Key health challenges in Ghana

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This report provides an oversight into some of the key issues facing the health sector in Ghana and describes the role professionally qualified accountants can play in achieving the country's health goals.

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Foreword

It is my pleasure as director finance of the Ghana Health Service to write the foreword for this report, which describes, among other things, the role that professional accountants can play in achieving Ghana's health goals. This report is the result of a health conference organised recently by ACCA in Accra, Ghana, which I chaired.

As a certified chartered accountant, I have seen over the years the contribution that professional accountants make, not only in ensuring the efficient and effective use of limited resources but also in contributing to the development and implementation of policies and strategies. It was, therefore, not a surprise to me when issues affecting healthcare policy and the provision of health care in Ghana were the preoccupation of the conference.

The ACCA qualification and its continuing professional development programme provided me with the confidence to move from a for-profit organisation to a not-for-profit one without any hiccups. Today, the qualification continues to be as relevant and useful for professionals in the public sector as it was for me some 10 years ago.

This report discusses some of the key health challenges facing Ghana and provides potential solutions to enable the government of Ghana to achieve its goal of creating a healthier population. Whoever reads this report will be able to appreciate the main issues confronting the healthcare system in Ghana, especially the National Health Insurance Scheme.

I am confident that this publication will find many grateful readers who will have gained a broader perspective of the healthcare system in Ghana and the Ghanaian government's agenda for creating wealth through health.

Ramatu Ude Umanta FCCA, director finance, Ghana Health Service

1. Introduction

'As a critical sector of the economy, the Ministry of Health seeks to improve the health status of all people living in Ghana thereby contributing to government's vision of transforming Ghana into a middle-income country by 2015.'

MINISTRY OF HEALTH, REPUBLIC OF GHANA

The Ghanaian government's national vision is to transform Ghana into a middle-income country by 2015. This is an ambitious target for a country where over a quarter of the population live in poverty, where disease is rife and where around half of the population have no access to basic services such as safe water or improved sanitation; along with ample resources it will require strong commitment and vision.

Ghana's National Health Policy, entitled 'Creating Wealth through Health' (MOH 2007), was designed to support realisation of the national vision. The policy recognises that ill health is both a cause and a consequence of poverty and acknowledges the impact that environmental factors have on health. It proposes a sector-wide approach to improving the health of the population and to reducing inequalities of access, based on both preventative and curative care.

The health policy is being executed through a series of Health Service Medium Term Development Plans (HSMTDPs) and Programmes of Work (POW).

A greater insight into some of the many issues affecting health policy and the provision of health care in Ghana was provided at a health conference organised recently by ACCA in Accra. The event gave politicians, health policymakers and senior ACCA members employed in the field of healthcare the opportunity to discuss some of the key health challenges facing Ghana, to debate potential solutions and then to consider the ways in which ACCA accountants can support the government in achieving its goal of creating a healthier population.

Speakers at the event, which was chaired by Mrs Ramatu Ude Umanta, director finance, Ghana Health Service, included:

- Norman Williams, head of ACCA Ghana
- Jamil Ampomah, ACCA director, Sub Saharan Africa
- Professor K. B. Omane-Antwi, vice rector, Pentecost University College
- Mr Mark Millar, interim chief executive, Milton Keynes NHS Foundation Trust, England and ACCA council member
- Dr Kwabena Opoku-Adusei, president, Ghana Medical Association
- Hon Robert Joseph Mettle Nunoo, deputy minister, Ministry of Health.

The wide-ranging discussions focused on four key themes.

- How close is Ghana to achieving the Millennium Development Goals related to health?
- Is the National Health Insurance Scheme delivering?
- How collaborative technology can be used to improve the provision of health care.
- The role of the accountancy profession in healthcare delivery.

2. The healthcare system in Ghana

Located in western sub-Saharan Africa on the Gulf of Guinea, Ghana covers an area of approximately 239,460 square kilometres. The country was formed in 1957 from the merger of the British colony of Gold Coast and British Togoland, becoming the first sub-Saharan country in colonial Africa to achieve independence. For administrative purposes, Ghana is subdivided into 10 regions, of which Greater Accra and Ashanti have the greatest proportion of urbanisation, at 90.5% and 60.6% respectively; the regions are subdivided into 170 administrative districts (comprising 164 districts/municipals and six metropolitan areas).

The population registered at the 2010 census stood at 24.6m, compared with 18.9m at the 2000 census, giving an average intercensal growth rate of 2.5%. The country has a relatively young population, with over 38% under the age of 15 and 20% in the age range 15–24 (Table 2.1). Greater Accra is the most densely populated region, with a density of 1,236 persons per square kilometre.

The vast majority of the economically active population work in the informal sector (Table 2.2) and are self-employed (Table 2.3). The main forms of employment are skilled agricultural, forestry or fishery (41%), sales and services (21%) and craft and related trades (15%).

Table 2.1: Population by age group

Age range	%
0–14	38.3
15–24	20
25–34	15.1
35–44	10.6
45–54	7.2
55–64	4
65–74	2.6
75–84	1.4
85+	0.6

Source: Ghana Statistical Service (2012) (Table 3)

Table 2.2: Emplyment sector of the economically active population aged 15 years and over

Sector	Male	Female	Total
Public	412,046 (8.1)	238,171 (4.5)	650,217 (6.3)
Private formal	499,715 (9.9)	222,583 (4.2)	722,298 (7.0)
Private informal	4,096,891 (81.0)	4,832,876 (90.9)	8,929,767 (86.1)
Semi-public /parastatal	9,959 (0.2)	4,062 (0.1)	14,021 (0.1)
NGO (local and international)	34,850 (0.7)	17,751 (0.3)	52,601 (0.5)
International organisations	3,387 (0.1)	1,387 (< 0.1)	4,774 (< 0.1)
Total	5,056,848 (100)	5,316,830 (100)	10,373,678 (100)

Source: Ghana Statistical Service (2012) (Table 30)

Table 2.3: Employment type of the economically active population, aged 15 years and over

Employment type	Male Number (%)	Female Number (%)	Total Number (%)
Employee	1,279,830 (25.3)	606,411 (11.4)	1,886,241 (18.2)
Self-employed without employees	2,748,801 (54.4)	3,465,788 (65.2)	6,214,589 (59.9)
Self-employed with employees	283,205 (5.6)	220,697 (4.2)	503,902 (4.9)
Casual worker	139,624 (2.8)	67,418 (1.3)	207,042 (2.0)
Contributing family worker	440,525 (8.7)	757,911 (14.3)	1,198,436 (11.6)
Apprentice	126,122 (2.5)	154,154 (2.9)	280,276 (2.7)
Domestic employee (household help)	29,265 (0.6)	36,546 (0.7)	65,811 (0.6)
Other	9,476 (0.2)	7,905 (0.1)	17,381 (0.2)
Total	5,056,848 (100)	5,316,830 (100)	10,373,678 (100)

Source: Ghana Statistical Service (2012) (Table 29)

Politically stable, Ghana is one of the fastest-growing economies in Africa, owing in part to the discovery of major offshore oil reserves in 2007. According to the International Monetary Fund (IMF), Ghana's real gross domestic product (GDP) increased by 14.4% in 2011 and is projected at 8.2% for 2012 and 7.8% for 2013, making it one of the fastest-growing economies in the world.

Despite this economic growth, Ghana is an aid-dependent country and in 2005/6, according to the Ghana Statistical Service, 28.5% of the population lived in poverty. The incidence of poverty was highest in the north of the country: at 70% in the Upper East Region, 88% in the Upper West Region and 52% in the Northern Region.

Ghana was upgraded from a low to a lower-middle income country in July 2011. This followed a statistical rebasing of the economy undertaken in 2010 to reflect new market sectors such as oil exploration, forestation and telecommunications. These developments had resulted in the growth of the economy by 60% from $18 billion to $30 billion. The government's national vision is for Ghana to attain middle-income status by 2015. The country's healthcare policy is aligned to this vision and to achievement of the Millennium Development Goals (discussed below) through a series of Health Sector Medium Term Development Plans (HSMTDPs).

Over the years, Ghana's healthcare system has seen many changes.

