HEALTH DIALOGUE

Case Study
Maternal and Child Health in Ghana

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Abbreviations

BMC	budget management centre
CABRI	Collaborative Africa Budget Reform Initiative
CHAG	Christian Health Association of Ghana
CHC	community health compound
CHO	community health officer
CHPS	community-based health planning and services
DHA	district health administration
DHMT	district health management team
DHS	Demographic Health Survey
GHS	Ghana Health Service
GoG	Government of Ghana
HIPC	heavily indebted poor country
HIRD	High Impact Rapid Delivery
IGF	internally generated fund
IMCI	Integrated Management of Childhood Illness
MCH	maternal and child health
MDBS	multi-donor budget support
MDG	Millennium Development Goal
MMR	maternal mortality ratio
MoFEP	Ministry of Finance and Economic Planning
MoH	Ministry of Health
NHIF	National Health Insurance Fund
NHIS	National Health Insurance Scheme
OECD	Organisation for Economic Co-operation and Development
RHA	regional health administration
RHMT	regional health management team
SBS	sector budget support
USAID	United States Agency for International Development
U5MR	under-five mortality rate

Preface

This case study was developed for use in the CABRI Dialogue on Health. The team supporting the dialogue is led by John Kruger. Other team members are: Orvill Adams (health expert), Ramlatu Attah (case study researcher) and Clara Picanyol (case study researcher). Tim Ensor and Alex Matheson provide guidance and quality assurance.

The aim of the case studies developed for the seminar is not to present a research report but to allow participants to apply the approaches, concepts, frameworks and tools presented in the main papers to real-life situations. The purpose of the case studies is to present a real-life problem to the participants for them to address and work through, using the information presented in the case study, the knowledge from the seminar presentation and their experience.

This case study was developed through an initial desk review of documentation and a country visit to interview the personnel involved in the policy design and implementation of the health sector in Ghana.

The author[1] would like to thank all who made themselves available to provide information and share their thoughts for the case study. The author is particularly thankful to Emmanuel Adjorlolo for his support throughout the mission. A list of all interviewees can be found in Appendix A.

Responsibility for errors in interpretation or facts remains with the author.

1 Ramlatu Attah

1. Introduction

While Ghana has been seen as exemplifying the challenges facing the health sector in Africa (Horton 2001), it has also been at the forefront of implementing a range of reforms with the aim of improving service delivery in the sector. These reforms include: integration of programmes and co-ordination of donor funding; decentralisation of service delivery; introduction of new financing mechanisms, primarily pooled funding through the National Health Insurance Fund (NHIF); and extensive public financial management reform.

Ghana, therefore, provides concrete examples of various reform strategies for improving performance and service delivery, and the opportunity to explore the link between these measures and the level and efficiency of service delivery in a specific service area, namely maternal and child health (MCH).

The focus on MCH is motivated partly by the international and policy prominence of this area. Millennium Development Goals (MDGs) 5 and 4 call for a 75% and 66% reduction in the maternal mortality rate (MMR) and under-five mortality rate (U5MR) respectively between 1990 and 2015. MCH remains an indicator of the African health challenge: the risk of dying due to maternal health causes is about 881 per 100 000 live births in sub-Saharan African countries, compared to only 16 per 100 000 live births in Organisation for Economic Co-operation and Development (OECD) countries. Similarly, the U5MR stands at 144 per 1 000 live births in sub-Saharan Africa and 6 per 1 000 in OECD countries (UNDP 2010).

In addition, MCH is seen as an area that is a good barometer of health system strength (or weakness). It has been remarked that:

> maternal mortality is a window into the overall strength of a country's health system…A pregnancy can test nearly all aspects of a health system: preventive care, counselling, surgery, drug administration, follow-up care, and emergency treatment. The number of women dying from maternal causes has historically shown that too many countries' health systems were failing that test. (IHME 2010)

In the case of Ghana, the area of MCH is of special interest because, after acknowledgement of significant improvements up to around 2000, commentators have pointed to progress stagnating, or at least slowing down, despite extensive health sector reform and a focus on planning and financing.

In the next section, some key characteristics of the Ghana health system and of MCH provision in Ghana are described. Thereafter, the case study turns to a description of selected reforms. The fourth section discusses issues related to the reforms, as raised in the literature and by stakeholders interviewed during the case study fieldwork. Finally, questions for discussion are identified. The discussion of issues and questions is intended to focus on identifying positive aspects and potential shortcomings of the reforms as they relate to MCH.

