POLICY BRIEF

Strategic Health Purchasing in Ghana

A Summary of Progress, Challenges, and Opportunities

MAY 2021

STRATEGIC HEALTH PURCHASING FOR UNIVERSAL HEALTH COVERAGE IN SUB-SAHARAN AFRICA

The Strategic Purchasing Africa Resource Center (SPARC), a resource hub hosted by Amref Health Africa with technical support from Results for Development (R4D), aims to generate evidence and strengthen strategic health purchasing in sub-Saharan Africa to enable better use of health resources. SPARC and its technical partners created a framework for tracking progress in strategic health purchasing and are applying it in countries across sub-Saharan Africa to facilitate dialogue on what drives progress and to promote regional learning.

GHANA AT A GLANCE

- Population (2019): **30.4 million**
- GDP per capita (2019): **US$2,202**
- Poverty headcount at $1.90/day (2016): **13%**
- Life expectancy (2018): **64 years**
- Current health expenditure (CHE) per capita (2018): **US$78**
- Domestic government expenditure as % of CHE (2018): **39%**
- Out-of-pocket expenditure as % of CHE (2018): **37%**
- External expenditure as % of CHE (2018): **12%**

Source: World Bank Databank

Health Financing Schemes in Ghana

Ghana is a lower-middle-income country that has committed to improving the health of its people and achieving universal health coverage (UHC) in the Medium Term Development Plan 2018–2021. The Medium Term Expenditure Framework 2018–2021 (MTEF) prioritizes strengthening implementation of the country's social protection and inclusion program. This includes strengthening the National Health Insurance Scheme (NHIS) and making it sustainable, increasing government expenditure for health and increasing the proportion of total health expenditure from domestic sources, co-financing HIV/AIDS and immunization programs, and addressing the sustainability of public health commodities as Ghana transitions to middle-income status.

Ghana has three main types of health financing schemes:

- **NATIONAL HEALTH INSURANCE SCHEME (NHIS).** This contributory scheme provides health insurance coverage for the labor force, including formal- and informal-sector workers. The NHIS is financed through a combination of an earmarked portion of the value-added tax, known as the National Health Insurance Levy (NHIL), a portion of the social insurance contribution of formal-sector workers, and premium payments for non-exempt subscribers. The premium is subsidized through the NHIL for exempt populations—people over age 70, people under age 18, beneficiaries of the Livelihood Empowerment Program Against Poverty (LEAP), pregnant women, and indigent people. The scheme is managed by the National Health Insurance Authority (NHIA). Although the NHIS is a contributory scheme, more than 60% of beneficiaries are exempt from paying a premium.
- **GOVERNMENT BUDGET FINANCING.** The Government of Ghana makes an annual allocation to the health sector from government revenue based on the MTEF. These funds are used for input-based financing, mostly for priority programs and health worker salaries.
- **PRIVATE INSURANCE.** Ghana has a small private insurance sector, including private for-profit insurance companies and community-based insurance schemes.

Health sector projects funded by external donors focus on priorities such as HIV/AIDS, malaria, tuberculosis, maternal and newborn health, and reproductive services.

Table 1 compares the purchasing functions of the main health financing schemes.