When the country first achieved independence it was committed to providing 'free for all' health care. This policy remained in place until the country's economic crisis in the 1970s and 1980s when government spending on health care dropped by 20%, leading to a shortage of supplies, demoralised staff and a halt on investment in infrastructure.

In return for support from the World Bank, the Ghanaian government agreed to impose a charge for health services, equating to 15% of recurrent expenditure. The impact of this 'cash and carry' system was a rapid decline in service use of more than 50% countrywide and of over 70% in rural areas. Studies have since found that residents moved away from modern medicine and turned to traditional medicine or self-medication for treatment.

In the mid-1980s payment exemptions were introduced for a limited number of health services and in 1997 these were extended to cover children under five years old, people over 70 and the poor. Application of these exemptions, however, was irregular. Difficulties included: health provider access to exemption funds, obtaining each patient's proof of age, validation of poverty, and non-uniform application of exemptions.

Around the year 2000, a number of health providers began to introduce health insurance schemes aimed at addressing the difficulties patients had in accessing and paying for care. Over time, as a development of this theme, Mutual Health Organisations were established. The schemes proved popular and by 2003, countrywide, there were 258 such schemes in existence–though total population coverage was just 2%.

Building on the success of these insurance schemes, legislation authorising healthcare financing reform was passed in 2003 and 2004 leading to implementation of the National Health Insurance Scheme in 2005. This aimed to make free health care available to all, but particularly to the poor and disadvantaged. Three categories of health insurance were authorised.

District Mutual Health Insurance Schemes – these were public insurance schemes open to all Ghanaian residents. The schemes were to be funded predominantly from the central government national health insurance levy supplemented by annual member contributions. Responsibility for regulating the schemes, accrediting providers and managing funds was given to the National Health Insurance Authority (NHIA).

Commercial Health Insurance Schemes – these schemes were to be funded solely from member contributions.

Private Mutual Insurance Schemes – these schemes were to be set up by a collection of people, perhaps members of a church or social club, to cater for group health needs. They were to be funded solely from member contributions.

District Mutual Health Insurance Schemes (DMHIS) have the largest membership base with around 8.2m members or around 33% of the population in 2011 (Table 2.4). Members of the scheme pay an initial registration fee followed by annual premiums and in return receive a defined level of medical care provided free at the point of delivery.

For those working in the formal sector, who are enrolled in the Social Security and National Insurance Trust (SSNIT) pension scheme, the premiums are taken at source so they are required to pay only the initial registration fee 'out of pocket', whereas those working in the informal sector must pay both the initial registration fee and an annual premium (of between GH¢72,000 to GH¢480,000, depending on socio-economic status) out of pocket.

A large proportion of the population are, however, exempt from the charges including:

- children under the age of 18 whose parents or guardians belong to the scheme
- people aged 70 or more
- pregnant women (since July 2008)
- indigents with no consistent form of support from another person and with no visible source of income and no fixed place of residence
- SSNIT pensioners–though they are required to pay the registration fee (Table 2.5).

Table 2.4: Active NHIS membership as a percentage of population by region in 2011

	Membership (%)
All Regions	33.3
Western	32.2
Central	24.6
Greater Accra	25.6
Volta	29.0
Eastern	36.0
Ashanti	37.8
Brong Ahafo	45.9
Northern	25.5
Upper East	45.3
Upper West	50.9

Source: NHIA Annual Report (2011: 17)

Table 2.5: Active NHIS subscribers by category, 2011

Subscriber category	%
Under 18 years	49.7
70 years or over	4.9
Indigents (aged 18–69)	4.2
SSNIT Pensioners	0.3
SSNIT Contributors	4.5
Informal sector	36.4

Source: NHIA (2011: 17)

Table 2.6: Individual NHIS membership by socio-economic group

Wealth quintile	Insured with valid card (%)	Registered with no valid card (%)
Lowest	28.7	7.9
Second	39.2	9.1
Third	49.4	8.7
Fourth	58.5	5.7
Highest	63.9	6.9

Source: NDPC (2009: 25)

The NHIS provides a generous package of benefits covering 95% of conditions and includes inpatient and outpatient services for general and specialist care, surgical operations, hospital accommodation, prescription drugs, blood products, dental care, maternity care and emergency treatment. Exclusions currently include cancer services–other than cervical and breast cancer–dialysis, organ transplants and appliances, including optical and hearing aids. The government has recently announced, however, that it plans to extend the NHIS to cover cancer services.

Although the NHIS has increased overall access to health care, there are real concerns that it has not been successful in its aim of meeting the health needs of the poorest members of society. A National Development Planning Commission (NDPC 2009) survey undertaken in 2008, for example, found that fewer than 30% of those in the lowest socio-economic quintile were members of the scheme, compared with over 60% of the wealthiest (Table 2.6). The main reason given for not belonging to the scheme was affordability (77%).

The Ghanaian NHIS has been the subject of many international studies, and although some of these have been complimentary, many have been highly critical. Alleged failings have included:

- long delays in provider reimbursement threatening the financial sustainability of hospitals
- accusations of fraud and abuse
- inaccurate record keeping
- 'gaming' by providers
- unclear lines of authority
- long delays in issuing patient registration cards
- duplicate registration of members to avoid payment of missed premiums.

In response to these criticisms, a new NHIA council was appointed in June 2009. Under its stewardship, the Authority is working to introduce an ambitious programme of reforms aimed at increasing membership and improving public confidence in the scheme. Amid concerns about financial sustainability, the Authority is also exploring ways of maximising revenue and containing costs, and is looking at alternative methods of funding the scheme.

Healthcare services are provided by the public sector: mainly by the Ghana Health Service (GHS) and the Christian Health Association of Ghana (CHAG), private for-profit and private not-for-profit organisations, and traditional medicine.

On paper, Ghana has a decentralised, multi-level health system:

- the Ministry of Health (MOH) with responsibility for health policy formation, regulation and strategic direction
- the GHS with responsibility for policy implementation
- regional administrations with responsibility for public health and curative services at the regional level and supervision and management of district level services
- district administrations with responsibility for providing public health and curative services at the district level
- sub-district level administrations with responsibility for the provision of preventative and curative services at health centres and community outreach posts
- community-based health planning and services (CHPS) with responsibility for providing basic preventative and curative services for minor ailments at community and household levels.

In practice, however, local organisations lack autonomy and the majority of decision making is done centrally: responsibility for setting staff establishment levels, appointing clinical and administrative staff and paying salary costs, for example, rests with the government.

Ghana's national health policy, 'Creating Wealth through Health' (MOH 2007) is being executed through a series of HSMTDPs. The latest plan, covering the period 2010–13, identifies poor access to health services and the low quality of services as the most severe problems in the sector. The HSMTDP identified five priorities.

1. Bridge equity gaps in access to healthcare services, ensuring sustainable financing arrangements that protect the poor.
2. Strengthen governance and improve the efficiency and effectiveness of the healthcare system.
3. Improve access to quality maternal, neonatal, child and adolescent healthcare services.
4. Intensify prevention and control of communicable and non-communicable diseases and promote healthy lifestyles.
5. Improve institutional care including mental health service provision.

Annual Programmes of Work (POWs) are developed around these five priorities and used to monitor and review the performance of the healthcare sector.

Ghana faces a double burden of disease. There is high prevalence of communicable diseases, including malaria, HIV/Aids, tuberculosis (TB) and diarrhoea as well as a rising incidence of non-communicable diseases (NCDs), such as cardiovascular disease, cancers, chronic respiratory disease, diabetes mellitus and sickle cell diseases. Each year, over 86,000 Ghanaians are estimated to die from lifestyle diseases with over half of these being under the age of 70.

The MOH has drafted a national policy, focused on prevention and control of the four major NCDs: cardiovascular disease, diabetes, cancers and chronic respiratory disease. The policy covers five key areas: primary prevention; early detection and care; healthcare system strengthening; research and development; and surveillance of NCDs and associated risk factors. Interventions being put in place to address the growth in NCDs include public awareness campaigns, screening programmes, promotion of healthy living and periodic medical checks.

THE MILLENNIUM DEVELOPMENT GOALS

In September 2000, Ghana was one of the 189 member states of the United Nations to sign the Millennium Declaration that pledged to end extreme poverty and deprivation by 2015.