2. Delivering maternal and child health in Ghana

2.1 Structure and financing of the health sector in Ghana

2.1.1 Key responsibilities

In Ghana, the Ministry of Health (MoH) is responsible for policy formulation, regulation, co-ordination, resource mobilisation, financing and monitoring and evaluation. Services are provided by the Ghana Health Service (GHS), the Christian Health Association of Ghana (CHAG), teaching hospitals and private providers. GHS is the main service provider in the public sector and is responsible for managing service delivery and developing implementation guidelines for the regions and districts.

In addition to this 'split' between the purchaser (the MoH) and the providers, health service delivery in Ghana is decentralised. Regional health management teams (RHMTs) provide co-ordination and assistance to districts in developing and carrying out district implementation plans. They also mediate communications between the national and district levels. At the district level, district health management teams (DHMTs) have been created to plan and implement health care service delivery. DHMTs have the authority to mobilise additional funds from donors. Financial management is handled by budget management centres (BMCs) at the district level (GSS, GHS & Macro International 2009).

2.1.2 Health financing

Although health spending as a proportion of GDP has declined slightly in recent years (see Table 2.1), allocations have been in close proximity to the Abuja Declaration target of 15% of government expenditure on health. The health sector received 14.4% of the total national budget in 2009 (MoH 2010).

Table 2.1: Nominal medium-term expenditure framework (MTEF) allocations to the health sector, 2006–2009

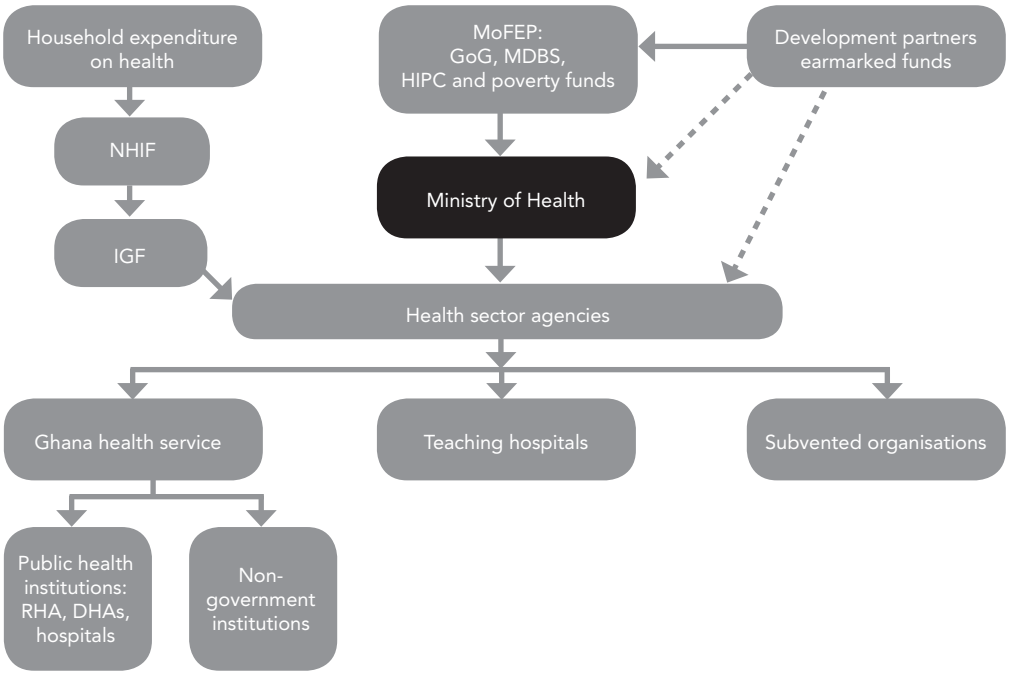
	2006 (GH¢ '000)	2007 (GH¢ '000)	2008 (GH¢ '000)	2009 (GH¢ '000)
MTEF – Health	478 655	563 756	752 233	921 929
MTEF – Total	2 948 398	3 869 832	5 059 868	6 446 157
Percentage allocated to health	16.2%	14.6%	14.9%	14.4%

Source: MoH (2010)

There are four broad sources of funding to the health sector:

- the government of Ghana (GoG) budget;
- development partner funding (both grant and loan);
- the National Health Insurance Scheme (NHIS), the main component of internally generated funds; and
- user fees.

Figure 2.1: Financing sources for the health sector in Ghana



Source: Bempah (2007)

Key

direct flow of funds

agency flow of funds

Quantifying the various sources of health care financing in Ghana is complicated by the fragmentation of budget at the national and sector levels; it is hampered further by the significant levels of off-budget funding in the health sector (MoH 2009a). With that said, in 2009, the National Health Insurance Fund (NHIF) was estimated to be the main contributor to the health sector budget, accounting for 37% of the health sector resource envelope (MoH 2010). The second largest contributor was the government, at 35%. Donor funds, which assist the sector through sector budget support (SBS) represented a little over a fifth (21%) of the total resource envelope.