Table 1. **Purchasing Functions in Ghana's Health Financing Schemes**

	National Health Insurance Scheme (NHIS)	Government Budget Financing	Private Insurance
% of Total Health Expenditure (2015/16)*	52%		1%
Main Purchaser(s)	National Health Insurance Authority (NHIA)	Ministry of Health (MOH)	Private insurance companies
Governance	NHIS and its governing body, the NHIA, were established by the NHIS Act of 2003 (Act 650). The Act was revised into the NHIS Act of 2012 (Act 852). The NHIA reports to MOH through a board whose members are appointed by the President and that includes a wide range of institutional representation. The Ministry of Finance (MOF) collects the NHIL and remits it to NHIA, and NHIA also collects contributions directly from contributing members. Providers have some financial autonomy over internally generated revenue (IGR) from user fees and payments from NHIA.	MOH is led by a minister who is supported by departmental heads that provide policy direction, and the Ghana Health Service (GHS) is responsible for public health facilities. The Health Facility Regulatory Agency (HEFRA) provides governance for service quality and is responsible for licensing and inspecting all providers. MOF allocates resources, with reference to MTEF, to MOH, national medical stores, and local governments. Public facilities receive budgets for operation and maintenance and develop plans and budgets. Public facilities have limited financial autonomy over budget funds.	Private insurance companies were established under the Insurance Act 2008 and are also governed by Act 852. NHIA has supervisory authority over private health insurance. Each company has a board of directors and is led by executive management. Private insurers collect contributions and have financial and managerial autonomy. Providers have financial autonomy over revenue from private insurers.
Financial Management	Budgets are set by NHIA management based on membership and projected revenue. Overruns occur when claims exceed revenues or when MOF transfers to NHIA are delayed. Overruns are covered from previous surpluses or supplemental allocations by MOF when the reserve fund has been depleted.	The annual budget appropriation process is led by MOF and is based on the MTEF and historical allocations. Budget overruns occur and are financed through supplementary budgets.	Budgets are set by management based on membership and projected revenue. Budget overruns occur when claims exceed premiums collected; they are declared as losses and may be covered by profits from the insurance company's other lines of business.
Benefits Specification	A benefit package was set by Act 852 and consists of some preventive care but mostly curative care at primary, secondary, and tertiary facilities. MOH defines the approved medicines list and standard treatment guidelines.	The government offers some program-specific packages for preventive, promotive, and curative health services, such as the Community-based Health Planning and Services (CHPS) program, Newborn Care Program, Reproductive Health Program, and Adolescent Health and Development Program. MOH also has an explicit essential medicines list.	Explicit benefit packages vary by insurance plan and typically include primary and hospital care, with exclusions.
Contracting Arrangements	HEFRA licensing is a prerequisite for NHIA credentialing and contracting with health facilities. All public facilities are included. NHIA does selective contracting with private facilities. GHS signs contracts on behalf of public facilities. Christian Health Association of Ghana (CHAG) signs contracts on behalf of faith-based health facilities. Other private providers, including for-profit providers, sign contracts directly with NHIA when they are credentialed.	Loose agreements are in place for input financing of public facilities. A memorandum of understanding with CHAG governs input-based financing of faith-based health facilities.	HEFRA licensing is a prerequisite for contracting with health facilities. Companies use selective contracting with public and private facilities.
Provider Payment	Ghana Diagnosis-Related Group (G-DRG) payment for most outpatient and inpatient services, and fee-for-service payment for medicines and unbundled services	Input-based budgets for salaries and other line items	Fee-for-service
Performance Monitoring	MOH quality framework is used for joint MOH-NHIA monitoring of service provision. HEFRA licensing and annual credentialing by NHIA apply. NHIA conducts ad hoc clinical audits. "Mystery client" surveys and client feedback forms are also used.	Monthly facility activity reporting on DHIS2; MOH quality framework is used for joint MOH-NHIA monitoring of service provision.	Clinical audits of claims data are used.

** 2015 Global Health Expenditure Database*

Progress and Challenges in Strategic Health Purchasing

Ghana has made significant strides toward strategic purchasing, particularly through the NHIS. The establishment of the NHIS created the opportunity to reduce fragmentation by merging community-based health financing schemes under the NHIS. Government budget financing has also been used to augment the NHIS by channeling financing to inputs and covering preventive, promotive, and curative services that are not fully covered under the NHIS. The NHIS has a defined legislated benefit package, which lists entitlements for the population and uses output-based provider payment methods. Performance monitoring is partially automated and includes multiple mechanisms for provider-level and system-level performance monitoring.

Highlights of progress and remaining challenges in each of the purchasing functions are described below.

GOVERNANCE. Institutional roles and responsibilities for purchasing are clear, and health facilities have some degree of financial autonomy to respond to purchasing incentives. The NHIS was established by the NHIS Act of 2003 (Act 650), which was revised into the NHIS Act of 2012 (Act 852). These two acts detail governance, membership, the benefit package, and all rights and obligations of the NHIA and its beneficiaries. The NHIA has a board appointed by Ghana's president and is managed by a chief executive officer and a management team. The Ghana Health Service (GHS) is responsible for public health facilities. The Health Facility Regulatory Agency (HEFRA) inspects and licenses all providers. There are some overlaps and duplication in HEFRA and NHIA inspection and monitoring of health facilities, which wastes resources, but discussions are ongoing to improve the situation.