This declaration led to the development of eight specific Millennium Development Goals (MDGs), each of which is linked to a number of targets and indicators (Table 2.7).

Table 2.7: Millennium Development Goals

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria, and other diseases
7. Ensure environmental sustainability
8. Develop a Global Partnership for Development

Source: UNDP (2010)

Three of the MDGs are directly related to health:

- Goal 4 – Reduce child mortality
- Goal 5 – Improve maternal health
- Goal 6 – Combat HIV/AIDS, malaria, and other diseases.

Ghana's national health priorities, as set out in successive Health Service Medium Term National Development Plans (MTDPs), are closely aligned to achievement of these three MDGs as well as the Abuja target of allocating at least 15% of the national budget to health care.

In addition, following concerns about the pace of progress towards achievement of MDG 5, Ghana adopted the Millennium Development Goals Acceleration Framework Country Action Plan (MAF) in 2010. This includes a number of focused, known to work, interventions aimed at redoubling efforts to reduce the maternal mortality rate so as to meet the MDG target of reducing maternal deaths to 185 per 100,000 live births by 2015.

Goal 4: Reduce child mortality

Target: Reduce by two-thirds, between 1990 and 2015, the mortality rate among the under-fives.

Table 2.8: Goal 4 indicators

	2003	2008	MDG 2015 target
Under-five mortality rate (deaths per 1,000 live births)	111	80	53
Infant mortality rate (deaths per 1,000 live births)	64	50	Not specified
Proportion of one-year-old children immunised against measles	83%	90%	100%

Source: UNDP (2010)

The United Nations MDG Progress report on Ghana published in 2010 (UNDP 2010) warns that Ghana was at that time not on track to achieve MDG 4. Although the national under-five mortality rate decreased by 30% from 111 deaths per 1,000 live births in 2003 to 80 deaths per 1,000 live births in 2008 these figures hide significant regional disparities. The under-five mortality rate in Upper West, for example, was nearly double the national average at 142 deaths per 1,000 live births (Table 2.9).

The national rates for infant mortality stood at 57 deaths per 1,000 live births in 1998, increased to 64 deaths per 1,000 live births in 2003 then fell to 50 deaths per 1,000 live births in 2008. This suggests the rate is now in decline, but there are significant regional disparities and the rates in Central, Upper East and Northern, for example, all increased in 2008.

The proportion of children aged 12–23 months immunised against measles increased to 90% in 2008; to stop transmission coverage needs to be over 90%.

The MOH is closely monitoring progress towards this target through three of the five objectives set for the health sector as outlined in the HSMTDP 2010–13 Sector Wide Indicators.

Health objective 1: Bridge equity gaps in access to health care and nutrition services, and ensure sustainable financing arrangements that protect the poor.

Health objective 3: Improve access to quality maternal, neonatal, child and adolescent health services.

Health objective 4: Intensify prevention and control of communicable and non-communicable diseases and promote healthy lifestyles.

Various programmes of work are in place to support these objectives including:

- increasing the number of nurses, midwives and physicians
- improving the ratio of clinical staff to population in rural areas
- reducing under-five malaria fatality rates
- introducing Rotarix vaccine to reduce the incidence of rotavirus diarrhoeal disease in children.

Table 2.9: Under-five mortality rate and infant mortality rate by region

	Under-five mortality (deaths per 1,000 live births)			Infant mortality (deaths per 1,000 live births)		
	1998	2003	2008	1998	2003	2008
Western	109.7	109	65	68	66	51
Central	142.1	90	108	83.8	50	73
Greater Accra	62	75	50	41.4	45	36
Volta	98	113	50	53.8	75	37
Eastern	89.1	95	81	50.2	64	53
Ashanti	78.2	116	80	41.9	80	54
Brong Ahafo	128.7	91	76	77.3	58	37
Northern	171.3	154	137	70.1	69	70
Upper East	155.3	79	78	81.5	33	46
Upper West	155.6	208	142	70.6	105	97
National	108	111	80	57	64	50
Rural	122	118	90	67.5	70	56
Urban	76.8	93	75	42.6	55	49

Source: MOH (2010: 10)

Goal 5: Improve maternal health

Target 5a: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio.

Target 5b: Achieve, by 2015, universal access to reproductive health care.

Table 2.10: Goal 5a Indicators

	2003	2005	2008	MDG 2015 target
Maternal mortality ratio (deaths per 100,000 live births)	Not known	503	451	185
Proportion of births attended by skilled health personnel	43%	Not known	59%	100%

Source: UNDP (2010)

The United Nations MDG Progress Report on Ghana published in 2010 (UNDP 2010) states that Ghana was not then on track to achieve MDG 5. The maternal mortality ratio decreased from 740 per 100,000 live births in 1996 to 451 per 100,000 live births in 2008. On the basis of this trend, the ratio is forecast to be 340 deaths per 100,000 live births in 2015, which is nearly twice the MDG target of 185 per 100,000 live births.

The majority of the deaths reported in 2010 were caused by complications such as haemorrhage (24%), abortion (11%), obstructive labour, hypertensive disorders or infection; problems that could have been treated with skilled care. A key factor in reducing mortality rates, therefore, is improving access to antenatal care and ensuring the presence of a trained nurse, midwife or physician at the birth.

The proportion of women receiving antenatal care from skilled healthcare professionals increased from 82% in 1988 to 95% in 2008 and the number of births attended by skilled healthcare personnel increased from 43% to 59% between 2003 and 2008. The quality of available care in urban areas is, however, significantly better than in rural areas; owing to limited laboratory services, for example, only 60% of pregnant women in the Northern Region have access to urine and blood testing compared with over 90% in urban areas.

Between 2003 and 2008 the proportion of women giving birth in a public sector health facility increased from 36.3% to 48.4% while the proportion giving birth at home decreased from 53.4% to 42%.

Women in the lowest quintile were more likely to give birth at home than those in the higher quintiles (Table 2.11). Reasons for giving birth at home rather than a healthcare facility include: thinking it unnecessary to give birth in a healthcare facility, lack of money, distance to healthcare facility, and having no transport.

The government declared maternal mortality rates to be a national emergency in 2008 and introduced a programme of free maternal health care, which included extending the National Health Insurance Scheme to cover the provision of ante-natal, infant delivery and post-natal care. Other targeted interventions included increasing the number of trained midwives, reviewing the geographical distribution of clinical staff, giving pregnant women tetanus injections and reviewing family planning services.

With around 11% of maternal deaths caused by abortion, the availability and use of contraceptives is a key factor in achievement of the MDGs. The preferred methods of contraception are Depo-Provera (44%), male condoms, (28%) and the combined pill (29%). Over the last few years there have been problems in meeting demand for contraceptives; in 2007, for example, there was a countrywide shortage of spermicide for use with male condoms. The unmet demand for contraceptives in married women stands at 35%.

Steps towards achievement of this MDG are being closely monitored by the MOH through the objectives outlined in the HSMTDP 2010–13, sector-wide Indicators and the priority intervention areas detailed in the MAF.

Table 2.11: Percentage of pregnant women in Ghana who delivered in a health facility, 2003 and 2008

	Public sector facility		Private sector		Home		Other or missing data	
Wealth quintile	2003	2008	2003	2008	2003	2008	2003	2008
Lowest	17.0	22.1	2.4	1.4	79.6	75.7	1.0	0.8
Second	24.1	41.7	6.0	7.0	69.0	50.2	1.0	1.1
Third	32.8	53.5	7.9	8.6	58.5	36.5	0.9	1.4
Fourth	57.3	68.8	15.5	11.3	26.4	19.6	0.8	1.0
Highest	68.0	71.5	21.4	21.2	9.2	6.6	1.4	0.6
Total	36.3	48.4	9.4	8.7	53.4	42.0	1.2	1.0

Source: Schieber et al. (2012: 44, Table 2.5)

Goal 6: Combat HIV/AIDS, malaria and other diseases

Target 6A: To have halted by 2015 and begun to reverse the spread of HIV/AIDS.

Target 6B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it.

