Strategy |
| HSMTDP | Health Sector Medium-Term Development Plan |
| HSSP | Health Sector Support Programme |
| IEA | Institute of Economic Affairs |
| IGF | Internally Generated Funds |
| IMF | International Monetary Fund |
| IPPD | Integrated Personnel and Payroll Database |
| LMIC | Lower Middle-Income Country |
| MDGs | Millennium Development Goals |
| M&E | Monitoring and Evaluation |
| MICS | Multiple Indicator Cluster Survey |
| MOF | Ministry of Finance |
| MOH | Ministry of Health |
| MTSP | Medium-Term Strategic Plan |
| NBSFA | Non-Budget Support Financial Aid |
| NHIS/NHIA/NHIF | National Health Insurance Scheme/Authority/Fund |
| PCR | Project Completion Report |
| PFM | Public Financial Management |

| | |
|---|---|
| PHC | Primary Health Care |
| PIP | Priority Intervention Programme |
| PPME | Policy, Planning, Monitoring and Evaluation |
| SBA | Skilled Birth Attendance |
| SBS | Sector Budget Support |
| STAR | Strengthening Transparency and Accountability in Ghana |
| TA | Technical Assistance |
| VFM | Value for Money |
| WHO | World Health Organization |

# Executive summary

Over two decades the health sector in Ghana has made considerable progress in improving health outcomes and in increasing access to health care. Services throughout the country are funded by central government and through a contributory National Health Insurance Scheme (NHIS). Urban-based curative services are reasonably well resourced and staffed but large disparities in access remain. Some regions and poor communities are underserved and lack staff and recurrent resources to deliver effective primary care. In recent years trends have been less positive and progress has slowed. The data for 2013 suggest some deterioration in a number of key service indicators, as well as increasing inequity, despite increased resources and continued donor support.[1]

Increasing macroeconomic instability, poor budgeting, a rapidly growing wage bill, limited resources for goods and services, and weak financial management controls across government are threatening past progress in health. These difficulties are compounded by weak leadership and management of core reforms in the health sector and the failure to deliver resources for front line service delivery, especially in rural areas. The Ministry of Health (MOH) has failed to achieve the performance targets agreed for sector budget support (SBS).

This review has therefore considered possible scenarios for the health sector over the next three years and a range of associated options for future support from the Department for International Development (DFID). Under the **high case scenario** it is assumed that there is a trend of improvement with a return to economic stability, fiscal consolidation is achieved and health spending is protected. Political stability is preserved, and there is stronger leadership by health ministers with action on corruption and commitments on health financing, delivery of primary health care and improvements in public financial management (PFM). Health indicators stabilise and improve.

The **medium case scenario** is a continuation of current trends with slowing economic growth, a continued squeeze on health spending and some diversion of public funds in the run-up to the next election. Health ministers make commitments but the MOH cannot deliver them and there is no action to tackle corruption, waste and inefficiency. The health sector remains vulnerable to decline and reversal of health indicators.

A more pessimistic **low case scenario** is also considered, with a marked slowdown in growth and a decline in health spending in real terms. The National Health Insurance Authority (NHIA) is unable to meet insurance claims and arrears build-up, with services reverting to pay as you go. The election leads to wide-scale diversion of funds and increased corruption. Health ministers are focused on the election and there is a loss of attention to sector reforms. The system is at risk of failure and health indicators worsen considerably.

Four main options for financial support are considered that are consistent with this range of possible scenarios:

[1] From the 2008 Demographic and Health Survey (DHS), 2011 MICS and 2014 Holistic Assessment of 2013 Performance of Health Sector.

- Option 1a: Continue SBS but with a specific focus on improving performance (i.e. in PFM, workforce management and health sector financing).
- Option 1b: Continue SBS with a focus on services and strong earmarking of funds for that purpose.
- Option 2: Provide non-budget support financial aid for primary care.
- Option 3: Support service delivery (challenge fund) for non-state and state provider project proposals for primary health care services.
- Option 4: Enhance accountability through non-state actors and civil society organisations (CSOs).

The review concludes that option 2 has the best fit against the selection criterion agreed with DFID. However, there are also some risks: for example, if the ministerial team is replaced or there is a new government with different priorities. Consideration should also be given to option 3 if the initial appraisal and design work on option 2 suggests there are major risks or problems, for example in relation to the capacity of the MOH and Ghana Health Service (GHS) to manage the proposed programme or ensuring sustainability.

SBS also remains an option if the MOH is able to explain the reasons for failure to date, demonstrate strengthened management, and provide new and realistic performance targets it could actually deliver. The review suggests that continued SBS would also require an International Monetary Fund (IMF) agreement to deliver a more sustainable budget for the government of Ghana (GOG) as a whole.

The option of withdrawal from the sector was considered. Given the imperative to control overall spending and reduce the budget deficit, government would likely face even tighter financial constraints in the health sector. The absence of SBS to finance recurrent funding would affect critical supplies including drugs and the day to day operational effectiveness of the system would be reduced.

Health systems remain weak and need to be made more resilient. There is potential for improvement if leadership, management and accountability in the sector can be strengthened. It will be important to build capacity of the system wherever possible to prevent reversals of previous gains during a period of macroeconomic turbulence. Greater resilience is also required to ongoing threats such as a resurgence of infectious diseases (cholera) or cross-border threats (e.g. Ebola).

There are other donors in the sector but numbers have been reducing and the donor dialogue has not been very effective. DFID has considerable experience and expertise and there is a case for continuing engagement in the sector, but there is a need to reorient financial aid support to ensure that it can achieve the greatest impact.

The recommendations are set out in Section 7 but are also listed below for convenience:

Recommendation 1: DFID should reach a definitive and agreed position with the MOH concerning the reasons for the non-achievement of the existing SBS performance targets and make an assessment of when/if these targets can actually be achieved.

Recommendation 2: If a decision is made to adopt option 1b, then the basis for tranche release should be considered as a first priority. An initial release could be linked to the completion of existing SBS targets, ministerial approval of the health sector financing strategy, agreement of the earmarking arrangement, and new policy and service delivery targets for the coming years 2015–17. An IMF agreement is a prerequisite.

Recommendation 3: If a decision is made to adopt option 2, then discussions should be opened with the GHS to agree objectives and management arrangements and to develop a programme delivery plan drawing on those already being developed for the planned World Bank project. Similarly, if option 3 is adopted then early discussions should be undertaken with the Christian Health Association of Ghana (CHAG) and other non-state providers.

Recommendation 4: DFID should contact the World Bank task manager and consider the possibility of co-funding of its new primary health care (PHC) project. If this is possible, then the pros and cons should be further examined as a relatively fast-track option for early development.

Recommendation 5: There should be further discussion of the technical assistance (TA) plan with the MOH and agreement of its objectives, indicators and allocated responsibilities. DFID should hold the MOH director of policy, planning, monitoring and evaluation (PPME) accountable for its delivery.

Recommendation 6: DFID should encourage the MOH to give priority to achieving ministerial approval and early implementation of the health financing strategy (HFS) as a core area for future reform in the sector.

Recommendation 7: DFID should engage more directly and on a systematic basis with the deputy minister to achieve progress with the financing strategy, the PHC policy and workforce optimisation. This arrangement should be used to drive greater accountability of MOH senior staff.

Recommendation 8: DFID should revitalise the donor dialogue by encouraging stronger leadership from GOG including ministerial engagement. The donor sector group has enabled discussion of overall sector performance but has had limited traction in delivering anticipated changes and reforms. If the sector group is continued, there should be a collective donor agreement on the expected results, as well as consideration by DFID Ghana (DFIDG) of the level of scarce health and governance adviser (or consultant) time to be devoted to ensuring an effective dialogue.

Recommendation 9: Consideration should be given by DFID to increase working with CSOs on the voice and public accountability aspects of health issues, regardless of which option is chosen for taking forward financial aid.

# 1. Introduction

## 1.1 Background

DFID Ghana's Health Sector Support Programme (HSSP) was approved in June 2013. It committed up to £67 million over five years to strengthen the health system and fill important gaps to help ready GOG to manage health services without donor assistance. The total commitment included £50 million of SBS, with base and performance-related elements. To date only £14 million of base case financing has been disbursed due to the failure to meet performance targets.

The programme's first annual review (June 2014) scored implementation to date as 'B' and recommended against releasing any of the performance tranche of SBS for 2014/15. Progress was judged inadequate and, despite increased financial and human resources, there was a regression in the sector's performance over 2013 and inadequate budget execution. Other components of HSSP performed well, including: earmarked support to three health agencies, TA embedded within the MOH and targeted support toward mental health.

Since the business case was developed, the macroeconomic situation has deteriorated and severely hindered government's ability to deliver. This is likely to further deteriorate in the short term. Government has also made spending decisions that question its commitment and ability to deliver value for money. While the MOH has highlighted the importance of SBS in an environment where funds for recurrent costs are starved, it has yet to demonstrate willingness to take the difficult steps needed to strengthen the health system.

However, HSSP has only been fully operational for six months, with the performance framework for SBS finally agreed only in March 2014. In addition, a new minister and deputy minister have recently been appointed and development partners are optimistic about their potential.

Given the above concerns DFID has questioned whether SBS remains an appropriate instrument and whether there are alternative scenarios to deliver improvements to services and the necessary reforms to strengthen the Ghana health system.

## 1.2 Review objective

The main objectives were to:

- identify and analyse the key political, economic and health sector-relevant issues that may impact the provision of health SBS over the next two years;
- consider the impact of these on the ability of the government to deliver better health systems and outcomes; and
- process these into potential scenarios and related responses for the HSSP.

## 1.3 Review scope and methods

The review was carried out in Ghana from 22 September to 3 October 2014. Initial briefings by DFID were followed by meetings with senior staff in government and its health agencies, development partners and CSOs (details in Annex B).We met with a number of local informants regarding developments in the health and finance sectors and attended a feedback session by the visiting IMF mission. Interviews were supplemented by review of project documentation and related literature. We presented conclusions and proposed options to DFID, and held separate wrap-up meetings with the chief director and the deputy minister of health.

# 2. Context

## 2.1 Health sector

Ghana's health system has delivered steady progress in increasing access to services and in improving health outcomes over two decades.[2] There is an extensive network of facilities, the NHIS has expanded access to services for large parts of the population and reduced reliance on out of pocket payments, and there has been progress to reduce attrition of doctors in particular and to increase the production of nurses, midwives and doctors. The community-based PHC system is slowly extending its coverage. There is a comprehensive set of policies, strategies and management tools.[3]

In recent years progress has slowed and the 2013 health sector performance data indicate deterioration in a number of key service indicators, for example, falling coverage of antenatal care, skilled birth attendance and immunisation, along with increasing inequity across regions and wealth quintiles.[4] This decline occurred despite increased human and financial resources. A number of health outcome performances are worse than trends found in other middle-income countries and those spending similar sums on health.[5] There are concerns about recent macroeconomic instability and the failure to address systemic issues, particularly health financing, PFM and an unsustainable wage bill, that crowd out funds for goods and services. These failures threaten further progress and the ability to sustain gains.

Ghana's demographic and epidemiological transition is well underway. Despite falls in fertility the population of about 25 million is expected to grow to 34 million by 2015. There is rapid urbanisation (now 50%) and high levels of urban poverty. Non-communicable diseases account for a mounting proportion of the burden of disease and 40% of deaths. However, Ghana still faces significant challenges in dealing with communicable diseases, with a substantial cholera epidemic across the country and the threat of Ebola in 2014.[6] There remains a substantial burden of child under-nutrition, and with falling levels of breastfeeding this is likely to increase.

Since 2011 Ghana has been classed as a lower middle-income country (LMIC) and donors are gradually withdrawing aid or have plans to do so. At present, development assistance still makes a significant contribution to the health sector directly through budget support or indirectly through health projects and commodity support from the Global Fund. The latest MOH annual report indicates that budget support/health fund contributions for 2013 were GHS 90.135 million and Global Fund assistance reached GHS 119.34 million. Together this amounted to development assistance of GHS 209.48 million.

Looking to the future, GOG has a new medium-term development plan but the budget support donors are concerned about macroeconomic instability and where the funds are going. There is little evidence so far that the MOH has a vision for the future

[2] See the Demographic and Health Survey 2008 and Multiple Indicator Cluster Survey 2011. The total fertility rate has fallen from 6.4 (1988) to 4.1 (2011), while the child mortality rate has fallen to 78/1,000.
[3] World Bank (2014) *Project Appraisal Document of Maternal and Child Health and Nutrition Improvement Project*, April.
[4] Ministry of Health Ghana (2014) *Holistic Assessment of the Health Sector Programme of Work 2013*, April. The annual assessment measures sector performance through routine data in 2013.
[5] The health sector in Ghana; a comprehensive assessment. World Bank, 2012.
[6] WHO Country Profile 2014.

evolution of the sector and has the leadership willing to make difficult strategic choices and address critical constraints such as PFM and workforce issues.

The emerging HFS holds out prospects for a new direction. But implementation will require the MOH to carry out it its primary role of stewardship of the sector and coordination much more effectively. This is made more difficult by the institutional fragmentation of the sector and because the ministry still duplicates functions of the GHS and other agencies. It will be an ongoing challenge to build broad-based stakeholder support for major reforms.

## 2.2 Financial and budgetary analysis

It is important to place the HSSP in the wider context of the overall fiscal and budgetary situation of GOG. Recent trends indicate an overall deterioration in the macroeconomic situation, with a potential slowdown in economic growth, rising inflation and volatility in foreign exchange markets.

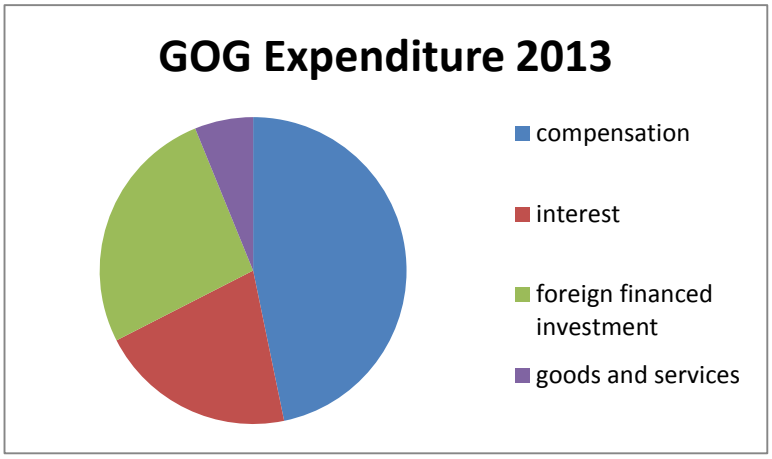
The economy has achieved high growth rates of around 8% per annum since the global recession due to favourable commodity prices and high levels of inward investment in sectors such as oil and gas. However, GOG has allowed public spending to increase to unsustainable levels due to large public sector wage increases and borrowing. The composition of spending has become dominated by the wages and salaries bill and interest payments. Most commentators expect the budget deficit to significantly exceed government forecasts of 8.3% of GDP for 2014.[7] According to figures of the Controller & Accountant General's Department (CAGD) publicly available on the GOG website, the actual wage bill outturn reached 87% of total revenue in 2013.[8]

Government has therefore opened talks with the IMF about a possible financing arrangement. The details of this are being worked out and it is not yet clear if it will proceed or what a potential adjustment programme would cover. However, it can be anticipated that it will involve tight control and reduction in public spending, with specific targets for the wage bill.[9] It could also mean reductions in planned spending on the social sectors unless they can be protected as a priority area.