FINANCIAL MANAGEMENT. A defined process is used to set the purchaser's budget, and mechanisms exist for tracking budget execution and spending in the NHIS and budget financing, but budget overruns occur. These overruns are managed through a reserve fund for the NHIS and additional allocations in supplementary budgets. The NHIS has recorded deficits since 2012 and has run out of surplus to meet budget overruns through the reserve fund, which threatens its sustainability. This results in delayed payment to providers and accrued debts over years. Providers charge NHIS beneficiaries informal payments because of these delays in payment. The NHIS is addressing the causes of the overruns, which include both delays in transfers from the MOF and open-ended provider payment systems.

BENEFITS SPECIFICATION. The NHIS benefit package is specified in legislation and is estimated to cover 95% of the disease burden in Ghana. Clinical guidelines defined by the MOH are used as service delivery standards, and the NHIS enforces these guidelines through contracting. The MOH defines the drugs covered in the NHIS benefit package. The schemes lack a systematic process for reviewing the benefit package, however. A health technology assessment process is under consideration to help ensure that purchasing decisions prioritize health needs.

CONTRACTING ARRANGEMENTS. The NHIS contracts with all public providers and selectively with private providers based on accreditation criteria and defined quality standards. Licensing by HEFRA is a prerequisite for contracting by the NHIS and private insurance companies. The NHIS contracts with provider associations, including Ghana Health Service for public facilities and Christian Health Association of Ghana for faith-based facilities. This improves the efficiency of the contracting process because the NHIS does not need to sign individual contracts with each health facility. NHIS contracts specify the services to be offered, medicines, service guidelines, quality requirements, the contract time frame, tariffs and provider payment, and penalties for not meeting contractual obligations. For example, claims for treatment or readmission for the same condition within three days are rejected by the NHIA. The MOH is also testing Preferred Primary Provider Networks (PPPNs) to improve efficiency and quality of health care. Under the PPPN system, NHIS beneficiaries select a primary care provider to access services for six months. The PPPN is the contracting unit with NHIS and is responsible for managing beneficiaries and has access to their medical records to improve quality of care. The PPPN system incentivizes providers to improve quality of care in order to maintain their existing beneficiaries and potentially attract new ones.

PROVIDER PAYMENT. The NHIS and private insurance schemes use output-based payment, while the government budget uses input-based payment. The NHIS pays providers using Ghana Diagnosis-Related Groups (G-DRGs) and fee-for-service. The NHIS uses differential tariffs for different providers. Public facilities receive subsidies through the government budget financing, so their tariffs are lower than those of private facilities. G-DRGs and fee-for-service are not well harmonized, and these open-ended payment systems have increased claims payments to unsustainable levels, threatening the financial viability of the scheme.

PERFORMANCE MONITORING. Provider-level and system-level performance monitoring is partially automated, and performance monitoring informs purchasing decisions by the NHIS. The NHIA uses a number of performance monitoring systems: annual credentialing and contracting, claims vetting, clinical audits, joint MOH monitoring, mystery client surveys, and a call center to take member complaints and suggestions, with follow-up for whistleblower complaints. Stringent claims vetting is estimated to have saved the scheme as much as GHc5 million (US$943,396) in 2019. The NHIA has also introduced electronic claims systems to facilitate claims vetting. This will save the NHIS funds and deter providers from submitting fraudulent claims.

Table 2 summarizes progress made in strategic purchasing functions along the dimensions of progress defined by SPARC for the main health financing schemes in Ghana. (See the annex for a detailed explanation of how the levels of progress are indicated using ○, ●●, and ●●●.)