Table 2.12: Goal 6 indicators (HIV/AIDS)

	2007	2008	2010	MDG 2015 target
HIV prevalence rate (% of HIV infected adults aged 15–24 years old)	1.9%	Not known	1.5%	≤ 1.5%;
Proportion of 15–24 year olds with comprehensive, correct knowledge of HIV/ Aids	Not known	28% females 34% males	Not known	Not specified
Proportion of population with advanced HIV infection with access to antiretroviral (ARV)	Not known	Not known	35%	Not specified

Sources: Target 6A, Ghana Aids Commission (2012:16, 17); Target 6B, WHO Global Health Repository.

Ghana appears to be on track to achieve MDG 6. HIV prevalence is estimated to have decreased from 2% in 2003 to 1.5% in 2010. Prevalence in pregnant women aged 15–24 has, however, increased slightly from 2% in 2010 to 2.1% in 2011. The total number of adults infected with HIV in 2008 was estimated to be 250,829, of which females accounted for more than half (147,958). Around 15% of those diagnosed with TB are co-infected with HIV.

Interventions under way or planned to fight the spread of the disease and to improve the quality of life of people infected with it include:

- strengthening referrals and collaboration between facilities and communities to increase antiretroviral therapy (ART) uptake and adherence
- providing support to the most-at-risk population (MARP)
- training of over 1,000 healthcare workers from facilities across the country in the management of HIV and AIDS
- monitoring, supervision and supporting sites providing ART services and assessing potential sites for ART accreditation.

Difficulties in tackling the disease include:

- stigma and discrimination against people living with the disease
- gender inequality
- staffing constraints.

Target 6C: To have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.

Table 2.13: Goal 6 indicators (malaria)

	2004	2006	2008	MDG 2015 target
Proportion of children under five sleeping under insecticide-treated bed nets	9.1%	32.3%	40.5%	Not specified
Proportion of households with insecticide-treated nets (ITNs) (pre- or post-treated)	Not specified	Not specified	Not specified	Not specified
Proportion of pregnant women sleeping under insecticide treated bed nets	7.8%	46.3%	30.2%	Not specified

Source: Republic of Ghana (2010: 41)

Table 2.14: Goal 6 indicators (tuberculosis (TB)

	2006	2010	MDG 2015 target
Proportion of tuberculosis cases cured under DOTS (internationally recommended TB control strategy)	50%	70%	Not specified

Source: UNDP (2010)

Malaria is a leading cause of both mortality and morbidity in Ghana, over 60% of hospital admissions of children under the age of five and 8% of hospital admissions of pregnant women are related to malaria. According to a report published by the Department for International Development (DFID 2011) there were an estimated 3.2 million cases of malaria in 2008 of which 900,000 cases related to children under the age of five. As the disease particularly affects pregnant women and children, interventions, such as promoting chemoprophylaxis for pregnant women and the use of ITNs, are often targeted at these groups.

It is estimated that, in 2008, around one-third of households owned at least one net and that the proportion of children and pregnant women sleeping under an ITN stood at 40.5% and 30.2% respectively (Table 2.13). A target has been set of achieving universal coverage of ITNs by 2015 with 80% of the population sleeping under a net. There are many challenges in achieving this target, however, including stock outs, distribution problems and cultural barriers.

Difficulties in tackling the disease include:

- poor waste disposal and drainage systems, resulting in stagnant waters
- limited diagnostic laboratory facilities; fewer than 14% of malaria diagnoses are laboratory based
- funding gaps
- lack of public confidence in first-line treatment drugs
- gaps in prescribing knowledge of health workers
- poor maintenance of ITNs
- public misconceptions.

Ghana has achieved 100% Directly Observed Treatment Scheme (DOTS) coverage. TB notification rates stood at 61 cases per 100,000 population in 2008, a slight increase on the 2004 rate of 57 cases per 100,000. The treatment success rate has improved from 50% in 2006 to 70% in 2010 (Table 2.14).

THE CHALLENGES FACING HEALTH SERVICE PROVISION IN GHANA

The mission statement of the Ghanaian MOH is to promote 'health and vitality through access to quality health for all people living in Ghana using motivated personnel'.

Achieving this ambitious goal will be a challenge. In addition to significant disparities of service between north and south and between rich and poor, factors such as cultural and religious beliefs, poor physical infrastructure and limited resources all work to hamper the provision of equitable healthcare services, creating challenges for planners and policymakers.

SERVICE DISPARITIES BETWEEN THE NORTH AND SOUTH

In Ghana there has long been a north-south divide with those in the Northern, Upper East and Upper West regions (an area containing around 17% of the population and covering around 40% of Ghana's land mass) having significantly less than those in the south. Fewer than 50% of the people in the three northern regions have access to electric power supplies, for example, compared with 72% nationally.

When compared with those in the south, the people living in the Northern, Upper East and Upper West regions have very limited access to secondary healthcare facilities but are somewhat better served by community services (Table 2.15). Perhaps as a reflection of the inequitable spread of facilities, the northern regions are also poorly served in the number of clinical staff with, for example, just 90 medical officers covering the whole region (Table 2.16).

Table 2.15: Distribution of healthcare facilities by region

	Ashanti	Brong Ahafo	Central	Eastern	Greater Accra	Northern	Upper Eeast	Upper West	Volta	Western	Total
Population	4,780,380	2,310,983	2,201,863	2,633,154	4,010,054	2,479,461	1,046,545	702,110	2,118,252	2,376,021	24,658,823
% population by region	19.4	9.4	8.9	10.7	16.3	10.1	4.2	2.8	8.6	9.6	100
Teaching hospitals	1	0	0	0	1	1	0	0	0	0	3
Regional hospitals	0	1	1	1	1	1	1	1	1	1	9
Psychiatric hospitals	0	0	1	0	2	0	0	0	0	0	3
Hospitals	92	26	22	25	97	17	5	8	27	24	3,43[1]
Poly clinics	0	1	0	0	7	0	0	0	1	2	11
Health centres and clinics	345	186	166	255	299	178	81	81	224	268	2,083
Maternity homes–private	106	46	34	47	55	8	2	6	24	61	389
Community Health Planning and Services	4	8	43	44	4	95	55	39	19	65	379
Total health facilities	548	268	267	372	466	300	144	135	296	421	3,217

1. Of which 156 are private hospitals
Source: MOH 2010: 14

Table 2.16: Distribution of healthcare professionals by region

	Ashanti	Brong Ahafo	Central	Eastern	Greater Accra	Northern	Upper Eeast	Upper West	Volta	Western	Total
Population	4,780,380	2,310,983	2,201,863	2,633,154	4,010,054	2,479,461	1,046,545	702,110	2,118,252	2,376,021	24,658,823
% population by region (2010)	19.4	9.4	8.9	10.7	16.3	10.1	4.2	2.8	8.6	9.6	100
Medical officers	499	106	76	140	820	38	34	18	72	77	1,880
Dental surgeons	7	2	0	3	13	0	0	0	2	4	31
Pharmacists	322	92	47	90	304	60	47	33	61	73	1,129
Medical assistants	85	50	38	47	70	59	34	15	29	37	464
Professional nurses	1,604	764	740	1,009	2,624	714	459	346	827	688	9,775
Auxiliary nurses	731	474	644	1,031	1,350	509	403	251	797	667	6,857

Source: MOH 2010: 16

SERVICE DISPARITIES BETWEEN RICH AND POOR

The introduction of the NHIS was intended to eradicate inequities of service provision between rich and poor but, to date, it has not achieved this aim. In a survey undertaken to assess access to health care for people from different socio-economic groups, the poorest members of society were found to be more likely to self-treat than to visit a hospital (Table 2.17).

There are also significant differences between the poorest and wealthiest members of the population in both the under-five mortality rate and the number of births attended by skilled health personnel. The under-five mortality rate for the poorest quintile of society, for example, was 102 deaths per 1,000 live births compared with just 60 per 1,000 live births for the wealthiest quintile (Table 2.18).