Examination of the public accounts for 2013 shows the share of actual expenditure made by GOG for the main areas of public spending (see Chart 1 below). This suggests that compensation of employees absorbed 44% of total expenditure, interest on debts absorbed 19.5%, and goods and services only 5.8%. Foreign financed investment (i.e. GOG spending in 2013 financed from donor project grants and overseas loans) accounted for 24.8% of spending.

[7] Economist Intelligence Unit report on Ghana August 2014
[8] See the Statement of revenue and expenditure for the year ending 2013. This shows total actual revenue at GHS 12.656 billion and compensation to employees at GHS 11.065 billion.
[9] Recent work by DFID with the Office of the President has also pointed to the potential for further payroll audits and removal of ghost workers.

**Figure 1:**




Source: CAGD Statement of Revenue and Expenditure for Year ended Dec 2013

Note: In the accounts foreign financed investment is a category that includes expenditure financed by donor project grants or by foreign loans

The overall Ghana budget is therefore dominated by salaries and interest payments, with very limited resources for recurrent funding. GOG has also published a five-year trend analysis over 2009–13, which confirms this pattern has been sustained.[10]

The CAGD also has a breakdown of spending for the MOH that shows the main categories of spending classified by function of government as shown in Table 1. These data confirm that GOG health budgets and spending are dominated by salary costs.

**Table 1: Health sector spending – all areas (GHS)**

| Health sector | Compensation[11] | Goods and services | Other | Non-financial assets (i.e. capital projects) | Total spending |
|---|---|---|---|---|---|
| 2013 | 1,404,042,520 | 51,743,237 | 8,500 | 39,782,740 | 1,495,576,997 |
| % of health budget | 93.9 | 3.5 | | 2.7 | 100 |
| 2011 | 731,798,045 | 12,095,625 | 6,547,596 | 20,751,164 | 771,192,430 |
| % of health budget | 94.9 | 1.6 | 0.8 | 2.7 | 100 |

Source: CAGD (2013), Classification of Expenditure By Function of Government (figures have been extracted for health)

However, discussion with the MOH director of budget suggests the picture is more complex. Health services rely significantly on internally generated funds (IGF), which

[10] See the table 'Five year trend analysis of revenue and expenditure' in the 2013 public accounts and the accompanying graphic.
[11] In the CAGD table most of this amount is for hospital and outpatient services but there is also a substantial chunk classified as n.e.c. or not elsewhere classified.

are generated through a 2.5% levy on VAT and social security deductions from employees. GOG also makes annual budgetary allocations direct to the National Health Insurance Fund (NHIF). These resources are transferred from the Ministry of Finance (MOF) to the NHIF, and are used by the NHIA to meet the costs of treatment/benefit entitlements under the national health insurance arrangements. IGF can also be generated at state facilities where patients pay on an 'out of pocket' basis, i.e. direct cash payment.

The VAT levy and contributions are therefore used to enable the NHIF to meet the costs of treatment provided by the GHS or non-state providers. Citizens covered by insurance can present themselves for treatment at a government hospital or clinic and receive treatment, with the costs being reimbursed subsequently by the insurance arrangements. By relying on this flow of payments, the MOH can ensure that at least some of the running costs of the health services are covered. However, the underfunding of the insurance system in relation to actual usage has meant a build-up of unpaid bills.

The picture as presented to the team by the MOH is shown in Annex D of the report for both 2012 and 2013. This suggests that taking IGF and donor flows into account, the breakdown is more balanced between compensation of employees and goods and services in overall GHS expenditure. However, if the data are accurate, then directly funded GOG service-related spending is negligible and overall the GHS remains dependent on aid for service-related spending (see SBS and earmarked programme categories in Table 2).

**Table 2: Actual expenditure for Ghana Health Service, 2013, in GHS million* (see also Annex D)**

| Ghana health service | Compensation | Goods and services | Assets | Total |
|---|---|---|---|---|
| GOG | 594.04 | 0.7 | 3.34 | 598.08 |
| IGF | 37.67 | 340 | - | 377.66 |
| SBS | 0.01 | 8.5 | 0.28 | 8.8 |
| Programmes-earmarked | - | 129.48 | - | 129.48 |
| Total | 631.71 | 478.69 | 3.62 | 1,114.02 |
| Percentage | 57% | 43% | | |
| Less external aid** | 631.71 | 349.21 | 3.62 | 984.54 |
| Percentage | 64.2% | 36% | | |

Source: Supplied to the review team by MOH director of budget

* The full table is shown in the annex. Spending on CHAG is excluded here. The external aid figure is taken to be the spend on SBS and programmes (earmarked).

** Own calculation based on advice from the MOH budget office.

The MOH draft HFS paper[12] underlines that existing sector funding arrangements are not sustainable as a basis to provide increasing access for the wider population. Multiple revenue streams make it difficult to plan the financing of the sector or incentivise providers. There is a need for cost control through increased efficiency and a cap on the extensive basic benefits package. The strategy is also examining possibilities for increased revenue mobilisation, for example through increases to the

[12] Ghana Health Financing Strategy Implementation Plan September 2014.

levy, social security and the possible introduction of new taxes on alcohol or tobacco consumption that would be earmarked for health.

Moreover, public provision through clinics and rural health posts is also difficult to sustain without more recurrent funding in the system. Some services such as immunisation and preventative work are public goods and cannot easily be charged. Services from PHC centres are supposed to be mainly covered by GOG and are reportedly not covered by insurance.[13] Even the MOH's own figures (see Table 2) make it clear that GOG's direct contribution to recurrent funding (i.e. **excluding IGF**) is almost zero.

## 2.3 Sector institutions

Ghana's health system is highly fragmented, with separation of policy, budgeting and monitoring functions (MOH) from service provision (GHS) and health financing (NHIA). Seventeen agencies vying for roles and responsibilities further complicate the structure of the system.[14] There is a substantial non-state sector, CHAG, whose facilities are an important provider of services in rural areas. Private for-profit providers are largely based in urban areas whereas non-governmental organisations/CSOs, informal drug sellers and traditional healers are in rural areas.

The national insurance scheme, introduced in 2003, builds on pre-existing district-level mutual health insurance schemes and has become the main source of finance for service delivery. Yet in 2013 it was estimated to cover only 37% of the population and despite an exemption scheme has limited reach among the most vulnerable populations.[15] The NHIA reimburses providers for costs of treatment but not for public health interventions such as health prevention and promotion. It covers 95% of the burden of disease with an extensive package of benefits. There are concerns that the better off capture more of the benefits from the subsidised scheme.[16]

The NHIA is underfunded and inefficient, with signs of falling confidence from suppliers of health care in its ability to reimburse costs. There are reports of facilities (CHAG, Military Hospital, Korle Bu Hospital) turning away patients with insurance cards. The NHIA's financial viability is questioned and will depend on increased revenue and expenditure management, cost containment and efficiency gains to balance demand with supply while increasing coverage toward the national goal of universal health care.[17] In the short term the NHIA plans to expand a successful pilot capitation model to control costs.

The MOH is responsible for stewardship of the overall system and coordination across the sector. While there is an inter-agency coordination structure under the lead of the minister, there are varied views on its effectiveness, with reports that the heads of large agencies such as the NHIA and the main teaching hospital bypass the ministry and deal directly with the Office of the President. Communication and coordination between

[13] Various interviews in MOH.
[14] Includes: NHIA, GHS, Food and Drug Administration, teaching hospitals, CHAG, national ambulance service, blood transfusion and mental health authorities, and professional councils (doctors, nurses/midwifes, pharmacists, traditional authorities, private hospitals/maternity homes). Each has its own governance board, committees, and national office.+/- regional and district offices with demands for management and technical staff.
[15] MOH Holistic Assessment 2014.
[16] World Bank MC nutrition programme appraisal.
[17] World Bank (2012) *Health Financing in Ghana*.

agencies has been identified as a problem and there is a lack of clear incentives for the system components to work together.

The regular turnover of ministers leads to short-term agendas and changes of priorities that may not have time to be rolled out within the health agencies before the minister is replaced. A new ministerial team was appointed in mid-2014. The minister is known to have a strong position on fighting corruption, while the deputy minister is an experienced health professional with experience of working in the Global Fund and DFID and is well respected in the sector. Development partners are optimistic about their potential. The current minister's priority is to rejuvenate and extend PHC through the community-based health planning and services (CHPS) model.[18] While long established and effective, where communities have supported the process, CHPS remains an underfunded priority.

The ministry works to a well-established calendar of planning, coordination (health sector working group and business and partner meetings) and monitoring processes (annual holistic assessment and health summit). The Parliamentary Select Committee on Health carries out annual performance hearings. The Health Sector Medium-Term Development Plan (HSMTDP) is followed and drives annual plans. There is a positive approach to monitoring/evaluation, with the annual assessment taken seriously.

An institutional and organisational assessment of the MOH and its agencies was carried out in 2012. Although the sector was reported to perform better than many others in Ghana, there was evidence of duplication of functions between the MOH and GHS and other health agencies and potential to obtain major efficiency gains. The staff structure and organisation of the MOH were not seen as consistent with its statutory role and functions. The assessment highlighted the overemphasis on policy development and inadequate attention to translating policy into action.[19]

The review highlighted the time-consuming culture of coordination and questioned the efficiency of management of MOH and its health agencies, with limited prioritisation, weak task allocation and poor accountability. Sanctions for non-performance exist on paper only. The MOH moves slowly; for example, the HSMTDP (2014–17) remains in final draft in late 2014, the release of financial statements is increasingly delayed, and the failure to meet performance targets has led to delayed release or loss of loss of funds from donors.[20]

A management audit of the MOH's Central Office was conducted in 2013 and senior staff underwent management training in early January 2014.[21] Donors are providing SBS support and senior technical advisory posts or intermittent consultancy support in the MOH on policy (DFID), PFM (Danida) and leadership development (Danida).

[18] Ghana has pursued a community based, nurse-led PHC approach through the CHPS model, a partnership between GHS and district assembles since 1994. Expansion has been slow although coverage was reported as half of the population (3,000 of 6,000 designated administrative areas). The PHC worker provides basic preventative, promotional and curative care from a fixed facility (the CHPS compound) and through door to door services to the community. Evaluation is mixed but shows positive outcomes where the district health assemblies have been engaged. The CHPS approach potentially reaches the most rural and disadvantaged areas and is an effective way to provide a well-targeted set of high-impact, cost-effective interventions.
[19] HERA (2012) *Institutional and Organisational Assessment of Ministry of Health and its Agencies*.
[20] The 2014–17 HSMTDP remains in draft. The first quarter (January–March) financial statement was released in September 2014 (EU). Lack of progress on PFM improvement plan (EU) and production of a memorandum of understanding (Danida) have led to the holdup of fund releases.
[21] Carried out by the Ghana Institute of Management and Public Administration.

The planned decentralisation process across government will decentralise budgets to under-resourced district assemblies. The lack of clarity and a timeframe for the process causes further uncertainty and concern.

## 2.4 Donors

The role of donors/development partners has evolved over the past 20 years. In 1997 Ghana's health sector was a forerunner of what became the sector-wide approach. This encouraged donors to pool funds and use common management arrangements to improve results and the effectiveness of aid. The advent of large global health partnerships from 2000 made more resources available to the sector but shifted the focus from the whole sector to targeted initiatives against specific diseases or interventions.

Aid is generally well aligned to the national health framework but the greater part is directed to earmarked programmes, particularly for AIDS, tuberculosis, malaria and childhood immunisation. It is often managed through parallel systems.[22] In recent years, the overall aid contribution to health has declined and donors have been providing about one-third of MOH discretionary financing in the budget. The number of donors supporting the health pooled fund (more recently provided through SBS) has declined and less than 10% of total aid is now provided in this way in typical years. SBS donors are now limited to DFID and Danida, with a modest contribution from the Japan International Cooperation Agency since 2011. The Netherlands ended its support in 2011. The EU SBS support (€50 million) for the MDG 5 Acceleration Framework remains on hold due to macroeconomic concerns. The multiple demands of donors and projects exacerbate the workload of MOH staff.

A health sector working group is jointly chaired by the MOH and donors. DFID has recently passed the chair to the World Health Organization (WHO). Review of the aide memoire, produced to monitor progress over the year, indicates slow progress against jointly agreed priorities. Donors reported that the PFM working group within MOH was poorly led and had become ineffectual and little more than a talking shop. This process needs to be revitalised if DFID is to continue SBS.

The influence of donors in health appears to be limited. While they enjoy good access and relations with senior Ghanaian staff, there is little evidence of leverage over policy, the pace of implementation or accountability. An evaluation of PFM reform found the degree of political commitment and leadership to be the main binding constraints to progress. It did not appear that development partner support was a positive factor in achieving reform. There has been a tendency to focus on technological solutions rather than changes to underlying processes.[23]

[22] For example, the Global Alliance on Vaccine Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the US President's Malaria Initiative.
[23] Betley, M., Bird, A. and Ghartey, A. (2012) *Evaluation of Public Financial Management Reform in Ghana 2001–2010*. Joint evaluation of the African Development Bank, Denmark and Sweden.

# 3. Health sector performance

## 3.1 HSMTDP

The high-level objectives of the HSMTDP (2010–13) are set out below. This review did not carry out a detailed evaluation of performance over the Medium-Term Strategic Plan (MTSP) period. However, observations indicate substantial failings in most areas.

| | Health sector objective | Observations |
|---|---|---|
| 1 | Bridge equity gaps in access and ensure sustainable financing arrangements that protect the poor through a focus on district health systems and PHC, sustainable financing strategies and human resources | Improved access through NHIA but scheme only reaches one-third of population, with most funds captured by better off. Evidence that inequality is increasing.<br>Health expenditure skewed to urban centres and tertiary hospitals. Districts starved of finance to run services.<br>PHC a priority in name only, with slow expansion of the CHPS model and limited funding.<br>Cannot sustain services without major reform of health financing. NHIA close to bankruptcy.<br>Wage bill is unsustainable and crowds out budget for goods and services. Distribution of staff not addressed. |
| 2 | Strengthen governance and improve the efficiency and effectiveness of the health systems through enhancing performance, a stronger policy and regulatory environment and better inter-sectoral collaboration | MOH does not effectively steward the sector. MOH duplicates many functions of GHS and agencies.<br>No effective performance management, many inefficiencies (e.g. drug procurement, capital projects).<br>Policy rich but implementation gap exists. |
| 3 | Improve access to quality maternal, neonatal, child and adolescent services including nutrition | Improvements to maternal health services largely due to targeted funding and NHIA exemption.<br>High levels of under-nutrition, mounting obesity in children and falling breastfeeding levels.<br>Child mortality static. |
| 4 | Intensify prevention and control of communicable and non-communicable diseases and promote healthy lifestyles | Still major communicable disease burden including cholera that requires strengthening of district services to reduce. |
| 5 | Improve institutional care including mental health service delivery, emergency services, medical products and blood safety | Establishment of service authorities for each area. Increased attention to mental health services. |

Many of these objectives remain the same in the new HSMTDP (2014–17).