Table 2.2: Allocation of MoH budget by source and economic classification, 2009

	GoG (GH¢ '000)	Donor SBS (GH¢ '000)	NHIF (GH¢ '000)	Donor EM (GH¢ '000)	User fees (GH¢ '000)	Total (GH¢ '000)
Personnel emoluments	278 991	-	10 320	-	10 583	299 894
Administration	11 119	123	13 490	-	17 777	42 509
Services	11 974	49 837	287 220	102 271	-	451 302
Investment	7 000	5 500	10 620	24 547	24 547	72 214
Total	309 084	55 460	321 650	126 818	52 907	865 919

Source: MoH (2010)

Table 2.3: 'Services' funding by function and source, 2009

	GoG (GH¢ '000)	Donor SBS (GH¢ '000)	HIPC (GH¢ '000)	NHIF (GH¢ '000)	User fees (GH¢ '000)	Donor EM (GH¢ '000)	Total (GH¢ '000)
Maternal and child health	600	21 150	-	-	-	30 273	52 023
Communicable diseases	460	4 657	-	-	-	63 698	68 815
Non-communicable diseases	750	2 420	-	-	-	-	3 170
Public financial management	195	910	-	-	-	-	1 105
Health sector strengthening	809	2 020	-	-	-	1 536	4 365
Operational cost	9 160	18 670	-	287 220	-	6 770	321 820
Total	11 974	49 827	-	287 220	-	102 277	451 298

Source: MoH (2010)

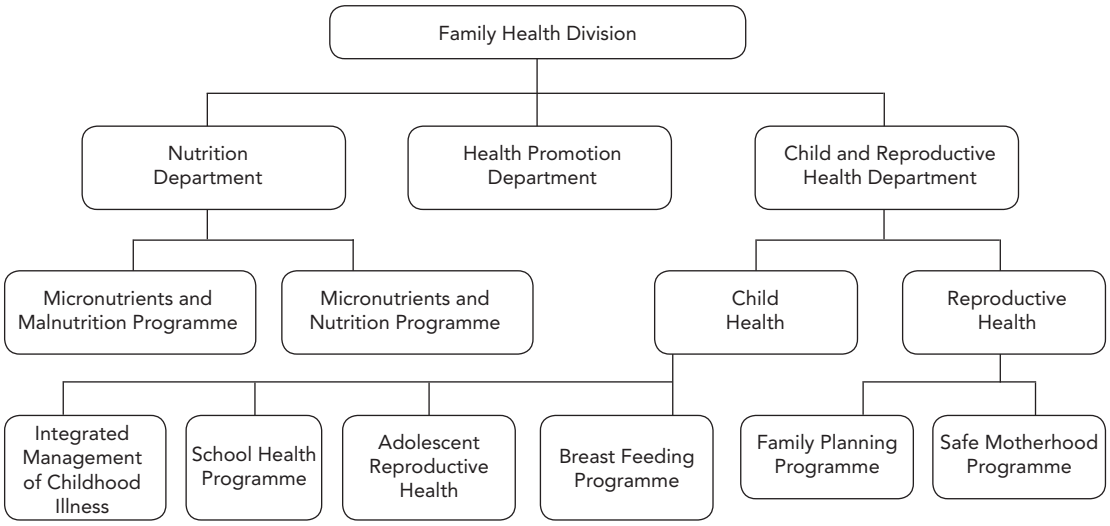
2.2 Structures for MCH in Ghana

2.2.1 Institutional framework for MCH

The Family Health Division of the GHS is responsible for maternal, child health, and family planning and sexual health activities. The division co-ordinates the implementation of reproductive and child health activities at the national level, and is made up of three main departments – Reproductive and Child Health; Nutrition; and Health Promotion – each of which has programme officers assisted by other health personnel. The division works with the regional health directorates, which are headed by regional directors of health services.

Each regional directorate has a family health unit, which sees to the implementation of reproductive and child health activities. The district directorates have structures similar to those of the regions. The districts report to the regions, and the regions send reports to the national level. At the national level, the Family Health Division works with other units and directorates under the GHS.

Figure 2.2: Organogram of the family health division of the GHS



Source: GHS (2009)

2.2.2 MCH programmes in Ghana

Two separate policy or strategy documents, one for maternal (reproductive and sexual health) and one for child health, specify the services to be delivered in this regard in Ghana. Annual reports from the reproductive and child health unit contain a more limited list of services rendered than those included in the broader policy documents (listing safe motherhood and infant health, family planning, STI/HIV/AIDS-prevention and management, post-abortion care, and prevention and management of cancers of the reproductive system), and UNFPA (2006) concludes that at the district level a much narrower package, focusing only on the first three on the list, is being delivered in reality.