Table 2.17: Service disparities between rich and poor

	1991/92			1998/99			2005/06		
Facility	Poor	Non-poor	All	Poor	Non-poor	All	Poor	Non-poor	All
Hospital	13.7	22.6	18.6	8.6	18.7	15.0	12.2	21.5	19.5
Pharmacy	1.7	5.0	3.5	1.4	3.9	3.0	22.7	20.3	20.8
Other	26.8	27.3	27.1	26.9	25.2	25.8	19.6	19.6	19.6
Did not consult	57.8	45.1	50.8	63.2	52.2	56.2	45.6	38.6	40.1

Source: Schieber et al. (2012: 41)

Table 2.18: Inequities of care

	Rural	Urban	Poorest 20%	Wealthiest 20%
Under-five mortality rate (per 1,000 live births)	90	75	102	60
Births attended by skilled health personnel	43	84	24	95
DTP3 immunisation (1-year-olds)	91	87	89	93

Source: WHO 2012

CULTURAL AND RELIGIOUS BELIEFS

There are many ingrained cultural and religious practices traditionally undertaken by Ghanian groups and tribes that have an adverse impact on health, including the early marriages of females, polygamy, female genital mutilation and the elaborate 'cleansing' of widows (whereby a widow must have sexual intercourse with a stranger to 'purify' herself). Some of these practices are against the law, but they continue to be practised in more rural areas. Research undertaken by Action Aid, for example, found that half the girls aged under 15 years in Bawku Municipality had undergone female genital mutilation, a dangerous practice that can cause pelvic infection from the use of unsterilised instruments and scar tissue that can cause prolonged and obstructed labour.

Early marriage is also common in some parts of the country. Although the legal age for girls to marry is 18, nearly 6% of girls between the ages of 12–17 are married.

These practices are often related to gender discrimination. If women have the same rights to education, employment and health care as men they are better empowered to make decisions and to stand up for their rights. Ghana's achievements in this respect are measured against the third MDG: To Promote Gender Equality and the Empowerment of Women. Although Ghana appears to be on track to achieve gender parity at both primary and junior high school, female representation in parliament currently stands at just 27 out of a total of 275 places.

MISCONCEPTIONS AROUND MENTAL HEALTH

Mental health services in Ghana are severely under-resourced; the country has just 12 practising psychiatrists and only three psychiatric hospitals. There are many misconceptions about mental illness, for example that children of staff employed in the field of mental health often become affected by mental illness, and this tends to discourage clinical staff from specialising in mental health.

Owing to resource constraints and the stigma attached to mental illness, the majority of the population suffering with psychiatric conditions are not treated with modern medicine; instead, they are sent to spiritual churches or prayer camps where they are sometimes severely mistreated. Mental health patients may also be kept in police custody for long periods without treatment. If patients are released from care, then the stigma attached to them from their disease makes their reintegration into the community difficult.

Reforms are now under way following the passing of the Mental Health Law in May 2012. The law promotes a community, rather than institutionalised, approach to care and makes provision for funding. The bill incorporates the spiritualist and prayer camp facilities, which currently cater for 70% of patients with mental illness, into the healthcare system; this will help ensure that they are properly regulated.

Plans are now being put in place to expand services, possibly by adding psychiatric units to larger hospitals. Discussions are also taken place about increasing the number of specialist staff, though before this can happen steps will have to be taken to remove the stigma associated with such roles.

STAFF SHORTAGES

Ghana suffers from a chronic shortage of health workers as well as inequities in both the distribution and skills mix of workers, and this severely restricts access to services and hampers achievement of national health objectives. The country has just over 11 doctors, nurses and midwives per 10,000 population, less than half the number (23 per 10,000) deemed necessary by the WHO for achievement of the health MDGs (Table 2.19).

Table 2.19: Average health workforce in Ghana compared with regional average (per 10,000 population)

	Ghana	Regional average
Physicians	0.9	2.2
Nurses and midwives	10.5	9.0
Total	11.4	11.2

Source: WHO (2012)

Rural areas, in comparison with urban areas, are particularly poorly served as regards access to health care; in 2009, for example, there was one doctor for every 5,103 people in Greater Accra, compared with one doctor for every 50,751 people in Northern Region (Table 2.20). The government has introduced a number of schemes to try to address this problem including the Deprived Area Incentive Scheme, which offered an additional allowance of 20–35% of basic salary, though this has since been discontinued; the Health Staff Vehicle Hire Purchase Scheme; and various housing schemes, but none has proved particularly successful.

Table 2.20: Population per doctor by region

	2008	2009
Ashanti	9,537	8,288
Brong Ahafo	21,475	16,919
Central	26,140	22,877
Eastern	17,571	16,132
Greater Accra	4,959	5,103
Northern	68,817	50,751
Upper East	33,475	35,010
Upper West	43,988	47,932
Volta	27,959	26,538
Western	31,745	33,187
National	12,713	11,929

Source: IOM (2011)

Some of the many reasons physicians give for preferring employment in urban areas is that rural facilities:

- lack career development opportunities (no opportunity to specialise, seek mentoring support, obtain study leave)
- offer limited promotional opportunities
- have long working hours with a heavier workload
- lead to professional isolation
- present difficulties in referring patients who are often not prepared to travel
- require physicians to be 'jacks of all trades', leading to concerns about quality of care
- provide no opportunities to supplement income through locum work
- do not have adequate local housing stock
- suffer from delays in receipt of insurance payments, which adversely affect supplies
- have inadequate infrastructure/ broken equipment.

More successful incentives to address shortage of doctors in rural areas, therefore, might be accelerated career advancement, contracts offering fixed terms of service, CPD opportunities and improved access to the internet.

In an effort to introduce equal pay for equal work, all public sector staff (which includes healthcare workers) are being transferred to a single-spine pay scale over a five-year period beginning in January 2010. The move is expected to enhance the salaries of many staff and, as a result, to reduce the number of staff migrating overseas, though it will not help redistribute doctors to more remote areas of the country. The cost of the pay reforms has been estimated at GH¢6 billion in the first 30 months of implementation. The government hopes that part of this cost will be offset by the introduction of public sector performance measures aimed at increasing productivity.

ENVIRONMENTAL AND OTHER FACTORS

As acknowledged by Ghana's National Health Policy, 'Creating Wealth through Health' (MOH 2007), many of the key determinants of health are outside the direct scope of the healthcare sector, as the following examples illustrate.

- There is often poor access to safe water and sanitation. According to a study published by the Water and Sanitation Program (2012), 16m Ghanaians use unsanitary or shared latrines and 4.8m have no access to latrines and so defecate in the open.
- Malnutrition is thought to be the cause of around 45% of all deaths in children beyond infancy.
- There is a lack of education, particularly among females. Levels of literacy have increased significantly since the census in 2000 and in 2010 literacy rates for those aged 11 years or more stood at 80.2% for males and 68.5% for females. There are, however, huge regional variations and in three regions literacy rates are less than 50%.
- Climate variability and change threaten food security.
- There is overpopulation of urban areas.

Other key factors include poor road networks, an old and obsolete electricity system leading to frequent disruptions in power supply, and the rapid rate of urbanisation leading to the growth of urban slums, increases in numbers of street children, and sanitation problems.

LEKMA HOSPITAL

Lekma hospital, which opened on 21 December 2010, is a multi-purpose hospital serving the residents of Teshie and surrounding districts, one of the most deprived and densely populated areas of Accra. Serving a population of 1 million people, the hospital has 100 beds and is clinically staffed by three specialist physicians, four junior doctors and 140 nurses.

In addition to carrying out general medical care, the hospital will carry out research into eradicating malaria, a leading cause of child mortality. The hospital also has a department providing Chinese medical services.

Since it opened the hospital has been plagued with problems and has been constantly in the news.

Initially, there was a serious problem accessing water supplies for drinking and cleaning purposes. The hospital building was funded by a grant from the Chinese and executed by the China Geo-Engineering Corporation. This introduced a critical plumbing problem, as the Chinese-sourced water pipes in the hospital were not compatible with the Ghanaian pipework. The issue was compounded by the acute water shortage in Tetshie. Liberty Mutual Health, a private health insurer whose clients use the hospital, has since donated two water tanks to resolve the problem.

More recently, long waiting times in the outpatient department have caused episodic instances of threatening behaviour by patients towards medical personnel, and this problem has necessitated increased hospital security.