The most recent population-based survey data is from the 2011 Multiple Indicator Cluster Survey (MICS). Annual reviews since then have used the holistic assessment tool that is based on routine data collected by the health information system. However, this has a number of recognised flaws and, while not comparable with survey data, does provide a measure of performance from year to year. The 2014 assessment of 2013 performance suggests no overall progress.

Over the plan period there have been improvements in access to health care but not consistently and to the level expected. There are ongoing concerns over quality. Increased use of services is linked to expansion of the NHIS but the funding crisis may threaten gains.

## 3.2 Millennium Development Goals (MDGs)

Ghana will not meet national MDG targets related to maternal health, child mortality, child nutrition and access to sanitation; however, there has been much progress, with gains driven largely by targeted project support. High levels of immunisation coverage have been largely maintained and new vaccines introduced although rates reportedly fell in 2013. The CHPS model is gradually expanding coverage of PHC but there are questions about whether the model has strayed from the original community focus to a more clinic-based treatment service. The steady decline in child mortality over two decades has stagnated at about 80/1,000 live births in recent years. Around 40% of child mortality is due to mortality in the first month of life.[24]

There have been improvements in maternal health services, particularly in increasing skilled birth attendance (SBA), but also signs that inequity in access is increasing. The increase in SBA was achieved as a result of introduction of free access to maternal health services in 2008. This led to a two-thirds increase in facility-based deliveries between 2007 and 2011, a doubling of caesarean sections and a decrease in the institutional maternal mortality rate.[25]

The improvement in staff numbers including midwives has not been matched by more appropriate distribution and the soaring wage bill has not resulted in performance improvements. There remains a high unmet need for contraception (as contraceptives are not yet reimbursed by the NHIA) and a continuing high level of unsafe abortion. There are no recent survey data on maternal mortality trends.

## 3.3 Impact of SBS on health outcomes and systems strengthening

SBS is an important but declining element of donor assistance and accounted for less than 10% of the health budget in 2013. It provides the MOH with the only source of discretionary funding at a time when the sector faces severe limits on running costs.

DFID recognised the difficulty of attributing change to SBS in the Project Completion Report (PCR) of its previous phase of SBS. It proved difficult to identify what SBS funds were used to purchase. The DFID 2014 review of the current SBS support found that

[24] From DHS (2008), MICS (2011) and Holistic Assessment (2014).
[25] Independent review by HERA presented at the April 2013 Health Summit.

most funding remained within the MOH and did not reach lower levels of the health system. Danida's audit found the same picture. The MOH explanation was that the ministry procures drugs and vaccines centrally that are then distributed down the system to district level.

The PCR of 2008–12 support judged that there was improvement to basic services through CHPS expansion including the posting of midwives at the PHC level and a major expansion of NHIS with increased utilisation of clinic services. The PCR scored the output *access to basic services improved* as A+, *health systems strengthened* as B, and *access to maternal, newborn and child health services* as A.

The 2013 PCR of the previous period of SBS (2008–2012) reached no clear conclusion on whether SBS strengthened the health system. SBS was one of the principal sources of financing for the MOH stewardship function, including monitoring and evaluation activities, training and capacity building. There was limited evidence that SBS helped in any way to buffer or smooth funding, to support the MOH and GHS oversight function at regional and district levels. These reported often drawing on project funds to cover debts built up while awaiting GOG funding releases.[26]

DFID's 2014 annual progress review judged that in 2013 SBS did not contribute to progress against either of the anticipated outcomes of improved health outcomes and health system strengthening. The specific targets were not met on public expenditure management, health financing, and rationalisation of the wage bill and workforce[27].

The DFID annual review team argued that the performance-based SBS model should be maintained because it introduces an incentive for the MOH to achieve key sector reforms but that performance criteria should be applied to all future tranches. However, there is little evidence that the availability of SBS has acted as an incentive for performance. Retaining this model would require a much stronger commitment by MOH including clarity on the use and earmarking of SBS; renegotiation of performance targets; management focus on the deliverables; and more accountability for achieving performance.

The main areas of system strengthening in the DFID support relate to those areas with the greatest impact on the system. Specifically, there is a need to bring the unsustainable wage bill under control, implement the HFS to increase revenue and reduce costs, and promote efficiency and effectiveness through improved PFM and optimised use of staff resources.

Despite the failure to meet the agreed performance targets for DFID SBS support there have been some areas of good progress such as the work on the HFS (discussed further in Section 3.5). There is a realistic agenda of work that could be completed in the remaining three years of the DFID programme and practical and achievable indicators need to be agreed with MOH. The public expenditure review is an important step in rejuvenating the PFM working group and agenda. HFS implementation is more complex and will involve actions on the part of the MOF and NHIA.

The TA plan and TA provided to MOH are reported to be valued; they will continue under all options and will help progress the health systems strengthening agenda. The

[26] DFID Ghana Health Sector Support Programme (2008–12) Project Completion Review, May 2103
[27] DFID Ghana Health Sector Support Programme (2013–18), Annual Progress Review June 2014.

challenge is to define and agree implementation targets that go beyond soft process indicators as a measure of performance and trigger for release of funds.

## 3.4 How has SBS contributed to sectoral spending?

It is surprisingly difficult to obtain a clear picture of how UK SBS has been used. This is primarily because it has been only loosely earmarked to non-wage recurrent costs and GOG has not been required to account for spending against more specific budget headings.

During the review, interviews with the MOH director of finance and director of budget confirmed that the majority of UK funds had been used to finance the goods and services budget in MOH HQ, although some funds had also been allocated to regional and district health services.

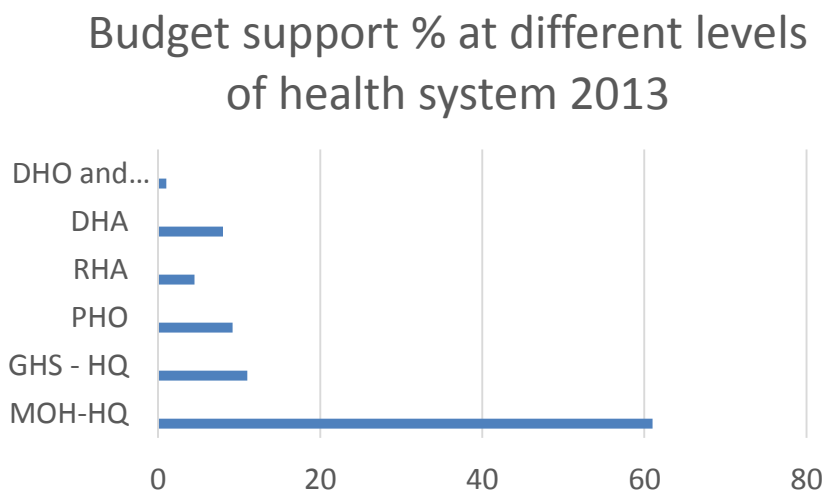
A detailed breakdown of SBS spend in HQ was obtained and has been passed to DFIDG. A significant proportion of the SBS has been used by MOH centrally to purchase drugs (including psychotropic drugs for mental health) and supplies that have then been distributed to the health services throughout the country. Although the expenditure has been incurred by the MOH, it has benefitted the wider system. Some SBS funding has also been used to pay outstanding debts and meet other urgent priorities of the MOH.

Seeking to trace SBS is not particularly relevant when DFID has hitherto chosen not to earmark the funds and when they are in effect pooled with other donor funding. Traceability is therefore limited. Discussions with the director of finance confirmed the following flow of all donor budget support/health fund contributions through the MOH for 2013. The total flow of GHS 90.131 million[28] (or £27.3 million or US$ 43.46 million at 2013 average exchange rates) was recorded in the MOH annual report for 2013 and included support from the EU, Danida, DFID, Japan and individual development accounts (for nutrition and malaria). The same report recorded this as amounting to 3.3% of the total resources available to the sector (including all GOG and IGF). All donor support is recorded as 12.4% of total sector resources.

The utilisation of budget support/health fund resources in the health sector is shown in Figure 2 and it is clear that the majority (60%) of the funding was used by the MOH, with just over 13% of the funds going directly to the regions and districts and less than 1% reaching DHOs and health centres.[29]

**Figure 2:**

[28] See the supporting schedule to the consolidated income statement, MOH annual report 2013.
[29] See also the table of Consolidated Income and Expenditure by BMC Group in Ministry of Health Revised Annual Report, 31st December 2014.




Source: MOH Revised Annual Report Dec 2013

## 3.5 How has SBS contributed to economic governance reforms?

SBS was intended to support wider systemic reforms in the sector in areas of economic governance. Performance targets were agreed to incentivise the delivery of PFM reforms through a target for budget execution; to promote improved human resource management by undertaking workforce planning and costing models as the basis for future staff optimisation and redeployment; and thirdly to encourage the development of a HFS as a basis for creating an affordable and sustainable system with increased coverage. Performance in the first area has been poor but is better in the other two areas.

Performance targets agreed by MOH and DFID were drawn from the MOH Medium-Term Health Sector Strategy 2014–17 and were designed as a mixture of measurable, short- and long-term targets. However, they do not appear to have been given much attention by MOH management, and departmental (or personal) accountability for their delivery remains unclear.

During the review, discussions were held with the director of budget, deputy director for human resources and staff working on the current draft of the HFS. The situation in relation to the PFM working group was discussed with the chief director and with other donors. The director of finance also explained the current position in relation to payroll controls and audits as well as procurement and contract monitoring. The position that emerged is:

### (i) PFM

The MOH has adopted programme-based budgeting but acknowledges that the credibility of the GOG budget generally is low due to overruns of spending, for example in relation to 2013 salary costs and the continued build-up of arrears. Despite this, the recent sector fiduciary risk assessment has concluded that the credibility of the MOH budget is better than that for other GOG ministries, departments and agencies.

The recent review of DFID SBS also indicated that the budget outturn performance target for 2013 had not been reached. However, the MOH considers the basis for the assessment flawed because it did not take into account the changes in budget classification for 2013.[30] The director of budget said it would be difficult to recalculate the actual level achieved on the same basis.

Revised budget estimates for 2013 were provided by the MOH (see Annex D) but they do not provide a basis for comparison with the target used in the DFID SBS logframe. There is some indication in Table 2 in Annex D that suggests that for the GHS the budget outturn **across all categories** of spending in 2013 was 75.7% of the approved budget.

More generally, the chief director has been leading the PFM group in the MOH. There are some areas of progress including efforts to establish revenue allocation models for goods and service spending, steps to establish management accounting and a payroll audit earlier this year. However, at the time of the review there was no clear plan or priorities articulated or presented to the team despite repeated requests. The existing plan is supposed to run from 2012 to 2015.

The director of budget acknowledged there was an ongoing problem of arrears of payments in the MOH and the need for greater controls. There was a particular problem with the NHIA because bills remained unpaid for insurance claims.

The PFM working group needs to be revitalised urgently with stronger leadership, clarity about its objectives and with accountability for deliverables. The planned public expenditure review (now being tendered) is an opportunity to revisit the challenges that remain and to develop an effective programme for the next few years in conjunction with the MOF.

The MOH continues to operate a single sourcing arrangement for large-scale capital projects, which raises questions over value for money (VFM). Crown agents are used to verifying that VFM is achieved under any proposed contract by undertaking cost comparisons and benchmarking. However, failure to submit such contracts to the 'test of the market' runs the risk that there are alternative bidders that would offer similar quality at a lower price. The opportunity cost remains unknown and there is also a risk that the process used in effect 'games the system'.

The MOH also monitors construction projects and where there are anomalies these are reported to the MOF and audits are conducted. Action is also taken to follow-up with suppliers to rectify any shortcomings including poor quality, cost overruns or fraud.

## (ii) Workforce, personnel and payroll

Recruitment and replacement of GHS staff start at hospital/facility level and are processed through the system for approval via district health offices to GHS HQ and then to the MOH. They are checked against staff lists and salary levels before new appointments are made. Retirees and deaths are dealt with in the same way.

[30] The original target was apparently set in relation to the services area in the budget (i.e. item 3) but this is no longer used in the 2013 budget and outturn data.

The paper system is open to abuse but the introduction of the new Integrated Personnel and Payroll Database (IPPD) electronic system has reduced the processing time and the numbers of people in HQ with access to personnel records. The payroll can only be altered by CAGD staff once the change is signed off by the MOH. There are plans to link the budget and the payroll to a human resources management information system by December 2014 and, in effect, to try to enforce an affordable and approved establishment list. This should be a priority for the Ghana Integrated Financial Management System (GIFMIS) in 2015.

There is a new electronic verification system and the MOH confirmed that monthly checks are in operation in most areas including HQ. In future, if anomalies emerge and departmental heads have signed the monthly payroll, then, in theory, sanctions will be imposed through stopping salary payments to the head of the section. Ultimately the MOH and GHS have limited incentives to ensure the payroll is tightly controlled as they regard it as the MOF's responsibility and get no benefit from any financial savings.

The MOH undertook periodic payroll audits in 2011 and 2012 (Ashanti region, Korle Bu hospital, MOH and GHS HQ) and in 2013 (Kumasi teaching hospital and Korle Bu again). The review team was shown a printout from the 2011 audit at Korle Bu that identified 43 entries who were deceased, retired or had left the post in question. Many payments had been going on for years. However, these entries had been subsequently removed from the payroll. If all the names were removed an annual saving of GHS 469,000 (or £94,000 at current exchange rates) would have been realised. In practice it may be less if some of the ghosts were in fact later verified as legitimate. The World Bank separately reported that 500 ghosts had been removed from Korle Bu in the last few years.

The director of finance confirmed that the MOH was under pressure from the MOF to control and reduce the wage bill and had several proposals for addressing this in the coming year:

- conducting a further round of payroll audits to check how the new controls were working and to make sure all retirees and other ghosts were removed;
- ensuring that training allowances were removed as planned and no payments were made;
- maintaining a freeze on recruitment of support and administration staff;
- developing a programme to remove and release support staff, especially those on short contracts, but also to retrench those who were on a more permanent arrangement; and
- using the staffing studies currently underway (and planned) to identify further opportunities to encourage staff in overprovided hospitals or clinics to leave the GHS or to relocate to other designated locations.