Table 2. **Progress Made Across Purchasing Functions in Ghana**

Purchasing Function	Indicators of Strategic Purchasing	National Health Insurance Scheme (NHIS)	Government Budget Financing	Private Insurance
Governance	Purchasing functions have an institutional home that has a clear mandate and allocation of functions.	●●●	●●	●●●
	Providers have autonomy in managerial and financial decision-making and are held accountable.	●●	●●	●●
Financial Management	Purchasing arrangements incorporate mechanisms to ensure budgetary control.	●●	●●	●●
Benefits Specification	A benefit package is specified and aligned with purchasing arrangements.	●●	●●	●●
	The purchasing agency further defines service delivery standards when contracting with providers.	●●●	●●	●●●
Contracting Arrangements	Contracts are in place and are used to achieve objectives.	●●●	●●	●●
	Selective contracting specifies service quality standards.	●●●	●●	●●●
Provider Payment	Provider payment systems are linked to health system objectives.	●●	○	●●
	Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.	●●	○	●●
Performance Monitoring	Monitoring information is generated and used at the provider level.	●●	○	○
	Information and analysis are used for system-level monitoring and purchasing decisions.	●●●	○	●●

To enhance the progress made so far, Ghana would need to overcome a number of weaknesses. The NHIA's purchasing power could be strengthened through consolidation of out-of-pocket funding and government sources. The release of NHIL funds collected by the MOF on behalf of the NHIA is often delayed due to political interference and government bureaucracy. This impedes the NHIA's ability to pay providers on time and threatens access to services and the financial sustainability of the NHIS. It also leads to providers justifying informal charges to beneficiaries and discourages new and renewing enrollments. The financial sustainability of the NHIS is also threatened by the open-ended provider payment systems, especially unchecked fee-for-service payments for medicines, which have led to persistent deficits and several bailouts of the NHIS by the MOF.

Opportunities to Improve Health Purchasing

Ghana is one of the few African exemplars in strategic purchasing. Over time, NHIS membership has grown and Ghana has made improvements, particularly in benefits specification, contracting, and performance monitoring. Many lessons from Ghana can be learned by other African countries in these areas, but more needs to be done to make progress toward UHC. For example, NHIS membership remains at about 40% of the population, and growth in claims has outstripped revenue collected, which threatens the financial viability of the scheme.

To further progress, Ghana may consider strengthening the role of the NHIA as the strategic purchaser by making better use of provider payment to achieve service delivery objectives and financial sustainability. For example, G-DRGs do not bundle services adequately, resulting in a long list of services and tariffs that are cumbersome to manage and are nearly equivalent to fee-for-service payment. A better balance is needed between the level of bundling (to create better incentives for efficiency and quality through a payment system that is easier to manage at the health facility and NHIA levels) and minimizing the burden of auditing and verification of claims. Capitation payment has been piloted in Ghana, with mixed results, and the reintroduction of capitation is under discussion. Ghana may consider blended payment methods to minimize the unintended incentives and consequences of individual payment mechanisms.

At the MOH level, better alignment of health policies can allow the NHIA to implement critical strategic purchasing policies such as a referral system for gatekeeping, quality policies, and a focus on priority interventions. The NHIA could implement appropriate information systems and tools to build the expertise and capacity needed. Automated processes such as e-claims may streamline processes such as the vetting of claims and thereby save time and resources.

The MOF may evaluate and revise its financial management processes to ensure prompt release of funds to the NHIA and thereby facilitate prompt provider reimbursements. Improved financial management may help the NHIA better forecast revenue and claims and manage revenues to facilitate payment to health facilities and enable timely payment to providers.

Finally, empowering NHIS beneficiaries can help enforce the stewardship role of the NHIA and health facilities in the use of resources. The NHIA could provide incentives for reporting provider behavior that deviates from regulations, especially in quality of care and informal charges. Beneficiaries can be included in governance to enforce purchaser accountability and explicit patients' rights legislation, including an explicit benefit package.

SPARC and the technical partners view strategic purchasing as a way to improve resource allocation, provide coherent incentives to providers, and improve accountability for health resources. As next steps, SPARC's partner in Ghana—Kwame Nkrumah University of Science and Technology—will validate the SPARC findings with Ghanaian stakeholders and determine appropriate actions to make further progress in strategic purchasing as a way to achieve UHC in Ghana.