Other problems identified in a meeting held in February 2013 between the Teshie Concerned Citizens Association (TCCA) and the outgoing health minister, Mr Alban Bagbin included:

- poor mortuary facilities
- the lack of good toilet facilities
- the unavailability of mosquito nets
- bad road network
- insufficient clinical staff
- lack of local accommodation for clinical staff
- problems with the water and electricity supplies.

An NHIS-accredited organisation, the hospital receives around 60% of its funding from the NHIS and the balance from 'cash and carry' services (patients without insurance cover).

The hospital is reimbursed a fixed tariff, based on Ghana Diagnosis Related Groups (G-DRGs), for each service it provides. There is currently no cap on the number of claims that may be made in any particular period and this places much stress on the health financing system.

Payments from the NHIS are generally delayed for three months or more, which creates serious cash flow problems for the hospital; in mid-September, for example, payments had been received only for care provided to the end of May. Delayed hospital reimbursements are a nationwide problem that is being slowly addressed by the NHIA. A claim-processing centre was opened in 2010 charged with reducing turnaround time to 60 days. Initially the centre dealt only with selected facilities, including the three teaching hospitals, but its area of operation is slowly being extended to cover all hospitals.

The payments received from the NHIS and patients are to cover basic supplies, equipment and the cost of drugs; responsibility for all staff-related expenditure rests with the government. This creates a lack of autonomy that can create challenges for hospital administrators. For example:

- clinical staff may be appointed centrally to a healthcare facility that lacks the essential medical equipment needed to treat patients
- administrators cannot manage the performance of staff or introduce local disciplinary or incentive schemes
- there is no ability to recruit staff with particular areas of skill or clinical expertise
- there is no potential for adjusting staffing levels to match fluctuating demand for services.

Hospitals are permitted to retain any profit or surplus they make for reinvestment. This may be used to employ casual staff, to cover bad debts from patients unable to pay, or to purchase additional supplies and equipment.

The Minister of Health has promised to address some of the many problems afflicting Lekma Hospital immediately but it is difficult to see how the problems can be resolved when service provision is restricted by centrally imposed constraints on staff numbers and when there are no powers for making decisions locally.

3. Roundtable discussion 1: How close is Ghana to achieving the Millennium Development Goals related to health?

As we have seen, in September 2000, Ghana was one of the 189 member states of the United Nations to sign the Millennium Declaration designed to improve social and economic conditions in the world's poorest countries by 2015. The declaration led to the development of eight Millennium Development Goals (MDGs) of which five are indirectly linked and three are directly linked to health. Achievement of these goals is a precondition for upgrading Ghana to a middle-income country by 2015.

Ghana's progress towards achievement of the MDGs is difficult to assess owing to large gaps in data. The latest review by the United Nations Development Programme (UNDP 2010), however, reported that, for the MDGs indirectly linked to health, Ghana was expected to achieve MDGs 1 and 2, potentially to achieve MDG 8, and to achieve MDGs 3 and 7 partially. For the three directly health-related MDGs, Ghana could potentially achieve MDG 6 but was not expected to achieve MDG 4 or 5 by 2015 (Table 3.1).

The target for MDG 4 is to reduce child mortality rate from 122 per 1,000 births in 1990 to 53 per 1,000 births in 2015. Although the rate has been slowly reducing over time, the latest data (from 2008) suggest that nationally the rate is still high, at 80 per 1,000 births. The fall in death rates was higher in rural areas (from 122 deaths per 1,000 births in 1998 to 90 deaths per 1,000 births in 2008) than in urban areas (from 77 deaths per 1,000 births to 75 deaths per 1,000 births). The UNDP review stated that Ghana would not attain MDG 4 without the scaling up of interventions targeted at improving child health.

Two of the prime causes of mortality in Ghanaian children under five years are pneumonia, a vaccine-preventable disease which accounted for 13% of deaths in 2010, and diarrhoea, which accounted for 7% of deaths in 2010, according to the WHO. In May 2012, the government introduced two new vaccines (Pneumonias I & Retrovirus) into the National Immunization Programme with the aim of preventing both diseases. These are expected to make a significant contribution towards reducing the child mortality rate and achievement of MDG4.

Ghana's achievement of MDG 5 was also deemed unlikely by the UNDP review (UNDP 2010). The target is to reduce the maternal mortality ratio by three-quarters between 1990 and 2015, from 740 deaths per 100,000 live births to 185 deaths per 100,000 live births. The latest data (from 2008) gave the rate as 451 deaths per 100,000 live births, which suggests that it is unlikely that Ghana will achieve the 2015 target.

The government has since declared maternal mortality rates to be a national emergency and has instigated a number of targeted interventions.

Better progress has been made towards achievement of MDG 6. Annual deaths from HIV/AIDS fell from 18,396 in 2007 to 17,244 in 2008.

At the health conference, the minister said that accountants had a key part to play in supporting Ghana's achievement of the MDGs. He said data are often aggregated from numerous sources so that the final figure is not meaningful, making it impossible to measure progress towards goals, and that this lack of knowledge, combined with limited understanding of the true cost of care, made it difficult to ensure that interventions were appropriately targeted. The minister said that accountants must start to take a more proactive role in the achievement of these goals.

Table 3.1: Ghana's progress towards attainment of the Millennium Development Goals by 2015

Goal	Expected to attain MDG by 2015
Eradicate extreme poverty and hunger	Yes
Achieve universal primary education	Yes
Promote gender equality and empower women	Partial achievement only
Reduce child mortality	Unlikely to be achieved
Improve maternal health	Unlikely to be achieved
Combat HIV/AIDS, malaria, and other diseases	Potentially achievable
Ensure environmental sustainability	Partial achievement only
Develop a Global Partnership for Development	Potentially achievable (shared responsibility between developing and developed countries)

Source: UNDP (2010)

4. Roundtable discussion 2: Is the National Health Insurance Scheme delivering?

Implemented in 2005, the NHIS was established 'to provide financial access to quality basic health care for residents in Ghana through mutual and private insurance schemes'.

Since then, the system has often been held up as an example of good practice and the country has received study visits from a number of countries and international organisations, including South Africa, Bangladesh, Democratic Republic of Congo and the United Nations.

In addition to receiving praise, however, the scheme has come under much criticism for not addressing the needs of the most deprived members of the population, for inaccurate data reporting, for being overly bureaucratic, for the cost of administering the scheme and for being inefficient, as outlined in a recent report by OXFAM (2011). At the time, much of this criticism was probably valid. The methodology for counting the number of members of the scheme, for example, involved much double counting so that reported membership was nearly twice actual membership (Table 3.2).

It was also difficult for many of the poorer members of society, those working in the informal sector, to join the scheme. Potential members had to visit an NHIS office, which may have been some distance from their home, complete the joining form and then submit that with two photographs, the registration fee and the annual premium of between GH¢72,000 to GH¢480,000 fee (depending on socio-economic status). The form would then be sent off to the head administrative office for checking. Once the application was approved–which took about two months–the patient would be sent a card via the local NHIS office entitling them to basic medical care for a year without further charge. At any one time, it was estimated that, around 10% of registered members were waiting to receive their membership card so were unable to obtain treatment.

The government's response to the criticism was to appoint a new NHIA council in 2009 and to charge it with restoring public confidence in the NHIS.

Has this new council managed to succeed where the previous one failed? Delegates at the conference said that there were numerous demands on and expectations of the NHIA and NHIS but that many of these were unrealistic. They said that achievement could only be measured against defined objectives.

The NHIA has three corporate goals:

- to attain a financially sustainable health insurance scheme
- to achieve universal financial access to basic health care
- to secure stakeholder satisfaction.

Delegates agreed that consideration of these would be the most appropriate way of gauging whether or not the NHIS was succeeding.

Table 3.2: Membership trends of NHIS

	2010	2011
Old methodology	14,157,708	17,518,744
New methodology	8,163,714	8,227,823*

*Provisional figure
Source: NHIA (2011: 16)

TO ATTAIN A FINANCIALLY SUSTAINABLE HEALTH INSURANCE SCHEME

The Ghanaian health system, like others around the world, is facing ever-increasing cost pressures. These, compounded by system inefficiencies and financial leakages, have placed the financial sustainability of the NHIS, in its current form, at risk. The NHIA has reported deficits since 2010; the balance sheet is in the red.