The MOH could consider using SBS to finance removal or redeployment of staff and this would have to be discussed further with DFID. This was done by DFID in earlier African programmes[31] so there is unlikely to be an issue of principle. However, the costs may be relatively high in Ghana following the recent public sector salary

[31] For example in Uganda and Tanzania from 1996 to 1998.

increases due to the introduction of the single salary spine. This would need to be examined and associated reputational issues considered.

The 'staffing norms' study was underway during the review and was expected to be completed by the end of November, when the last visits to health facilities could be completed. The HR Department in the MOH and GHS has used a 'workload indicator-staffing need' tool to assess staff levels against workloads and needs.

Around 60% of the facilities have been covered. The HR deputy head confirmed that the tool has identified many areas and facilities where staff numbers are in excess of what is justified and predicted by the tool. Once the work is completed (end of November), options for redeploying staff will be considered and implemented in 2015. The MOH has tried to develop inducement and relocation support schemes in the past but these have never been fully supported or sustained. The ministry is keen to explore how SBS could be used for this purpose. Any effort to finance staff reductions or relocations needs to be accompanied by system improvements to ensure that the benefits arising can be sustained. TA would be used as required to address the incentive and system related issues.

MOH is also recruiting consultants to undertake additional work to model workforce needs, affordability and distribution. This will supplement the staffing norms work because there is a concern that it may be based on WHO staffing norms that are unlikely to be affordable in Ghana.[32]

### (iii) HFS

The MOH has been working on the strategy paper since the middle of last year. The review team examined the final draft strategy and the latest draft implementation plan and reviewed progress with the principal planning officer (budget). The strategy is tackling major financing challenges and has successfully set out the areas that GOG needs to address and the policy choices/decisions that are needed to deliver an affordable health service with growing coverage.

The strategy and implementation plan is expected to be completed when the Parliamentary Committee on Health is consulted and when more work can be done to cost some of the policy options and ideas proposed. It is expected that the work will be completed by the end of 2014.

The financing strategy is a critical area of work that has potential to fundamentally change the prospects for the future development of the sector. It should continue to be given high priority by government and donors.

The next major steps in the process should be a formal approval and publication of the strategy and implementation plan by the minister of health followed by commencement of the first phase of implementation. The deliverables will need to be fully articulated in the plan but it is expected to involve early formation of a multi- stakeholder committee to oversee the programme of work; modelling and analysis of revenue

[32] Consultants will be the Centre for Workforce Intelligence.

mobilisation options; costing of services; and identification of efficiencies by the agencies. Decisions are needed about legal and regulatory changes.

In principle, it would be possible for DFIDG to link progress by the MOH with approval and implementation of the HFS to the release of any future SBS. It may also be possible to use the same approach with the proposed option related to the non- budget support financial aid that would be concentrated on PHC services (see Section 6).

The first phase of the HFS involves a core activity around the expansion of the NHIS PHC per capita payment system. The aim is to increase insurance coverage of PHC services simultaneously with an effort to extend PHC preferred provider networks. Linking a properly funded payment system with a provider network is a potentially powerful model provided it is affordable. Delivering this component could be conveniently linked to the options outlined in Section 6.

## 3.6 Future directions in health

The new MTSP (2014–17) remains in draft. The six high-level objectives align with DFID priorities.[33] Much of the agenda for the next four years remains the same as in the previous MTSP period, as do the challenges that the ministry will face in meeting them, ensuring sustainable financing, realising greater management efficiencies, increasing coverage of essential services while reducing inequities, and reforming PFM.

The Ghana health sector will have to deal with a number of additional challenges. Despite reductions in fertility there will be continuing high population growth and demand for services. The large unmet need for contraception results in high levels of unsafe abortion.[34] At the 2012 London Summit on Family Planning the president announced that family planning services would be provided free but there has been no action. A greater proportion of the workload will relate to non-communicable diseases that are more costly to manage but Ghana will also face a substantial burden of communicable disease that can only be sustainably addressed by system reforms. The health sector will see increasing levels of child obesity as well as continuing high levels of undernutrition.

Ghana has made substantial progress in improving health outcomes and in restructuring the institutional arrangements of the health system. However, further progress in delivering the objectives of the MTSP will be difficult, as will sustaining the gains, without action on the key determinants of how the health system functions.

[33] Objectives are to: bridge the equity gap, ensure sustainable financing, achieve greater efficiency in governance and management, increase quality of health services, develop capacity and address non-communicable and communicable diseases.
[34] Machiyama and Cleland (2013) *Insights into unmet need in Ghana*. London School of Hygiene and Tropical Medicine, February. STEP-UP.

# 4. Political economy

Ghana achieves positive assessments against internationally accepted indicators of political governance. There is freedom of expression, elections are held regularly and incumbents leave office peacefully, even if the actual campaigns themselves have involved a degree of political violence.

However, on closer inspection, political society and institutions have some profound structural weaknesses. Many of these relate to long-standing historical and cultural characteristics that have been previously covered by Ghanaian political scientists and will not be revisited in detail here.[35] Suffice it to say that the dominance of Southern elites, the concentrated power of the executive, and the tendency for political power to be sustained through patronage and rewards are all long-standing structural characteristics that adapt and change slowly. Diversion of GOG funds remains an issue, especially in the run-up to elections.

These structural aspects combine to make regime survival the overriding concern for the political elite. Such an imperative acts as a constraint on the emergence of issue-based politics as well as fuelling patronage and corruption. This brief overview will concentrate on recent developments and electoral experience. This will serve as a useful backdrop to assessing the prospects for action by the current and subsequent governments to address health sector issues in Ghana up to 2017 and beyond.[36]

Perhaps the biggest challenge to Ghana in the health sector is to develop a common vision of the future and to settle on a formula for financing the health system that is affordable and can meet the health needs of the majority. There is an urgent need for a strategy to enable increased access for poor and disadvantaged groups. One commentator we interviewed underlined the complete failure of GOG to deliver the funds that were allocated in the budget and the lack of cash being delivered to all public services.

Superficially there appears to be a growing political interest and commitment to health. The latest HSMTDP identifies many of the key challenges and it has been endorsed by health ministers. The president and the cabinet have highlighted the need for action to address PHC and have agreed to donate 10% of their salaries to the MOH for this purpose. The minister of health reportedly attaches a high priority to extending the CHPS programme.

However, consultation with Ghanaian political scientists during the review suggests a degree of caution is needed. Firstly, previous ministers are regarded as having a poor track record of delivery and one was forced to resign over corruption related to construction projects. A recent audit report was highly critical about the diversion of NHIA funds and review contacts suggested this was related to the last election. Secondly, although a public discourse around health is developing, there is little sign of it translating into new policies reflected in party manifestos. Thirdly, despite the overwhelming pressure to compete and win elections, there is little sign that health or other development-related issues influence voting intentions.

[35] See for example Clark, Jeremy and Smail, Amy (2012) *Political Economy and Institutional Assessment: The Education Sector Ghana*, November; and Abdulai, Abdul-Gafaru Abdulai (2009) *Political Context Study- Ghana*.
[36] This section is based on interviews with local experts and representatives of institutions.

The nature of political institutions and society in Ghana mitigate against the emergence of cross-party support for critical issues such as macroeconomic adjustment or health policy. The frequency of elections and the closeness of the result make competition between the ruling National Democratic Party and the opposition intense. The sheer number of elections (presidential, parliamentary, local, etc.) is said to 'crowd out the development space'. Cross-party collaboration is rare and accountability is undermined as successive governments blame the previous ones for failure to improve services or to tackle corruption and abuse. Parliament remains weak and collaborative efforts in parliamentary committees have limited effects in strengthening accountability. The parties are in effect 'gaming the system'.

Interviews suggest there are some developments that could create pressure for change in the health sector. The print and electronic media have been active in highlighting corruption problems such as the recent audit report on the misuse of NHIA funds during the last election. Citi FM has run radio articles about the plight of poor people without access to health services. The public in general are apprehensive about threats from cholera and Ebola and are anxious about the quality of care and access to it. Medical staff are restive and have forced out board members at Korle Bu hospital apparently for misuse of hospital resources.

However, the run-up to the next election in 2016 is likely to be driven (like the last one) by populist interventions and an unwillingness to confront challenges with unpopular programmes such as spending controls and efficiency drives, including removing or redeploying underused health staff. The opposition has yet to enter the public dialogue on health issues and so far has not criticised the government directly or forced a debate. There has been no follow-up to the audit of NHIA. There is clearly a gap for issues of accountability and misuse of resources in the health sector to come to the fore, together with a more constructive debate about future priorities.

The chances of this happening in the run-up to the next election depend on whether the political parties begin to consider health-related issues as an influence over voting intentions. The commentators consulted during the review were pessimistic. The public had such low expectations that they would be unlikely to sustain any effort to influence the parties. Although the media were active, more needed to be done to bring out the health policy choices and issues. At present there is 'some voice and no accountability'.

The election itself was anticipated to increase public spending in the run-up to 2016 and make it hard to deliver any 'home-grown' or IMF-sponsored adjustment programme. Political violence could be anticipated. Parties had less concern about public opinion or that of the donors because winning the election would provide access to future oil revenues from the state. In that sense the contract between taxpayers and the state was being weakened.

The new ministerial team for health is regarded as both close to the ruling party and made up of competent professional managers, with a deputy minister who understands the sector and the importance of the donor relationship. They are respected outside the party. Despite this, the political and institutional context is not considered conducive to progress by outside commentators. The ministerial team will more than likely move on after the elections in 2016, giving two years at most to make some progress.

The Strengthening Transparency and Accountability in Ghana (STAR) programme has conducted a political economy analysis of the health sector, which highlights the fragmented nature of the institutions involved and the diversity of interests and incentives. The report underlines the importance of seeking a broad dialogue and consensus or at least a coalition of interests around key health policies such as the HFS. Any future DFID support should seek to understand these interests and incentives in order to align any redirected programme with the political priorities of ministers and the incentives of stakeholders.

# 5. Scenarios

## 5.1 Revisiting planned outcomes

The development of future options for DFID and donors in the Ghanaian health sector needs to be driven by both the desired outcomes and an assessment of the possible scenarios arising over the next three or more years. When the SBS programme commenced in 2013, DFID's intentions were to contribute to the strengthening of the health system in Ghana in order to support increasing service delivery and sustainability over time.

The aim of the HSSP was to help consolidate Ghana's position as a middle-income country with the capacity and capability to respond to new challenges in a more efficient and cost-effective way.[37] Recent trends and the 2014 annual review rating of B suggest that the assumptions underlying the programme need to be revisited. The outcomes are still relevant but the level of expectation and ambition needs to be reduced.

A less ambitious outcome for DFID and the donors could be for Ghana to consolidate and sustain the health status already achieved. Under more negative scenarios, a narrower outcome would be to protect the poorest from the worst effects of spending and service cuts.

## 5.2 Analysis of trends for the scenarios

Scenarios are derived from thinking through a range of possible futures, usually over a three–five-year time horizon, based on analysing trends and horizon scanning. This typically involves examination of recent trends, spotting of patterns and extrapolation adjusted for expert views through interviews. It can also involve an element of horizon scanning to identify possible future events that may be new, unexpected, major or minor.[38]

The relevant data sources have been examined for key trends in political economy, the global and Ghanaian economy, social issues and the health sector itself. The analysis has been used to prepare three scenarios as a framework within which the various options have then been developed. The key trends over the next three years are discussed below.

Current government policy is for a gradual reduction in the macroeconomic imbalances to preserve economic growth with cuts in public spending. The budget deficit was expected to fall to 8.5% of GDP in 2014 and to 6% by 2016, with real GDP growth of 5.4% in 2015 and 8.1% in 2016.

The latest IMF Article iv assessment provides a more pessimistic picture. Without additional fiscal measures a drop in growth to 4.75% in 2014 and a deficit of 10.25%

[37] Ghana Health Sector Support Programme 2013–18 Business Case, June 2013.
[38] See for example Ramalingam and Jones (2007) *Strategic Futures Planning: A Guide for Public Sector Organisations*.

are anticipated. Any IMF agreement would likely involve a more rapid fiscal adjustment including reduction in the wage bill, further spending cuts and removal of subsidies.

A period of austerity would be required to enable higher and more sustainable growth through the rest of the decade. Ghana is vulnerable to external shocks that could further damage investment and growth prospects. Any further weakening in export prices (oil, cocoa and gold) could spark a more drastic depreciation or even a foreign exchange crisis. Against this, oil exports are expected to expand considerably from 2015 onwards.

The political economy of Ghana is explored in more depth in Section 4. Trends over the next three years are likely to reflect the underlying nature of the political society and key institutions that have been created since independence. In the run-up to the 2016 elections, party political financing may generate pressure for rent seeking and inappropriate use of public resources. Health issues may become more prominent in public debate, partly as a result of perceived failures and concerns about the threat of infectious diseases.

Governance indicators measured by the World Bank[39] suggest a fairly steady improvement in voice and accountability from 2003 to 2013 as evidenced by a well-established and often critical media. Political stability is greater, with regular and freely contested elections. Political violence has not increased although instability could return if the next election result is contested.

However, the governance score for control of corruption has declined between 2008 and 2013, as has the score for government effectiveness. These trends are likely to continue generally and in the health sector. Recent press reports on financial mismanagement and diversion of resources at the NHIA and the misuse of resources by board members at Korle Bu hospital suggest that ongoing concerns about corruption persist. Institutional effectiveness will continue to be undermined by institutional fragmentation and financing problems.

Ghana's population is growing at around 2.2% per annum, with a projected total of 25.9 million persons in 2013 rising to 32.5 million by 2025. The population is relatively young, with an average age of 20.6 in 2013.[40] Communicable diseases account for the greatest share of the burden of disease, but as per capita incomes increase so does the prevalence of non-communicable diseases such as heart disease and diabetes.

There will be an increasing demand for urban-based curative services at the same time as basic services need to be expanded to poor rural areas, mainly in the centre and north of the country. The high levels of inequity of access to services have increased in recent years and will become more pronounced. Improvements in health indicators have plateaued and future trends will depend on whether challenges to financing, management and access can be overcome. Under some scenarios of worsening economic conditions, the existing service levels may be difficult to sustain.

The rapid growth in the Ghanaian economy has produced a substantial reduction in income poverty and this trend is likely to continue. Growing inequality will remain a substantial challenge in the coming years. The rapidly expanding urban population has

[39] Kaufmann *et al.* (2013) *World Bank Governance Indicators*.
[40] UNESA (2013) *World Population Prospects: The 2012 Revision*, New York.

led to stress on health and other services and will create an increasing need for action by government. Some commentators have also highlighted problems with unemployment and underemployment of the 15–24 age group.[41] However, recent data from the Ghana living standards survey indicate that a high proportion of the working-age population are working at least some of the time.[42]

There are significant geographic disparities in income. The challenge is to redistribute the wealth mostly generated in the South by commodity exports and extractive industries to poor communities of food crop farmers in the north. Increasing access to good quality basic health and education for the poorest and women remains a key challenge.