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STRATEGIC PURCHASING AFRICA RESOURCE CENTER

RESULTS FOR DEVELOPMENT

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Annex. **Strategic Purchasing Progress Indicators**

Governance	**Purchasing functions have an institutional home that has a clear mandate and allocation of functions.**	○	An agency or agencies have responsibility for carrying out one or more purchasing functions, but mandates are not clearly defined and capacity is weak.
		●●	An agency or agencies have responsibility for carrying out most or all purchasing functions and capacity is improving, but some overlaps and gaps in responsibilities remain. Mechanisms are in place for stakeholder engagement.
		●●●	An agency or agencies have responsibility for carrying out all purchasing functions, capacity is strong, and there are no overlaps or gaps in responsibilities. There is inclusive and meaningful stakeholder engagement.
	Providers have autonomy in managerial and financial decision-making and are held accountable.	○	Public providers have no autonomy or extremely limited autonomy to carry out financial and managerial functions, and they have limited ability to respond to financial incentives created by provider payment systems.
		●●	Public providers are given a larger degree of financial and managerial autonomy, but accountability mechanisms are weak.
		●●●	Public providers are given a large degree of financial and managerial autonomy, and accountability mechanisms are effective.
Financial Management	**Purchasing arrangements incorporate mechanisms to ensure budgetary control.**	○	A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending, but these mechanisms are not well enforced.
		●●	A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending. These mechanisms are enforced, but budget overruns routinely occur.
		●●●	A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending. These mechanisms are enforced, and budget overruns rarely occur.
Benefits Specification	**A benefit package is specified and aligned with purchasing arrangements.**	○	A benefit or service package is defined and reflects health priorities, but it is not well specified, is not a commitment, and/or is not aligned with purchasing mechanisms.
		●●	A benefit or service package is defined, reflects health priorities, and is a commitment, but it is not well specified and/or not aligned with purchasing mechanisms.
		●●●	A benefit or service package is defined, reflects health priorities, is a commitment, is well specified, and is aligned with purchasing mechanisms, and a transparent process for revision is specified.
	The purchasing agency further defines service delivery standards when contracting with providers.	○	The purchaser defines some general standards for delivering services in the package (e.g., for gatekeeping), but enforcement through contracts is weak.
		●●	The purchaser defines some general service delivery standards and some specific service delivery standards (e.g., number of prenatal care visits) that are enforced through contracts.
		●●●	The purchaser defines general service delivery standards and specific service delivery standards in line with national service delivery policies and clinical protocols, and service delivery standards are enforced through contracts.
Contracting Arrangements	**Contracts are in place and are used to achieve objectives.**	○	Loose agreements are in place between the purchaser and public providers for specified services in exchange for payment instead of or in addition to input-based budgets. Formal agreements may be in place with some private providers.
		●●	Formal agreements are in place between the purchaser and public providers for specified services in exchange for payment or in addition to input-based budgets. Formal agreements may be in place with some private providers.
		●●●	Formal agreements are in place between the purchaser and public and private providers to help achieve specific objectives, and they are linked to performance.
	Selective contracting specifies service quality standards.	○	The purchaser has loose, nonselective agreements or contracts with all public providers and selective contracts with some private providers based on some definition of quality standards.
		●●	The purchaser contracts at least somewhat selectively with public and private providers based on accreditation or some other definition of quality standards.
		●●●	The purchaser contracts selectively with public and private providers based on uniformly applied quality standards.
Provider Payment	**Provider payment systems are linked to health system objectives.**	○	Some output-based payment is used.
		●●	Output-based payment is used, and payment systems are linked to specific service delivery objectives.
		●●●	Output-based payment is used and is linked to specific service delivery objectives; payment systems are harmonized across levels of care, and they allow purchaser budget management.
	Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.	○	Provider payment rates are determined based only on the purchaser's available budget.
		●●	Provider payment rates are determined based on the purchaser's available budget and at least one other factor (e.g., cost information, priorities, or negotiation with providers).
		●●●	Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.
Performance Monitoring	**Monitoring information is generated and used at the provider level.**	○	Some form of monitoring happens at the health provider level (e.g., supportive supervision visits, monthly activity reporting, claims audits, quality audits).
		●●	Provider-level monitoring is at least partially automated and is used for purchasing decisions.
		●●●	Provider-level information is automated, fed back to providers, and used for purchasing decisions.
	Information and analysis are used for system-level monitoring and purchasing decisions.	○	Some form of analysis is carried out at the system level (e.g., service utilization, medicines prescribed, total claims by service type).
		●●	System-level analysis is automated and carried out routinely.
		●●●	Information and analysis are used for system-level monitoring and purchasing decisions.