The NHIS has five main sources of funding: a 2.5% National Health Insurance (VAT) levy, a 2.5% SSNIT deduction from workers in the formal sector, premiums paid by workers in the informal sector, government funds and returns from investments. Although the scheme is funded in part by member premiums, therefore, the level of income is not directly related to the number enrolled; the major source of funding, around 70%, comes from the VAT levy, making the NHIS effectively a tax-funded scheme (Table 3.3).

Cost pressures on the scheme are many but include the following factors.

- Patient demand is increasing. Between 2005 and 2011, for example, outpatient visits increased from around 598,000 to 25,486,000 and inpatient admissions from nearly 29,000 to 1,452,000 (Table 3.4).
- The scheme has expanded to cover a wider range of diseases. The government has recently announced, for example, that it plans to extend the scheme to cover all cancers, not just breast and cervical cancers as at present.
- There is growth in non-communicable diseases, which are generally more costly to treat than contagious and infectious ailments.
- Meeting the needs of a growing population is challenging. By 2030 the population of Ghana is expected to increase by nearly 40%.
- There is no effective gatekeeper system.
- There are delays to patients in accessing care till the later stages of disease when treatment costs are higher.
- There are escalating claims costs from health care providers.

The National Health Insurance Authority is now identifying and implementing strategies aimed at containing the costs of the scheme and increasing revenue. Two main areas of focus are: reviewing primary care services and reducing financial leakages.

Table 3.3: NHIS revenue for the year ending 31 December 2011

	% of NHIF income	GH¢ (millions)
National Health Insurance (VAT) Levies	73	449.96
SSNIT Contribution	17	107.61
Investment income	5	31.87
Premiums paid by informal workers	4	27.66
Sundry income	0	0.57
Total	100	617.67

Source: NHIA (2011: 41)

Table 3.4: Service use in 2011 compared with 2005

	2005	2011
Members	Not known	8,227,823
In-patient provision (number of admissions)	28,906	1,451,596
Outpatient provision (number of visits)	597,859	25,486,081
Claims payments (GH¢ millions)	7.6	549.77

Source: NHIA (2011:19, 20, 21)

Reviewing primary care services

The NHIA piloted a capitation payment system for primary care providers in Ashanti during 2011. This proved successful and plans are now under way for a countrywide roll out.

In support of this change, nationwide enrolment in preferred primary care provider has also been introduced. This is expected to result in a number of benefits including:

- helping to contain costs by addressing the issue of patients visiting more than one provider to obtain treatment for the same illness
- helping to improve quality as patients will be able to choose providers, which will introduce an element of competition
- simplifying and speeding up the payments process.

Reducing financial leakages

Like all insurance schemes, the NHIS has been subject to various financial leakages. These have included:

- patient contributions that have not reached the scheme
- invalid claims by providers
- abuse of the free maternal care programme
- non-compliance with gatekeeper procedures.

The NHIA is actively working to address each of these to minimise future losses from the scheme.

To address the issue of missing premiums, for example, patient contributions from across the country are now all being deposited in a consolidated premium account. This will help ensure premiums are properly accounted for and that income is used efficiently, and it will simplify the monitoring and reporting processes.

The problem caused by providers who submit duplicate or invalid claims is being addressed through the introduction of electronic claims processing (which started in November 2012); in addition, the scaling up of clinical audit and the introduction of 'mystery shoppers' will help identify inefficiencies and system abuse.

Free maternal care was introduced in July 2008 with the aim of supporting achievement of MDG 4 and MDG 5. The programme was subject to much abuse, however, so in 2010 the guidelines were revised to require pregnant women to register with the scheme before accessing services. This change has helped eliminate misuse of the programme.

Finally, non-compliance with gatekeeper procedures is being addressed through the introduction of nationwide enrolment in one's preferred primary care provider.

TO ACHIEVE UNIVERSAL FINANCIAL ACCESS TO BASIC HEALTH CARE

The NHIS was introduced to make free health care available to all, but particularly the poor and disadvantaged. At present, however, the scheme has not achieved this aim; only 29% of the poorest members of society are members compared with over 64% of the wealthiest.

The poorest members of the population are exempt from paying the annual premium but, owing in part to difficulties in identifying indigents, such people are often not enrolled in the scheme. Others, who may be on low incomes but are not classified as poor, may find the annual premiums unaffordable, may have difficulty in accessing the local NHIS office or may just forget to renew their registration. In the longer term the government hopes to address these issues by moving away from annual payments to a 'one-time premium payment'. This is expected to broaden coverage of the scheme and to reduce bureaucracy. Although the affordability of this proposal has been strongly questioned, the government believes it to be possible because member contributions comprise such a small proportion of NHSIA income. The government has yet to announce an implementation date.

In the meantime, the NHIA has set itself the objective of increasing active scheme membership to 60% of the total population and to 70% of the vulnerable population by 2014. This is being implemented through the organisation of special registration exercises and through targeted communication campaigns.

TO SECURE STAKEHOLDER SATISFACTION

Apart from the government, the main stakeholders of the NHIA are health providers and patients.

For providers, the main cause of complaint has been the long delays in processing of claims. The authority is working to address this through the establishment of a number of ultra-modern claims processing centres. The first, located in Accra, is already operational and three more centres will be opened during 2013. These are expected to reduce turnaround time to 60 days.

In addition, the authority will be piloting electronic claims during 2013; this is expected to reduce processing time further.

The Authority is also planning a number of consultation and review meetings with stakeholders throughout the year. A meeting is being organised, for example, to discuss the results of the capitation pilot in the Ashanti Region and plans for rolling this out across the country.

For patients, one of the main causes of complaint is bureaucracy; this is a particular problem for those employed in the informal sector, who often have to wait two months or more after registering to receive their membership card giving them access to services. During 2013, however, the NHIA is planning to introduce biometric identity cards; these will be issued instantly at the point of registration, giving patients faster access to services.

Nonetheless, overall patient satisfaction with the NHIS is high. In the 2008 citizens' assessment survey of the NHIS, 82% of insured members reported being either very satisfied or satisfied with the scheme; satisfaction levels extended across all socio-economic levels Table 3.5).

During 2013, the NHIA plans to build on these satisfaction levels by issuing a subscribers' handbook that sets out the many benefits of the scheme and explains the obligations of subscribers. The booklet will be made available on registration or membership renewal.

To summarise, it appears that the NHIA is actively introducing a series of targeted initiatives designed to support achievement of its three corporate goals. Many of the criticisms identified in the OXFAM (2011) report have been addressed, including the allegations of data inaccuracies and financial leakages. The members of the new authority have high ambitions for the scheme and are now ploughing ahead with further reforms that will overhaul payment procedures, speed up member registration and tighten up financial controls. There are still two outstanding areas of concern that must be addressed before the scheme can be viewed as a success: financial sustainability and low membership among the poor. Solving these problems will be essential for meeting the government's target for universal health care coverage that is free at the point of use.

Table 3.5: Overall level of satisfaction with the performance of NHIS

Socio-economic group	Very satisfied	Satisfied	Indifferent	Dissatisfied	Very dissatisfied
Lowest 20%	25.5	56.0	8.1	9.7	0.6
Next 20%	35.9	51.2	5.0	7.4	0.5
Next 20%	30.0	58.1	3.3	7.7	0.9
Next 20%	24.6	55.0	5.6	12.7	2.1
Upper 20%	24.7	49.9	7.7	16.5	1.1
Total	27.9	53.9	6.0	11.1	1.1

Source: NDPC (2009: 53)

5. Roundtable discussion 3: How collaborative technology can be used to improve the provision of health care

Information communication technology (ICT) has the potential to transform the provision of health care in Ghana. It can:

- improve access to care
- improve the quality of care
- reduce the cost of care.

In Ghana the NHIA appears to be taking the lead in embracing the opportunities offered by technology to transform service provision. The Authority's plan to introduce biometric scheme membership cards, for example, will reduce patient waiting times, while the opening up of dedicated claims-processing centres will speed up the payment to providers, so reducing hospital cash flow problems. The authority is now planning to pilot e-claims, which, if successful, will further speed up processing times.