In order to derive the scenarios we have extrapolated key trends and made judgements about possible developments based on interviews with DFIDG staff, Ghanaian experts from think tanks and officials within government. For ease of presentation we have chosen to use three simplified scenarios to express the range of possibilities and possible direction of travel in Ghana over the next three–five years.

## 5.3 Range of possible scenarios

***Scenarios for Ghana health sector – range of possibilities***

| High Case – trends improve | Central Case – some deterioration in current trends | Low Case – trends deteriorate |
|---|---|---|
| Description | | |
| • Economic stability and growth potential enhanced<br>• GOG makes good progress with fiscal consolidation and health spend is largely protected<br>• Strong possibility of an IMF agreement Q1 2015<br>• External economic shocks are managed<br>• Political stability maintained with | • Growth slows and economy remains vulnerable to external or internal shocks<br>• Health spending remains squeezed by budget constraints<br>• No IMF agreement or one is signed but is not delivered<br>• Higher inflation undermines living standards<br>• Election financing leads to diversion of | • Growth slows markedly, with big falls in investment and exports<br>• Economic instability takes hold with periodic foreign exchange crises<br>• Rapid rise in inflation causes street protests<br>• Health spending declines in real terms<br>• HSIA cannot meet payments so health |

[41] The Africa Economics Outlook 2012 states that 25.6% of the 15–24 age group is unemployed.
[42] Ghana Living Standards Survey 2012/13.

| | | |
|---|---|---|
| minimal election violence in 2016<br><br>• Strong political commitment to address health financing and push CHPS<br><br>• Stronger action on PFM and corruption in the health sector<br><br>• Public pressure for improved services<br><br>• GOG rolls out more basic health services to poorer regions when affordable<br><br>• MOH and agencies are better led, funded, more strategic and able to drive reform<br><br>• Ebola arrives but is contained<br><br>• Health indicators start to improve again | public funds and assets<br><br>• There is disruption during and after the election<br><br>• Political commitment to health sector uncertain at presidential level<br><br>• Health ministers pushing CHPS and HFS<br><br>• No action to tackle corruption, fraud and waste in health<br><br>• MOH management improves only marginally<br><br>• Ebola arrives and MOH is ill prepared and stretched to cope without external support<br><br>• Health services are maintained as far as possible by NHIS but few services reach poor<br><br>• Health indicators continue to stagnate or in some cases decline | services become less available<br><br>• Services revert to 'pay as you go' and inequality of access grows<br><br>• Election financing leads to large-scale diversion of public funds<br><br>• Corruption worsens and procurement controls weaken<br><br>• Ministerial team is focused on the election and there is no commitment to health<br><br>• MOH management worsens and loses focus<br><br>• Ebola arrives and MOH struggles to cope<br><br>• Health indicators worsen considerably |
| Threats and opportunities<br><br>• Window to achieve reform progress<br><br>• Services can be sustained if GOG meets recurrent funding requirements | • Change of government or minister may reduce GOG commitment | • Risk of reversal of previous health gains<br><br>• Institutional weaknesses of MOH and agencies prevent |

| | | |
|---|---|---|
| • Corruption and diversion remain threats<br>• Risk of over ambition<br>• Change of government or minister may reduce GOG commitment<br>• Pace of change is limited by MOH and agency capacity<br>• Fiduciary risk may slowly lessen | • Basic primary care services are harder to sustain<br>• Health system remains dependent on funds available to NHIA/NHIS<br>• Corruption diverts and misuses public resources<br>• Fiduciary risk remains substantial | effective engagement or use of aid<br>• Motivation and performance of health staff collapsing<br>• Endemic corruption in the system<br>• Fiduciary risk is high |
| DFID strategic response<br>• Partnership principles must be met<br>• Re-engage MOH on financial aid but with prior actions and conditions | • Partnership principles must be met for non-budget support financial aid option<br>• Explore ring-fenced programme / project for financial aid or challenge fund | • Partnership principles not met but financial aid will not flow through state in this scenario<br>• Explore non-state funding options and work with demand side |

DFID needs to make a judgement about how far any of the scenarios outlined above is likely to hold for the next few years. Importantly, under each scenario the health sector will remain under financial pressure and a period of tight restraint on public health spending is likely. Apart from financing, the main factors affecting health sector performance are likely to be political commitment, leadership and sector management. In the case of options 1a, 1b and 2 there is a risk that changes of government or minister will reduce the commitment of government to deliver the proposed programme.

There are important recent developments that suggest the high case scenario is plausible. GOG is currently in discussion with the IMF about a possible programme that would introduce a more sustainable fiscal framework and protect health spending. The ministry's new political leadership may increase commitment to deliver reform and revitalise donor dialogue. The president may use the political cover of an IMF programme to push through reforms and appears committed to PHC. The health minister also wants to address key challenges including health financing.

However, the health sector has a long-established culture and track record of single-sourced capital investments that do not secure VFM, crowd out the health budget and create opportunities for misuse of public resources. Progress on HSSP-related reforms have been slow and MOH credibility and capacity are low.

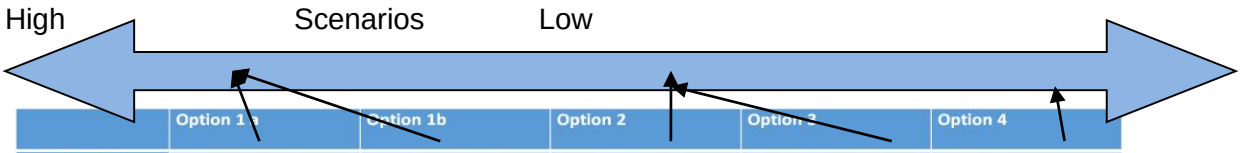
In practice, GOG may find it difficult to stick to an IMF agreement even if one is formally agreed because of the financial demands of election campaigning in 2015/16. Campaign financing requirements may also create pressure to divert public funds and the NHIA was notoriously implicated in the last election.

Given the overriding imperative for the incumbent government to win the next election it is most likely that the central case (with some deterioration toward the low case) is the best guide to the next few years.

The high case scenario seems less likely at present but could materialise if the economic crisis is severe enough to create strong positive incentives for an IMF deal and if the president uses the political space to push through unpopular measures before the election.

# 6. The options

There is a range of possible options that can help achieve DFID's stated objectives across the scenarios outlined above. These can be summarised as:




| | Option 1a | Option 1b | Option 2 | Option 3 | Option 4 |
|---|---|---|---|---|---|
| **Description** | SBS- improving health sector performance | SBS for services | Non BS Financial aid for primary care (CHPs) | Service Delivery (Challenge) Fund | Enhancing accountability through non state actors |
| **Scenario** | HIGH CASE : | HIGH CASE : | CENTRAL CASE : | CENTRAL CASE: | LOW CASE |
| **Objectives** | Improve health sector PFM, workforce management and financing.<br><br>Ensure GOG operating costs for public health services are met<br><br>Promote scrutiny of health budget priorities, management and execution | Improve basic health services and promote new PHC policy across sector<br><br>Provide funds for services at regional level and below<br><br>Incentivise GOG to match DFID spend using conditions | Support ongoing CHPS programme and new roll out<br><br>Improve health outcomes , access and uptake of PHC in specific regions or locations<br><br>Target specific area for improved scrutiny, audit and tracking studies | Increase access and availability of quality PHC to poor regions and people<br><br>Sustain basic services during period of political and economic instability<br><br>Engage non state sector in poorer regions | Build up evidence base to underpin media and influencing campaign.<br><br>Sustained systematic attempt to influence position of President and key politicians across all parties<br><br>Support MOH to articulate and propose new policy and start implementation eg HFS |
| **Partnership principles** | Yes | Yes | Some | Some | None |
| **Strengthening the health sector** | Yes | Yes | Part | No | No |

These options are not mutually exclusive and it may be possible, for example, to add a civil society component to all of them rather than restrict its use to option 4. However, for coherence and ease of presentation we have presented the options as choices for DFIDG.

### Sector withdrawal option

Although DFID has a sizeable commitment to the health sector, it is also an option to withdraw from providing financial aid to the sector completely on the grounds that the benefits from continued investment are uncertain and potentially low. There is also a substantial fiduciary risk that is hard to manage or mitigate in the absence of a stronger reform effort. Withdrawal of support could have some beneficial effects since it would

significantly increase pressure on GOG to finance the MOH and GHS recurrent budget and so avoid any moral hazard arising from overreliance on donors.

Realistically, the short-term fiscal environment makes it unlikely GOG could replace donor funding immediately or in totality. The most likely outcome would be that MOH and GHS would face a funding shortfall that could jeopardise the central procurement of drugs by the MOH and the operations of the GHS at all levels, including at regional and district levels. Although DFID funding is proportionately small in the sector, as a whole it is disproportionately important to the MOH and GHS as the only reliable source of discretionary spending. Services would likely be affected by a complete suspension of UK funding. There could be reputational damage to DFID, particularly given the high visibility of any Ebola outbreak.

It is assumed that under all scenarios non-SBS elements of the existing programme will continue – that is, TA in MOH and support to three health authorities and to mental health.

## SBS options

Under the most optimistic scenario GOG would stabilise the economy, consolidate the fiscal position and ensure that growth and public spending are placed on a more sustainable footing. In the health sector public spending would remain constrained but the macro context would be more sustainable and budget management more credible.

The MOH want SBS to continue and it is a valuable option if the sectoral institutions have the political support and authority to take action that can improve the efficiency and effectiveness of resource management in the sector and the quality of service delivery for the poor.

The medium-term development plan envisages that MOH leads sectoral efforts to improve PFM and the utilisation of the workforce and to develop a health sector financing strategy. SBS could support the delivery of a planned programme by linking the releasing of funds to the achievement of agreed targets.

There are some challenges to the use of this modality in the health sector. Firstly, the MOH has a poor track record of delivery to date. Secondly, the deliverables should include not just new policy and plans but also the implementation of specific improvements, for example in financial systems, payroll controls, workforce management or the initial stages of the HFS. Thirdly, SBS needs to encourage GOG to improve the financing of the sector over time rather than promoting aid dependence.

These challenges can be met in a number of ways. A precondition of any resumption of budget support should be for MOH to explain the reasons for non-achievement of the existing targets and to agree revised dates for their achievement. Specific targets for ongoing reform areas can then be agreed for the coming years to 2017.

Budget support releases can be linked to the achievement of performance targets in a payment by results approach as suggested in the recent HSSP annual review. According to DFIDG economists, the experience with GBS suggests that this approach seems to work best in a Ghanaian context.

Releasing tranches against performance creates an incentive for delivery but it also introduces uncertainty into the budget and expenditure management process in MOH. If GOG it not guaranteed any tranche of SBS then it may delay spending decisions until funds are available. This will disrupt drug purchases in the centre and funding for goods and services will not be available for non-hospital based GHS staff.

**Option 1a for SBS** involves linking the support to an ongoing performance improvement programme designed to maximise efficiency and effectiveness in the sector while addressing longer-term financing issues. The MOH would need to define the parameters of the programme and suitable targets to which the SBS could be linked. Initial discussions with MOH staff suggest the following areas could provide a basis for such a programme:

| SBS-related areas | Programme | Implementation actions |
|---|---|---|
| **Workforce** | Workload assessment underway and further consultancy on wage bill costs | Redeployment of staff to underserved areas. Voluntary departure/removal of casual staff |
| **PFM** | Conduct of PER review and revamp of PFM plan and working group | To be decided but should address budget credibility, efficiency issues, VFM in procurement and control of arrears, monitoring of spending, etc. |
| **Personnel and Payroll** | More extensive payroll audits<br><br>Continued implementation of new IPPD systems<br><br>Removal of training allowances | New IPPD electronic verification fully operational<br><br>Allowances for all trainees terminated<br><br>Removal of retired names and ghost workers from payroll |
| **Financing Strategy** | Finalisation of policy/strategy paper and engagement of stakeholders | Approval of strategy by Minister of Health and commence initial phase of implementation plan |

If a performance framework like the above could be developed with the MOH, then DFID could use a payment by results approach with tranche releases linked to their achievement. SBS would be earmarked for non-salary costs and would be flexibly used within that category.

**Option 1b for SBS** would also aim to support sectoral institutions to deliver new policy and quality services. In this case the focus would be strongly on sustaining or enhancing basic services for the poor. The MOH is committed to reviewing and updating its PHC policy and to increasing access to basic services at district, health clinic and community health post level. At present very little of UK SBS is spent at the lower levels of the system.

Under this option DFID would earmark the SBS funds more tightly to ensure that a higher proportion of the available funding is available at regional and district level. Funds would be earmarked to goods and services (i.e. non-salary costs) but there would be an agreed percentage split between the MOH and GHS. The MOH director of budget thought this was a viable option.

Funds can be channelled down through the system to district level using the existing MOH and GHS bank account and treasury systems. DFIDG could draw on the experience of the education sector to agree an effective reporting system. The GHS confirms that it prepares reports at district level and these could indicate additional activities and programmes conducted using DFID money. Some data may also be available on access and coverage, which could indicate service levels.

Under this option the advantages of a payment by results approach are less clear cut. In principle SBS could be linked to the implementation of the new PHC policy but it may be more appropriate to adopt service delivery targets. If the objective is to sustain or enhance services it would be preferable to provide a regular and predictable flow of SBS funds.

Both SBS options face a substantial fiduciary risk at present and this will only reduce if the current GOG efforts to improve PFM through the GIFMIS programme begin to bite.[43] Some improvement could also be achieved if the PFM working group is revitalised in the MOH and this should be a condition of support. The MOH can also be encouraged to implement expenditure tracking and monitoring by civil society.

DFIDG can also reduce the risk of 'moral hazard' by agreeing a commitment with the MOF and MOH for a gradual increase in goods and services funded by GOG both in the actual budget itself and in terms of budget execution (i.e. actual releases)

## Option 2: NBSFA

Financial aid can also be provided in a more programmatic modality that seeks to target a part of the health system or areas that are critical and could be ring-fenced and sustained with financial aid. This may be appropriate in the central scenario where it is possible to work effectively with critical parts of the state system.

The advantages of this approach are that it allows a stronger focus on a specific programme with defined well-defined objectives, results, implementation plans, management and reporting arrangements. Donor control over resource use is increased and fiduciary risks can be managed through accurate budgeting, effective spending controls and independent financial monitoring/audit. Outcomes can be properly evaluated. The drawbacks are that donor dialogue and influencing focus on the programme itself and not on the wider health sector and its related PFM systems. There is little scope to address diversion of resources or corruption except in relation to the programme itself. Programmes also often require parallel systems and project management units, which undermine aid effectiveness and burden partners.

Discussions with the MOH and GHS indicated that they have an ongoing programme to extend PHC throughout the country using the CHPS programme. Ministers are keen to extend coverage and improve access. There is debate about the type of services to be offered and the need to emphasise health education and community visits rather than new health post construction. Supporting the CHPS programme would be a means to target services and increase access for the poorest regions and communities. It would be important to explore the options and agree a programme that would enhance service delivery and not simply support (the highly visible) health centre

[43] See Adam Smith Institute (2014) *Ghana FRA*.

construction. There are also questions about sustainability to be resolved since CHPS would depend on public funding when aid was withdrawn.

The NBSFA would take the form of a tightly earmarked financial flow through the MOH to the GHS. Funds would be held in a suitable account tied to the CHPS programme and the delivery of a range of specific PHC services. Funds would be released in line with the implementation of the agreed programme. The GHS would be responsible for managing and implementing the programme. They would also report regularly to DFID on progress against the agreed targets.

The GHS has already undertaken programme preparation work and will be putting in place management arrangements in order to deliver a new World Bank project that also supports CHPS.[44] The project has two components: community-based maternal and child health and nutrition interventions. They include piloting community performance-based financing and institutional capacity building. The project is targeted on specific regions/districts and will support outreach services related to maternal health. It will involve recurrent funding, equipment provision and some health post construction. Financial incentives will be offered to CHPS staff to achieve delivery and quality standards. Results and indicators are expressed in terms of uptake and use of services as well as health outcomes.

The project will follow common management arrangements for the health sector that set out financial management, procurement and monitoring/evaluation procedures. These have been used in previous projects and found satisfactory. The MOH will be responsible for oversight and the GHS for delivery. There will not be a project management unit. The arrangements need further examination but in principle could be used for any additional financing that might be required for the programme.

The first step for DFID would be to appraise the situation and identify any funding gap. A DFID programme would have to be designed with its own log frame focusing on improved primary services. Longer-term financial sustainability needs to be addressed. There may be scope for district councils or communities to contribute directly and GOG is considering how far NHIS can cover PHC services. The programme also needs to address issues of human resources including staff training, retention, motivation and absenteeism.

A variant of option 2 would be for DFID to co-fund the World Bank project. Bank staff are considering this idea. The advantage would be speed of execution (the project is designed and ready to go) and it would enhance aid effectiveness by avoiding any duplication of effort. DFIDG has concerns about the level of in-country expertise available and the difficulties of working with Washington-based staff.

We also considered the option to provide additional support to existing projects through the GHS. Many programmes benefit from substantial support from donors, particularly those supporting the major communicable diseases and child immunisation. DFID supports targeted investment in malaria (£19 million) and family planning (£17 million). Both scored B in the most recent reviews, with concerns that GOG failed to deliver services as planned. Further DFID investment in these areas is therefore not indicated.

[44] World Bank (2014) *Maternal and Child Health and Nutrition Improvement Project*, April.

Their sustainability will be dependent on progress in dealing with the systemic challenges identified.

## Option 3: Service Delivery Challenge Fund

Under the central scenario it may become increasingly difficult to ensure that aid can be effectively used and delivered through the state system and other channels need to be considered. Ghana has an effective not-for-profit sector that delivers health services largely through facilities owned and managed by religious organisations. CHAG is an umbrella organisation that brings the various denominations together. The team was unable to meet with them during the mission but discussions with STAR and think tanks indicated that the concept was likely to be well received.

DFID has used challenge funds in many settings to extend delivery of social services to the poor or underserved areas and test innovative approaches to a specific problem.[45] The challenge fund concept would encourage the not-for-profit sector to sustain and enhance or scale up PHC provision where they have existing facilities or to extend coverage into new regions or districts. It would also be open to GOG so that the GHS structures (at HQ, regional or district level) would also be able to put forward proposals for consideration.

The fund would have clearly defined objectives, eligibility criteria and procedures for the preparation of proposals. The purpose would be to encourage the provision of basic health services in deprived regions/districts and communities. The types of services supported would be broadly defined and based on previous successful models or designed to test out new approaches. It could also embrace capacity building, for example undertaking training of health workers and provision of recurrent support for drugs, transport and public health education. Projects would be expected to be sustainable in the sense that they can demonstrate how staffing and recurrent funding requirements could be met in future. The proposers could consider a range of options including charging, community contributions or use of other donor funding.

An appraisal and detailed design will be needed by DFIDG. However, DFID has extensive experience in this area and the STAR project in Ghana provides some important lessons. A fund manager is likely to be needed to manage the challenge fund including seeking and appraising proposals, selecting projects, managing and disbursing funds, and monitoring results. Potential beneficiaries would submit project proposals against an agreed template and the fund manager would select and fund the ones that most closely met the scheme criteria including VFM. Fiduciary risks would be addressed by the fund manager, including by ensuring that beneficiaries have adequate financial management and accounting systems. Independent audit would be used.

## Option 4: Enhancing accountability through non-state actors

If conditions deteriorate markedly then it may no longer be feasible to finance health service provision through the state. Addressing the structural constraints in the system will require such a fundamental shift that it may be judged that the best VFM can be

[45] Recent examples of DFID funds include the Bangladesh Health Innovation Challenge Fund, Tanzania Human Development Innovation Fund and Ethiopia Reproductive, Maternal and Newborn Health Innovation Fund.

gained by launching an evidence-based policy-influencing effort and public advocacy or lobbying campaign. This option would finance the relevant activities with the aim of generating stronger demand for change and channelling this into voting intentions and party political agendas.

The approach would be twofold. Firstly DFID would finance think tanks and CSOs to gather evidence about level of access, service quality, and the health status of the poorest regions and communities. This would highlight the degree of inequity in service provision and access. The Centre for Democratic Development and the Institute for Democratic Governance are involved in similar work in other sectors. Results could be publicised in the media and articles or papers could be prepared to encourage public debate on GOG policy and programme priorities. Think tanks like the Institute of Economic Affairs (IEA) are already geared up to do this kind of work and are also well placed to inject new thinking into political debates in the run-up to the next election.

A systematic policy-influencing effort could be mounted to ensure that health issues are more to the forefront of the political agenda and public debate. The aim would be to accelerate the adoption and implementation of new policy, for example in relation to financing the health sector.

A second aspect of the programme would be to support CSOs to promote public accountability by undertaking public expenditure tracking surveys and consultation with rural communities to highlight and publicise where health sector resources are going. The aim would be to inform the public and so increase pressure on GOG to allocate a larger share of resources to deprived communities.

Alongside this effort with civil society it is also proposed to maintain the link with the MOH. The analysis suggests that the TA programme is increasingly well used and focused. Continuing this programme would enable the MOH to develop new policy proposals and change programmes that could provide a sound basis for the future development of the sector. This is an important counterpoint to the proposed civil society programme. It would also provide an incentive for the MOH to work with CSOs and to continue the partnership with DFID.

## The ‘wild card’

DFIDG also asked us to consider whether there was one transformational change or reform that would lead to permanent improvement in the health sector. The current work on the HFS has the potential to be transformational if it is adopted and implemented as it would seek to rationalise current funding arrangements through pooling, ensure affordability, cap and define the health benefits package, restore the financial position of the NHIS, and incrementally extend coverage to the poorest regions and communities.

The MOH has produced a comprehensive strategy but taking it forward will require dialogue and buy-in from a range of powerful stakeholders including the Office of the President and MOF. It remains to be seen whether this can be achieved. Cross- party support would also be required to ensure that it can be carried forward after the election. The PPME unit of MOH anticipates that the earliest agreement for any new legislation or introduction of new revenue sources (e.g. raising the VAT levy or sin taxes) would be 2017.

It is theoretically possible to develop an option based on a compact, i.e. DFID links a single large payment of SBS to the delivery of the financing strategy. However, the pace at which this can be taken forward remains uncertain and it is not clear if there is a single aspect to which a disbursement can be linked. Parliamentary approval of new legislation required to implement the HFS is a possibility.

# 7. Conclusions and recommendations

## 7.1 Conclusions

The choice of option can be made on the basis of a judgement about the most likely scenario that will apply over the next three years in Ghana or by systematically applying an agreed set of criteria. On the basis of discussions with DFID we have assessed the various options against the following criteria and a separate note has been provided in the annex on cost effectiveness, which will need further rigorous analysis:[46]

| Criteria | Consistency /contribution to IMF objectives | MOH ownership and support | DFID transaction costs | Degree of sector policy influence and institutional reform | Risks to DFID's reputation and fiduciary risk | Robustness to external economic shocks and weakness of MOH |
|---|---|---|---|---|---|---|
| **Option 1a** | High | Low | High | High | High | Low |
| **Option 1b** | Medium | High | Medium | Medium | High | Low |
| **Option 2** | Medium | Medium | Medium | Med/Low | Medium | Med/Low |
| **Option 3** | Low | Low | High/Med | Low | Med/Low | High |
| **Option 4** | Low | Low | Medium | Medium | Med/low | High |

It was not possible (as requested by DFIDG) to assess the options in any meaningful way against their prospects of generating benefits for the poor before 2016. All of these options apart from option 4 have potential to generate resource savings or service improvements that can benefit the poor. In principle, SBS would allow a faster response because it is already in place and a new business case is not required.[47]

However, if this option were pursued there would still be a period while the new focus was discussed and revised targets, programmes and reporting arrangements were agreed. The MOH would also have to re-establish credibility by achieving existing targets. As a result, SBS may have only marginal advantages over the other options in terms of speed of delivering benefits. The speed of implementation of other options is entirely dependent on how far DFIDG prioritises the work required to prepare a new business case (if it is required).

Using the criteria in the table the assessment suggests:

[46] The terms of reference did not include consideration of cost effectiveness, which would require additional economic analysis. However a note is provided in the annex as a starting point.
[47] The implication of the 2014 review recommendation to end the base payment of SBS (normally released in January) is that no payment is possible until August 2015. This payment will be based on 2014 sector performance judged by the holistic assessment carried out in April 2015. The analysis suggests a very strong likelihood that performance may decline further, so in effect further release of budget support is unlikely unless the indicators are revised.

*Option 1a – SBS for performance improvement* is most consistent with broader economic and fiscal reform objectives and would include important reforms to PFM, the workforce and sector financing. The MOH wants to continue with SBS. However, MOH accountability for delivering on the policy reform agenda needs to be stronger, especially in the area of PFM and workforce management. There are also limits to how far the MOH could deliver a programme on its own. A broader group of stakeholders would need to be engaged (e.g. the MOF) and DFID transaction costs could be high to determine and agree the reform agenda as well as to set performance targets.

*Option 1b – SBS for service delivery* is likely to have the highest ownership from the MOH as it retains the SBS modality and is more strongly focused on service delivery and policy reform in the area of PHC, which is a high ministerial priority. However, it would be vulnerable if the leadership and management capacity of the MOH did not improve or changed as there would be less likelihood that planned new policy on PHC or other areas such as health financing would be taken forward. If the macroeconomic position were to worsen and an IMF agreement was not reached, SBS could not prevent continued deterioration in sector funding and services.

*Option 2 – NBSFA* strikes the best balance across the selected criteria. It would have ownership in the GHS and some individuals in the MOH. Ministers would back it, although as a second best to budget support. It would mean much less or no leverage for DFID over sector policy but it would allow a dialogue over all related PHC and service delivery issues. DFID also could do more to protect its own funds and to audit their use. This option should be more robust against MOH capacity limitations as the GHS is already getting organised for a World Bank programme. There would be problems of sustainability if the macro position worsened but this could be mitigated to an extent through user charges or community-level contributions.

*Option 3 – a challenge fund* would be a last resort for MOH. However, it offers a credible means of sustaining basic services and support to the poorest. It would have no direct influence on the state sector although engagement with the non-state providers could offer a powerful demonstration effect and engender some competition with any state-sponsored proposals. This option would incentivise non-state provision in poor regions and communities. It would also be more robust to external shocks as the not-for-profit sector would contribute staff and facility costs. DFID could set targets and monitor spend as well as undertake selective audits. All of these measures would considerably reduce fiduciary risks. DFID transaction costs could be high but drawing on the STAR experience could reduce this considerably.

*Option 4 – enhancing accountability* is (along with option 3) strongly preferred by CSOs because they lack confidence in the ability of the state to tackle misuse of funds in the health sector and to deliver services effectively. It has no MOH backing and would only be able to influence policy in the short term if it were possible to maintain a working relationship with the MOH, e.g. by continuing their programme of TA support. In practice, it should be regarded as a longer-term influencing effort that seeks to accelerate the public debate, promote political accountability and change political party attitudes to health issues. There are existing models to build on and transaction costs for project development would not be large.

**In conclusion** option 2 would seem to offer the best way forward for DFID because it can potentially deliver a programme that would benefit the poor in an acceptable

timeframe. Transaction costs are unlikely to be excessive and fiduciary risks can be managed and mitigated more effectively. However, given that this option is still vulnerable to a change in government, the institutional weaknesses of the MOH and GHS and sustainability is not assured, then option 3 should be considered as well.

## Other findings and recommendations

The health sector context and recent trends are discouraging. After many years of steady progress in improving health outcomes and increasing access to services, supported by multi-donor pooled funding and recently SBS, the sector today is operationally fragmented and financially constrained. Additionally, it has made little progress in tackling structural problems such as inefficient use of the workforce and abuse of payroll systems. Large-scale capital projects are unlikely to be achieving VFM. The MOH leadership and management appear weak, with the result that accountability is undermined.

On the positive side there has been considerable progress in tackling communicable diseases and in developing outreach for the poor through community health centres and PHC services, which appear to have been particularly effective in the Upper East region. Although the NHIS is reportedly bankrupt, it still functions to meet the costs of hospital and clinical services; if its financial position can be corrected, and benefit packages defined and costs capped, it offers a potentially workable model. There is some very promising work underway on health financing and this should be encouraged and supported as a potentially transformational agenda.

This situation raises serious questions about the rationale for continued financial support and whether SBS is the appropriate aid modality. Notwithstanding the LMIC status of Ghana, the health needs of the country remain substantial, with the poorest regions and communities being badly underserved. Health systems remain weak but have potential to be improved if leadership and management in the sector can be strengthened. It will be important to build capacity of the system wherever possible to prevent reversals of previous gains during a period of macroeconomic turbulence. Greater resilience is also required to ongoing threats such as a resurgence of infectious diseases (cholera) or from cross-border threats (e.g. Ebola).

Donors therefore need to remain engaged in the sector. DFIDG should take the opportunity to reorient its financial aid support to ensure that it can achieve the greatest impact. This will mean considering all the options presented here for the use of financial aid.

The MOH is beginning to take ownership of the TA being provided by DFID and this needs to be further encouraged. The adoption of clear objectives, targets and responsibilities is a good start for improving the management of the TA funds by PPME. However, more attention needs to be given to timeframes for approving policy and then translating GOG commitments into action so there is a prospect of implementation. The MOH (PPME) has made a start on this.