Technology can also be used to improve the quality of health care. The WHO, for example, is working with government agencies and manufacturers around the world on a trial that aims to identify counterfeit drugs using SMS text messaging. In Ghana, according to a report by the International Policy Network (2009), fake drugs are a serious health threat with nearly half the drugs sold being substandard. As part of the trial, a database is being created of pharmaceutical products, and packets of medication are being assigned an encrypted code (batch number, expiry date and one-off code) hidden under a scratch panel. Clinicians and patients can then use SMS messaging to check if a packet of drugs is counterfeit. After removing the scratch panel, the unique one-off code is revealed and can be sent by SMS to a server, which then sends back an instant message stating if the drug is real or fake.

Another use for technology is in reducing costs and making more efficient use of resources. There have been allegations, for example, of public sector workers remaining on payrolls even though they have left the country. The fraudulent payments have occurred owing to the use of unsophisticated management information systems and limited internal control systems. The introduction of biometric registration of public sector workers will help address this problem by identifying ghost names on the payroll. Removing these will reduce the overall payroll bill thereby making more health resources available for health care.

Delegates at the conference identified many other uses for technology, including monitoring outbreaks of disease; recording and transmitting a patient's vital signs; appointment booking; conducting tele-consultations; and providing training and support to healthcare professionals, particularly those in rural locations. They said that the full benefits of ICT could not be realised, however, until the necessary infrastructure is in place. It was noted, for example, that bandwidth was often a restricting factor. Issues such as this are now, however, being addressed and, as more people gain access to the internet and become computer literate, the full benefits of ICT will be realised.

6. Roundtable discussion 4: The role of the accountancy profession in healthcare delivery

'ACCA members' top priority must be to use money wisely and accountably so as to ensure delivery of the best value for money.'

MARK MILLAR, INTERIM CHIEF EXECUTIVE MILTON KEYNES NHS FOUNDATION TRUST, ENGLAND AND ACCA COUNCIL MEMBER

The government of Ghana has set itself the challenging target of providing everyone with health care that is free at the point of use in return for payment of a single 'one-off' premium.

This is an extremely ambitious goal and is one that has tested some of the most highly developed countries around the world. Achieving this goal will require policy formation, funding, institutional development, investment in infrastructure, ICT expertise and the commitment and support of staff. It will be a challenge and will take time to set up but, if successful, the Ghanaian government will have a healthcare system of which it can be truly proud.

Accountants, with their professional expertise, have a key part to play in meeting this target, including:

- providing information to support decision making
- ensuring the most effective use of funds (that they achieve value for money)
- introducing controls to identify and eliminate any leakages in the system.

PROVIDING INFORMATION TO SUPPORT DECISION MAKING

Whether funded through taxation, insurance schemes, 'out of pocket' payments by patients, charitable donations or a combination of these, health care budgets worldwide are being strained by the need to fund new drugs and by technological advances, changing disease patterns, ageing populations and the ever-increasing demands and expectations of patients.

In Ghana, the health budget is significantly under resourced and is heavily dependent on discretionary donor funding that is often ring-fenced for a specific project. This makes the establishment of an equitable, patient-centred healthcare service particularly challenging. Accountants, working in partnership with clinicians, can help address this challenge by optimising the provision of health care within available funds.

There are numerous questions, including those below, that need answering before decisions can be taken on how and where resources can be most appropriately invested to give best value for money.

- Are the health facilities appropriate and sufficient to meet the needs of each area? If there are insufficient health centres then patients will self-refer to hospitals, where care costs more.
- How are funds currently invested, in primary and community care or more costly secondary care?
- How much does an episode of care cost in each health facility and how does this compare, in terms of cost and quality, with other providers?
- Are resources invested mainly in preventative care, in health promotion, or in curative care? Preventative care is less costly but prevalence of disease often requires significant investment in curative care.
- Is funding targeted at national health priorities, including achievement of the three MDGs related to health?

The minister said that it is the responsibility of accountants to provide such information and that, in doing so, they will play a key part in helping the MOH meet its objective of ensuring a more efficient and effective use of resources.

ENSURING THE MOST EFFECTIVE USE OF FUNDS (TO OBTAIN VALUE FOR MONEY)

The minister reminded delegates that Ghana began instigating a programme of healthcare reforms in the 1990s and that since then, numerous, mostly donor-driven, health campaigns had been implemented. He noted, however, that there was little information available to show which of these campaigns had produced the best value for money and should therefore be prioritised, and which should be abandoned.

As an example, the minister described how each year the health service invested heavily in services targeted at preventing malaria but that it was not known which intervention–ITNs, spraying mosquito breeding grounds or drugs–was the best value for money. He said that the government is looking to accountants to provide such information.

Another example given by the minister was the question of whether the health service should invest in 2x4 or 4x4 ambulances for transporting patients in rural areas; the cost of a 2x4 vehicle is lower but is more likely to get stuck in the mud when rushing a patient to hospital.

The minister said that the health service lacks the data needed for informed decision making such as this and that it is the responsibility of accountants to provide it.

The health minister said that as well as gaining a better understanding of programmes of care, another key task for accountants, working in partnership with clinicians, was developing knowledge of how each healthcare facility operates, including its local demographics, the types and levels of service it provides, and the number of patients treated. This will help enhance the quality of health care provision by, for example, ensuring appropriate stock levels of consumables, and will also help to contain costs by eliminating waste from out-of-date stocks.

He said that, without this data, the MOH will not be able to achieve its objective of providing a more equitable quality healthcare service to the population of Ghana.

INTRODUCING CONTROLS TO HELP IDENTIFY AND ELIMINATE ANY LEAKAGES IN THE SYSTEM

In addition to providing information for resource allocation and performance monitoring, accountants have a critical role to play in ensuring sound financial management; poorly defined or non-existent control systems, limited auditing and minimal management reporting make it difficult to identify and eradicate financial leakages.

The Ghanaian healthcare system has been the target of both large-scale corruption and so-called 'quiet corruption', which has been defined by the World Bank as 'the failure of public servants to effectively deliver goods and services previously paid for by the government or donors'. An example of quiet corruption is the allegation that some individuals, who are listed on the government's healthcare payroll and receive a monthly salary from the government, do not turn up for work and may not even reside in Ghana. Although this is corruption on a small scale it negatively affects patient services as it suggests clinical staffing numbers are higher than they actually are. Payroll fraud, such as this, is one issue the government hopes to eradicate with the introduction of the single pay spine.

The NHIA has also been the subject of a number of frauds, particularly in relation to the financing of unnecessary services. As a result of the past issues related to alleged corruption, governance and accountability, the NHIA has scaled up its clinical audit processes and is taking a tough line on deception. In January 2013, for example, four NHIA officials were dismissed after inflated payments had been made to the Bruham clinic.

Delegates at the conference agreed that accountants, with their professional expertise, have a key role in ensuring sound financial management by:

- introducing improved governance procedures
- strengthening operational procedures
- ensuring that robust systems of financial reporting are in place
- improving financial transparency through faster reporting
- instilling confidence in the system.

'Those working in the health sector must demonstrate high levels of transparency, accountability and responsibility in the management of financial resources. ACCA as a professional body will continue to promote these values and will hold to account any member who violates them.'

MARK MILLAR, INTERIM CHIEF EXECUTIVE MILTON KEYNES NHS FOUNDATION TRUST, ENGLAND AND ACCA COUNCIL MEMBER

7. Conclusion

Improving the health of the population is essential if Ghana is to achieve its aim of becoming a middle-income country by 2015.

Over the next few years the pace of change will be relentless: there are plans to roll out capitation payments to all providers of primary care; the electronic processing of claims is being extended countrywide; free-of-charge care available to NHIS members is being broadened to include all cancer services and the NHIA is aiming to achieve a near doubling of NHIS membership from 33% to 60% of the population.

This is a challenging agenda for any government, but is particularly ambitious for a country with such a high burden of disease, undeveloped infrastructure and lack of resources.

Professionally qualified ACCA accountants have a key role in supporting fulfilment of this health agenda. It is not enough for them to be simple 'number crunchers': they must ensure sound financial management and continually offer support to the decision-making process through the provision of relevant, timely and accurate information.

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