The TA fund has potential to do more than fund reviews and policy work. It could also be used flexibly, for example to support the establishment of joint MOH/GHS task forces around specific programmes or deliverables such as the reorganisation or redeployment of the workforce or any other area where improvements can realistically

be delivered. Funds could be used to finance consultants or support costs to enable GOG staff to deliver specific programmes. Training of GOG staff could also be considered. Such teams could be directly accountable to the vice minister, with an agreed system of recognition for achievement and sanctions for failure to deliver. This area was not the subject of the current review and was not discussed with GOG but DFID could consider further how to use the TA fund to boost capacity and improve incentives in the MOH and GHS.

The SBS donor dialogue has allowed for regular review of sector performance and there has been an open and honest dialogue about the recent downturn in health indicators. But it has not served well as a platform for tackling wider governance challenges in the sector. For example, DFID has had to pursue some of its key concerns on a bilateral basis. This was particularly the case over the tendering and procurement of the planned new Ridge hospital. The WHO will be the next chair but has limited experience of SBS and broader governance issues.

## 7.2 Recommendations

The following recommendations are put forward as possible actions arising from this report:

Recommendation 1: DFID should reach a definitive and agreed position with the MOH concerning the reasons for the non-achievement of the existing SBS performance targets and make an assessment of when/if these targets can actually be achieved.

Recommendation 2: If a decision is made to adopt option 1b, then the basis for tranche release should be considered as a first priority. An initial release could be linked to the completion of existing SBS targets, ministerial approval of the financing strategy, agreement of the earmarking arrangement, and new policy and service delivery targets for the coming years 2015–17. An IMF agreement is a prerequisite.

Recommendation 3: If a decision is made to adopt option 2, then discussions should be opened with the GHS to agree objectives and management arrangements and to develop a programme delivery plan drawing on those already being developed for the planned World Bank project. Similarly, if option 3 is adopted, then early discussions should be undertaken with CHAG and other non-state providers.

Recommendation 4: DFID should contact the World Bank task manager and consider the possibility of co-funding of its new PHC project. If this is possible, then the pros and cons of this option should be further examined as a potential fast disbursement option.

Recommendation 5: There should be further discussion of the TA plan with the MOH and agreement of its objectives, indicators and allocated responsibilities. DFID should hold the PPME director accountable for its delivery.

Recommendation 6: DFID should encourage the MOH to give priority to achieving ministerial approval and early implementation of the HFS as a core area for future reform in the sector.

Recommendation 7: DFID should engage more directly and on a systematic basis with the vice minister to achieve progress in the financing strategy, the PHC policy and workforce optimisation. This arrangement should be used to drive greater accountability of MOH senior staff.

Recommendation 8: DFID should revitalise the donor dialogue by encouraging stronger leadership from GOG including ministerial engagement. The donor sector group has enabled discussion of overall sector performance but has had limited traction in delivering anticipated changes and reforms. If the sector group is continued, there should be a collective donor agreement on expected results, as well as consideration by DFIDG of the level of scarce health and governance adviser (or consultant) time to be devoted to ensuring an effective dialogue.

Recommendation 9: Consideration should be given to increase working with CSOs on the voice and public accountability aspects of health issues, regardless of which option is chosen for taking forward financial aid.

# Annex A Terms of reference

**HEALTH SECTOR SUPPORT PROGRAMME - SCENARIO PLANNING**

**Background**

The Secretary of State approved DFID Ghana's new Health Sector Support Programme (HSSP) in June 2013. This committed up to £67 million for five years to strengthen the health system and fill important gaps to help ready the Government of Ghana to manage health services without donor assistance. The HSSP programme was anticipated in DFID Ghana's Operational Plan (OP). It contributes almost 50% of the DFID Ghana Departmental Results Framework target for skilled birth attendance and contributes indirectly to the OP result on family planning. Sector budget support makes up the lion's share of the programme (£50 million) and is performance based. To date we have disbursed £14 million of base case financing. £6 million was allocated to performance financing, however this was not dispersed because none of the targets were met.

The programme's first annual review scored implementation to date at "B" (moderately did not meet expectations) and recommended against releasing any of the performance tranche of SBS for 2014/15. There has been some progress but it has not been enough and we have seen a regression in the sector's performance over 2013 (despite an increase in financial and human resources), a lack of strong health improvement gains and poor budget performance. Outside of SBS the other elements of the programme (support to three MOH agencies, technical assistance and our support to improve mental health services) have made a solid start.

The environment has changed since the business case was originally written. The deterioration of the macroeconomic situation over the last 10 months has severely hindered government's ability to deliver. It is not set to get better in the short term. Despite remaining committed to poverty reduction, Government has made some spending decisions (most notably single sourced loans for the expansion of the Ridge Hospital in Accra) which question its commitment and ability to deliver value for money. In addition, there has yet to be a clear indication from the Minister of Health of the priority attached to sector budget support and a willingness to engage in the frank dialogue and reform focus that comes with it. However, HSSP has only been fully operational for 6 months, with the performance framework for SBS being agreed in March 2014. In addition, a new Minister and Deputy Minister have been appointed in the last few weeks. The former is known to have a strong position on fighting corruption, while the latter is an experienced health professional well respected in the sector (and is an ex-DFID adviser). Other development partners are optimistic about the potential of this new ministerial team.

Components of HSSP outside of SBS which have delivered well include earmarked support to three agencies within Health, the TA adviser embedded within the Ministry and targeted support toward mental health. While the new ministerial team is seen as a good development and the positive gains over 2013-14 show there is potential, we cannot be certain how the next year will play out. It is a good point to challenge our SBS approach given the concerns about health performance plateauing, the Ministry's ability to deliver value for money, the fiscal squeeze continuing and the likelihood

serious reform may be impaired in 2015 with the approach of elections. In addition, we will no longer be the Development Partner lead from September 2014. This role has allowed us to shape DP engagement and been a critical way to influence the Ministry

## 1. Objectives

1.1. There are three main objectives for this review as follows:

- Identify and analyse the key political, economic and health sector-relevant issues that may impact the provision of health sector budget support over the next 2 years.
- Consider the impact of these on the ability of the government to deliver better health systems and outcomes.
- Process these into potential scenarios and related responses for the HSSP.

**Objective 1: The context for sector budget support**

- Undertake a political economy analysis, horizon scanning to 2016 elections.
- Ministry's performance on systems and management over last 3 years (budget execution, wage bill and cleaning up of the pay roll, procurement and prevalence of sole sourcing)
- Drivers of change analysis for the Ministry of Health – the new ministerial team, changing role of donor funding, health insurance as a driver of change.
- Fiduciary risk, DFID's current risk

**Objective 2: Performance of the health sector**

- Analyse the impact of sector budget support on Ghana's performance on health MDGs and the medium term development plan over the last 3 years.
- Assess the impact of the SBS modality on strengthening the health system and improving health outcomes.
- Understand the health sector landscape and future directions. Does it align with DFID's priorities and risk appetite?

**Objective 3: Conclusions, recommendations and scenarios**

- Construct scenarios for Ghana in the run up to the 2016 operational plan.
- Consider the impact of these on the potential to deliver the HSSP programme.
- Consider how we might respond in terms of improving our financial and influencing resources to the different scenarios to secure the best deal for DFID on:
  - improving health outcomes,
  - strengthening the health sector and sustainability
  - minimising risk and maximising VFM.

## 2. The Recipient

2.1 DFID is the recipient of the service.

## 3. Scope

3.1. The team will:

- Review key documents
- Assess progress on Health Sector's Financing Strategy and Public Expenditure Review.
- Review key budget data from the last 5 years. See indicator list from Jens-Peter
- Hold discussions with senior MOH and Ministry of Finance officials and other development partners
- Examine the changing donor context, changes in aid modalities and alignment: Speak to Danida, EU and other SBS and GBS donors.
- Hold discussions with Crown Agents, GOG's appointed procurement quality assuror.
- Hold internal DFID discussions

## 4. Outputs

4.1. The team of consultants will deliver the following outputs:

- Presentation of preliminary findings and scenarios to DFID.
- A narrative report.

## 5. Key Documents

5.1. The following documents will be made available to the consultant:

- HSSP 1 PCR
- HSSP 2 business case
- HSSP 2 annual review
- DFID Internal Audit methodology and risk and control documents.
- Key health documents – detail
- Key MoF documents – detail
- Key procurement legislation.

## 6. Timing and Duration

6.1 the consultants will be expected to start work in September. It will last three weeks comprising one week to review documents, one week in country and one week to write up.

## 7. Skills and Experience Required

Experience with budget support aid modalities, governance and health sector funding. This includes: public financial management, health financing, experience in measuring health indicators and outputs.

**DFID Ghana**
July 2014.

# Annex B People consulted

| | |
|---|---|
| **DFID Ghana** | |
| Sally Taylor | Head of Office |
| Charlotte Pierre | Head of Human Development |
| Susan Elden (by TC) | Former Senior Health Adviser |
| ShamwillIssah | Health Adviser |
| Archie Laing | Programme Officer |
| Nahumn Ackon | Senior Programme Officer |
| Jens-Peter Dyrback | Senior Governance Adviser |
| **MOH** | |
| Dr Victor Bampoe | Deputy Minister of Health |
| Salimata Abdul Salam | Chief Director |
| Dr Afisa Zakaria | Director, PPME |
| Senaya | Director of Budget |
| Herman Dusu | Director of Finance |
| Emmanuel | Director of Policy |
| Kwakye Kontor | Principal Planning Officer, PPME |
| Dr Kwesi Asabir | Deputy Director of HR |
| Damien Bishop (by TC) | Technical Adviser, MOH |
| **MOF** | |
| Patrick Nomo | Director of Budget |
| Peter Jaidoo | Budget Unit |
| Edward Abroka | |
| **GHS** | |
| Dr Agongo | Director, PPPME |
| Charles Aquarh | |
| Dan Osei | Deputy Director, Planning Department |
| **NHIA** | |
| Nathaniel Otoo | Deputy Chief Executive (Operations) |
| Alex Odoi Nartey | Deputy Chief Executive (Finance and Investment) |
| Jones Ofosu | Head of Administration |
| Heads of Departments | |
| **Donors** | |
| Lena Hothes | Health Adviser, Danida |
| Janet Mortoo | Economist, European Union |
| Smile Kwawukume | World Bank |
| Aimee Miller | World Bank |
| Dr Tinorga | Consultant, World Bank |
| Dr Victor Ngongalah | Chief Health & Nutrition Specialist, UNICEF |
| Dr Daniel Yayemain | Child Health Specialist, UNICEF |
| Selassied'Almeida | Health Economics Adviser, WHO |

| Civil society | |
|---|---|
| Mary Tobbin Osei | CEO, STAR |
| Professor Gyimah-Boadi | Ghana Centre for Democratic Development |
| Charles Jebanj (?) | Director, IEA |
| Charles Mensa | IEA |
| Jean Mensa | IEA |
| Kobina Bainson | Consultant |
| Sam Adjei | Centre For Health & Social Services |
| Prof Emmanuel Akwetey | Institute for Democratic Governance |

# Annex C MOH payroll

| DECEMBER 2013 PAYROLL COST BY CATEGORY | | | | | | |
|---|---|---|---|---|---|---|
| CATEGORY | No. | Monthly payroll cost | Market premium | Total monthly pc | Annual payroll cost | % of total APC |
| DOCTORS | 2,615 | 5,747,554 | 10,926,288 | 16,673,842 | 200,086,104 | 14.4 |
| NURSES | 3,7325 | 35,505,590 | 19,782,281 | 55,287,871 | 663,454,453 | 47.7 |
| PHARMACISTS | 580 | 842,099 | 536,945 | 1,379,044 | 16,548,528 | 1.2 |
| BIOMEDICAL SCIENTISTS | 653 | 868,935 | 515,161 | 1,384,096 | 16,609,150 | 1.2 |
| RADIOGRAPHERS | 84 | 112,073 | 66,664 | 178,738 | 2,144,850 | 0.2 |
| MANAGEMENT (DIR,DEP DIR,ETC | 188 | 511,033 | 613,240 | 1,124,273 | 13,491,278 | 1.0 |
| ADMINISTRATION & HRM | 616 | 961,246 | 221,826 | 1,183,072 | 14,196,864 | 1.0 |
| TRAINEES | 18,525 | 9,132,843 | 0 | 9,132,843 | 109,594,122 | 7.9 |
| OTHERS | 30,508 | 21,080,682 | 8,438,020 | 29,518,702 | 354,224,425 | 25.5 |
| TOTAL | 91,094 | 74,762,056 | 41,100,425 | 115,862,481 | 1,390,349,777 | 100.0 |

Table 4: Analysis of compensation of employees 2013, source IPPD

# Annex D MOH spending 2013 – provided by MOH Budget Unit

| TABLE 1: ACTUAL EXPENDITURE BY SOURCE OF FUND AND ECONOMIC CLASSIFICATION FOR PRIMARY AND SECONDARY HEALTH SERVICES, 2013 IN GHS MILLION | | | | |
|---|---|---|---|---|
| | **COMPENSATION OF EMPLOYEES** | **GOODS & SERVICES** | **ASSETS** | **TOTAL** |
| **GHS** | | | | |
| GOG | 594.04 | 0.70 | 3.34 | 598.08 |
| IGF | 37.67 | 340.00 | - | 377.66 |
| SBS | 0.01 | 8.50 | 0.28 | 8.80 |
| Programme (Earmarked) | - | 129.48 | - | 129.48 |
| **Sub-Total** | **631.71** | **478.69** | **3.62** | **1,114.02** |
| **Add** | | | | |
| Direct transfer (MOH) | - | 15.25 | 87.09 | 102.34 |
| CHAG | 166.26 | 241.73 | 4.98 | 412.97 |
| **Total funds for primary and secondary services** | **797.98** | **735.66** | **95.69** | **1,629.33** |
| Budget outturn for sector | 1,526.82 | 998.92 | 153.93 | 2,679.67 |
| Share of funds for primary and secondary services | 52.3% | 73.6% | 62.2% | 60.8% |
| Total funds for primary and secondary services (excl. programme earmarked) | 797.98 | 606.18 | 95.69 | 1,499.85 |
| Share of funds for primary and secondary services excluding earmarked grants | 52.3% | 60.7% | 62.2% | 56.0% |
| *Source: CAGD; MOH Budget Unit; CIMU; MOH Finance* | | | | |
| The direct transfer from MOH comprises funds used for the procurement of health commodities and implementation of priority programmes for primary and secondary health services. | | | | |

| | | | | |
|---|---|---|---|---|
| | | | | |
| | | | | |
| **TABLE 2: 2013 BUDGET EXECUTION BY LEVEL IN GHS MILLION** | | | | |
| **BMC** | **APPROVED BUDGET** | **BUDGET OUTTURN** | **% Execution** | |
| MOH HQ | 286.12 | 237.56 | 83.0 | |
| SERVICE DELIVERY | | | | |
| GHS | 1,606.18 | 1,216.36 | 75.7 | |
| CHAG | 243.09 | 412.97 | 169.9 | |
| Teaching hospitals | 229.25 | 354.27 | 154.5 | |
| Psychiatric hospitals | 17.13 | 37.24 | 217.4 | |
| REGULATORY AGENCIES | 67.22 | 61.32 | 91.2 | |
| SUBVENTED ORGANISATION | 17.61 | 20.46 | 116.2 | |
| TRAINING INSTITUTIONS | 144.99 | 339.49 | 234.1 | |
| **TOTAL** | **2,611.59** | **2,679.67** | **102.6** | |
| *Source: 2013 MTEF Budget; CAGD; MOH Budget Unit* | | | | |
| The budget outturn exceeded the approved budget for the health sector by 2.6%. This is as a result of increase in the expenditure on compensation for CHAG, teaching hospitals, psychiatric hospitals, subvented organisations and training institutions. | | | | |
| | | | | |
| | | | | |
| | | | | |
| **TABLE 3: 2013 BUDGET OUTTURN BY SOURCE OF FUND AND ECONOMIC CLASSIFICATION (IN GHS MILLION)** | | | | |
| **SOURCE OF FUND** | **COMPENSATION OF EMPLOYEES** | **GOODS AND SERVICES** | **ASSETS** | **BUDGET OUTTURN** |
| Government of Ghana | | | | |

| | | | | |
|---|---|---|---|---|
| GOG | 1,518.66 | 3.63 | - | 1,522.29 |
| IGF | 8.16 | 906.93 | 6.55 | 921.64 |
| Annual Budget Funding Amount (ABFA) | - | - | - | - |
| Social Intervention Programme (SIP) | - | 12.14 | - | 12.14 |
| DONOR | - | 76.21 | 147.38 | 223.60 |
| **TOTAL** | **1,526.82** | **998.92** | **153.93** | **2,679.67** |
| *Source: CAGD; MOH Budget Unit* | | | | |
| | | | | |

**MOH spending 2012 – provided by MOH Budget Unit**

| TABLE 1: ACTUAL EXPENDITURE BY SOURCE OF FUND AND ECONOMIC CLASSIFICATION FOR PRIMARY AND SECONDARY HEALTH SERVICES, 2012 IN GHS MILLION | | | | |
|---|---|---|---|---|
| | **COMPENSATION OF EMPLOYEES** | **GOODS & SERVICES** | **ASSETS** | **TOTAL** |
| **GHS** | | | | |
| GOG | 889.05 | 4.31 | 4.47 | 897.83 |
| IGF | 7.13 | 89.60 | 5.09 | 101.81 |
| Priority Intervention Programme (PIP) | - | 11.74 | - | 11.74 |
| SBS | - | 32.84 | 20.81 | 53.66 |
| **Sub-Total** | **896.18** | **138.49** | **30.37** | **1,065.04** |
| **Add** | - | - | - | - |
| Direct transfer (MOH) | - | - | 55.16 | 55.16 |
| CHAG | 179.56 | 1.10 | 0.80 | 181.46 |
| **Total funds for primary and secondary services** | **1,075.74** | **139.59** | **86.33** | **1,301.67** |

| | | | | |
|---|---|---|---|---|
| Budget outturn for sector | 1,629.70 | 223.83 | 149.89 | 2,003.42 |
| Share of funds for primary and secondary services | 66.0% | 62.4% | 57.6% | 65.0% |
| *Source: CAGD; MOH Budget Unit; CIMU; MOH Finance* | | | | |
| The direct transfer from MOH comprises funds used for the rehabilitation and completion of capital projects for primary and secondary health services. | | | | |
| | | | | |
| | | | | |

**TABLE 2: 2012 BUDGET EXECUTION BY LEVEL IN GHS MILLION**

| **BMC** | **2012 BUDGET APPROPRIATION** | **REVISED BUDGET** | **BUDGET OUTTURN** | **% Execution** |
|---|---|---|---|---|
| MOH HQ | 212.82 | 221.55 | 25.75 | 11.6 |
| SERVICE DELIVERY | | | | |
| GHS | 456.61 | 1,153.17 | 1,120.20 | 97.1 |
| CHAG | 149.86 | 281.63 | 181.66 | 64.5 |
| Teaching hospitals | 195.18 | 320.57 | 273.64 | 85.4 |
| Psychiatric hospitals | 23.07 | 40.42 | 35.67 | 88.2 |
| REGULATORY AGENCIES | 42.98 | 59.13 | 37.51 | 63.4 |
| SUBVENTED ORGANISATION | 37.60 | 37.27 | 10.54 | 28.3 |
| TRAINING INSTITUTIONS | 50.17 | 376.01 | 318.44 | 84.7 |
| **TOTAL** | **1,168.29** | **2,489.75** | **2,003.42** | **80.5** |
| *Source: 2012 MTEF Budget; CAGD; MOH Budget Unit* | | | | |
| The 2012 budget appropriation was revised as a result of an increase in expenditure on compensation of employees; thus the total budget execution was 80.5%. | | | | |
| | | | | |
| | | | | |

| | | | | |
|---|---|---|---|---|
| **TABLE 3: 2012 BUDGET OUTTURN BY SOURCE OF FUND AND ECONOMIC CLASSIFICATION (IN GHS MILLION)** | | | | |
| **SOURCE OF FUND** | **COMPENSATION OF EMPLOYEES** | **GOODS AND SERVICES** | **ASSETS** | **TOTAL** |
| Government of Ghana | | | | |
| GOG | 1,615.95 | 9.25 | 30.48 | 1,655.69 |
| IGF | 13.75 | 142.46 | 8.14 | 164.34 |
| PIP | - | 11.74 | - | 11.74 |
| DONOR | - | - | - | - |
| SBS | - | 60.38 | 28.53 | 88.91 |
| Loans/mixed credits | - | - | 82.74 | 82.74 |
| **TOTAL** | **1,629.70** | **223.83** | **149.89** | **2,003.42** |
| *Source: CAGD; MOH Budget Unit; CIMU; MOH Finance* | | | | |

# Annex E Note on the cost effectiveness and economics of the options

## 1. Introduction

Updating the economic appraisal of DFID SBS was not part of the terms of reference of the review. However at DFIDG's request this note has been produced for illustrative purposes only and will require a more substantial assessment than was possible in the timeframe available to the review team. It is hoped that it will serve as a starting point for any further analysis.

Follow-up appraisal also requires a position to be taken on the rest of the HSSP programme (i.e. the TA fund and support to the four agencies). In the discussion that follows we have assumed that DFID support in all of these areas continues. We have therefore concentrated solely on examining the incremental costs and benefits of the options for financial aid.

## 2. Possible costs of the options proposed in the review

The incremental costs of the various options being proposed depends on the resource gap to be filled; the additional funding available from DFID; and the absorptive capacity of the system or programme. In each case it is assumed that the existing TA support to the MOH is continued and any additional TA costs are identified. Based on past DFID experience with these approaches in Ghana and elsewhere the situation under each option is likely to be:

**Option 1a: SBS for improved performance and efficiency.** It is anticipated that the full £36 million balance of the remaining SBS could be disbursed against an agreed programme and targets with associated costs for additional TA studies/advice/reports of perhaps £1.5 million. The TA costs could be met from existing TA allocations. There would be some management costs for GOG. **Total costs £37.5 million.**

**Option 1b: SBS for service delivery.** It is anticipated that the same amount of financial aid could be used although it would be earmarked to service delivery through the GHS at regional, district and lower levels of the system. TA would also be required to support any management costs and monitoring/expenditure tracking work to trace funds to district level and to assess their effects. **Total costs would be comparable to those for option 1a.**

**Option 2: NBSFA.** The cost of this programme will be determined by the pace of improvement to PHC services and the planned coverage. If the programme were country-wide it might well be possible to effectively utilise all the remaining DFID financial aid. If there were a stronger regional focus with less ambitious delivery targets, then fewer resources could be required. The GHS would need to cost the programme and identify financing gaps after taking into account funds already available from the World Bank. The incremental cost would cover provision of any health post refurbishment, equipment, drugs, health education materials and recurrent funding. As with option 1b there would be a need for additional TA costs for

monitoring/expenditure tracking, etc. **Total cost could be £30 million (say £28 million financial aid and £2 million TA and consultancy costs).**

**Option 3: Service delivery challenge fund.** In theory the size of the fund would only be limited by the level of demand and it could also be large enough to absorb all the remaining financial aid. In practice, since it is a new approach, DFID may want to proceed more cautiously at first. Additional TA funds would also be required to manage the fund, including assessing proposals, managing and allocating funds, administering grant agreements, monitoring progress, etc. If the fund ran for three years in the first instance it could aim to disburse say £24 million over three years with say £1–2 million in fund management costs. **Total cost say £26 million.**

**Option 4: Enhancing accountability through civil society.** This option is unlikely to require the same level of funding as the others. There is no service delivery and the main costs would be accountable grants to three–four CSOs working on public policy, accountability and expenditure tracking. Total spending could be around **£10 million over** three years.

## 3. Possible benefits of the options shown in the review

This section depends on being able to describe the benefits from each of the options and then using realistic assumptions to try and quantify and value them in order to obtain an indicative monetary benefit. In attempting to do so, the note has drawn heavily on the existing economic appraisal of HSSP. Where relevant we have also drawn on the recent World Bank economic appraisal of a forthcoming health services project.

The key assumptions are:

- **SBS option 1a** generates benefits from policy reform and these can take the form of some or all of the following:

  -efficiency savings including financial savings from reducing the payroll or from other recommendations arising from the PER;

  -enhanced workforce performance/productivity, for example through better deployment and utilisation of staff;

  -predictability and continuity of services by delivering budgeted spending; and

  -increasing and sustaining coverage of health services by adopting an affordable health strategy.

- **SBS (both options)** also generates improved services by:

  -enhancing the quantity of services by increasing sectoral spend above the level it would otherwise achieve; and

  -improving the quality of health spending if it enhances institutional capacity/incentives and/or restores the balance between salaries/other charges in the budget.

- **SBS: option 1b** will also earmark and channel additional resources to regional, district and lower levels of the health system. This will enhance hospital, clinic-based and basic health services provided by community health officers. Funds can be transferred using existing financial systems with performance linked to increases in access, utilisation and quality of PHC services at the sub-district and community level.

- **Option 2: NBSFA** can generate improvements in very specific areas of the health sector and services but has much less effect on the wider system. It can do this by targeting specific regions and PHC services and closely defining outputs. The required resources can be provided and gaps in the supply chain closed. Incentives can be provided and results monitored. In this framework both the quantity and quality of specific district-led PHC services through CHPS zones can be expected to improve key indicators by:

  - improving performance and reducing the wide variations between regions in: under-five mortality (e.g. 124/1,000 in the Northern region, 56 in greater Accra region), skilled delivery (37% in the Northern region against the 57% national average), and undernutrition (1/3 children stunted in the Northern region against 1/5 in Ghana); and

  - providing cost-effective, high-impact interventions that target the major causes of the burden of disease (communicable disease and maternal and child health including contraception), as well as working on preventative and promotional aspects of health to address determinants of health.

- **Option 3: A competitive challenge fund** can be assumed to have similar results/benefits to option 2 in relation to the provision of specific PHC services provided in particular regions. In addition it can be assumed that the predominance of non-state providers will produce higher productivity and service quality than in the state focused NBSFA because of higher levels of efficiency. Option 3 will therefore:

  - enable targeting of PHC in disadvantaged areas through non-state and MOH/GHS providers; and

  - introduce performance incentives linked to coverage, utilisation and quality of services, leading to enhanced level of output and coverage compared to state-led options.

- **Option 4: Enhancing accountability.** The benefits of increased accountability regarding CSOs are harder to define and measure but could potentially include financial savings from a reduction in corruption and diversion/misuse of public funds and contracts. Also, improvements in service delivery are likely to result from increased accountability. It is anticipated that:

  - greater scrutiny will force GOG action to improve access, inequity and quantity/quality of health services for poor; and
  - demands for transparency and accountability will reduce opportunities to divert funds, encourage better controls and introduce more competitive procurement.

## 4. Health benefits

The previous DFID analysis of SBS[48] assumed that the aid benefitted the whole population and would have an impact on under-five and maternal mortality. A projection of the amount DFID could contribute through SBS was prepared and a coefficient was applied based on the expected change in government health spending per capita on the under-five mortality rate and maternal mortality rate. Using World Bank data DFIDG calculated that a 1% increase in GOG spending per capita would produce a 0.425% reduction in the under-five mortality rate and 0.5801% in the maternal mortality rate. This estimate was then converted into disability-adjusted life years (DALYs) based on average life expectancy in Ghana. The overall benefit was monetised based on a one to one ratio of DALYs to average GDP per capita in purchasing power parity terms.

The previous DFID analysis concluded that an option consisting mainly of SBS plus some small funding for flexible TA would generate an **internal rate of return of 36% with a benefit cost ratio of 2.05**. This is a high return and can be a guide to the potential returns from option 1b under a high case scenario. Option 1a is focused more on policy reforms and some separate assessment of potential efficiency savings will be needed if this option is taken further.

The World Bank has also carried out an economic appraisal of its planned new Mother and Child Health and Nutrition Project,[49] which involves a range of support through GHS similar to the proposed option 2. This suggests that the project will achieve a decrease in maternal mortality of 56% against a 20% decrease in the without project case. The under-five mortality will decline by 44% against 28%. The difference between the two scenarios is an estimated 32,000 lives saved with a **benefit to cost ratio of 2.3**. This is also considered quite high and means that for every US$ 2,300 invested in the project Ghana would save the life of one mother or child.[50]

## Conclusion

It is not possible to provide a definitive view on the cost effectiveness and economic returns of the options proposed without further in depth analysis using a rigorous methodology. The World Bank analysis can be considered to provide a rough approximation of the likely level of benefits from adopting the proposed option 2 but would require specific work to confirm this if the option is developed into a full business case.

The returns to option 3 are likely to be similar but the benefit stream would be greater because of higher performance and productivity in the non-state sector. Direct delivery costs may also be lower for the same reasons but these would be offset by additional fund management costs. All of these aspects would need much closer examination of available evidence on these points.

The returns to SBS calculated earlier by DFID are still likely to be valid provided the conditions hold that enable the efficient and effective use of the funds and the

[48] Ghana Health Sector Support Programme 2013–18 Business Case.
[49] Appraisal document: World Bank (2014) *Multi donor health results innovation Trust Fund – Mother and Child Health and Nutrition Project Ghana*.
[50] World Bank document, Annex 6, Financial and Economic Analysis, pp. 76–79.

progression of policy reforms. If this is not the case (i.e. the mid or lower case scenarios hold), then returns will be considerably lower than previously estimated by DFID.

Option 4 cannot be easily assessed but it is clear that multi-million contracts were allowed in the health sector and if greater scrutiny were able to improve the procurement process and reduce misuse or diversion of funds in the sector, it is likely that this option could have very high returns.