In addition to the core activities, the following programmes have been instituted recently to accelerate improvements in MCH (GSS et al. 2009):

- *Regenerative Lifestyle and Nutrition Programme*. This programme focuses on non-communicable diseases, such as obesity and hypertension, and MCH. It identifies, trains and supports change agents at the community level to communicate healthy lifestyle messages to promote services and health-seeking behaviour.
- *High Impact Rapid Delivery (HIRD)*. The HIRD programme promotes high-priority, cost-effective interventions to improve MCH at the district level. This programme provides specific funding for service delivery, with the aim of increasing the focus on and funding of reproductive and child health services by DHMTs (MOH 2009b).
- *Community-based Health Planning and Services (CHPS)*. CHPS is a strategy that aims to increase access to MCH services. CHPS refers to a specific process for moving health services into underserved areas through community mobilisation. The first step to adopting CHPS in a district is to achieve buy-in by traditional community leaders and begin the planning process. Communities must support and actively participate in the initiative. Community leaders and volunteers co-operate to mobilise resources and labour to construct a simple health facility known as a community health compound (CHC), consisting of space for a clinic and living quarters for a health care provider. CHCs are staffed by community health officers (CHOs), who are nurses trained specifically for this role. Once the CHC is ready, a CHO is posted to the community. CHO responsibilities include clinical sessions at the CHC, household visits for family-planning services, health education and ambulatory care, and outreach services for immunisation. Community support for the CHC is organised in the form of a community health committee and community health aides who work with the CHO on a volunteer basis.

2.2.3 Financing maternal and child health in Ghana

Table 2.4 shows the identifiable allocation for MCH activities by source of funding and the activity funded. In 2009, a total of 52 million Ghana cedis in earmarked funding (EM) was allocated for MCH activities. A few points are worth highlighting.

First, the relative importance of earmarked funds for MCH activities is notable. This review was unable to reach a consensus on the implications of high earmarked funds for the sector. On the one hand, earmarked funding ensures that MCH activities appropriately remain a priority in district plans. However, a drawback of earmarked funds is that they are linked to donor priorities and frequently fail to be connected to the planning and activity schedules of regional and district staff. In particular, earmarked funding is said to flow sporadically to various programmes throughout the year, which constrains planning and implementation of priority programmes.

Second, funds from donors through SBS represent a 40% contribution to the MCH budget. This is set against the background of the entire sector, in which SBS is regaining prominence over earmarked funds. In 2009, donors contributed GH¢108.6 million to the health sector, out of which 37.2 million (34%) was earmarked for specific MoH programmes. This was lower than in 2008, when almost half of the on-budget donor contributions (48%) were earmarked, the major part (71%) being contributions by the Global Fund.

Table 2.4: Identifiable budget allocations to MCH by source, 2009

	GOG (GH¢ '000)	Donor SBS (GH¢ '000)	HIPC (GH¢ '000)	NHIF (GH¢ '000)	User fees (GH¢ '000)	Donor EM (GH¢ '000)	Total (GH¢ '000)
Contraceptives	400	2 500	-	-	-	1 103	4 003
Free Maternal Delivery Initiative	-	10 000	-	-	-	-	10 000
MDG5 task force	-	50	-	-	-	-	50
Vaccines	-	2 000	-	-	-	7 078	9 078
ITNs	-	1 600	-	-	-	11 747	13 347
Supplementary feeding programmes	200	-	-	-	-	1 802	2 002
MCH campaign	-	5 000	-	-	-	7 581	12 581
Total	600	21 150	-	-	-	29 311	51 061

Source: MoH (2009b)

2.2.4 MCH services and evidence on outcomes

A 2008 United States Agency for International Development (USAID) report on MCH in Ghana refers to 'little improvements in health outcomes in Ghana over the past 10 years…despite significant donor resources' (USAID 2008). This is related to 'limited services reaching the community and household level' and 'to the quality of MCH services'.

Other assessments such as the Maternal and Neonatal Program Effort Index (MNPI), however, point to a higher level of services than in other countries. Ghana scores a total of 65 on a composite index against an average of 56 for 50 countries assessed. The index focuses on characteristics like service capacity of health facilities, access to services, care received, family planning and policy and support functions (USAID 2006).

Table 2.5: Recent estimates of trends in maternal and under-5 mortality in Ghana

	1980	1990	2000	2010
Maternal mortality per 1 000 live births	731	549	538	409
Under-5 mortality per 1 000	149:4	122:2	98:6	77:5

Note: Under-5 mortality is the probability of death between birth and the age of five years

Source: Hogan et al. (2010); Rajaratnam et al. (2010)

Recent analysis by the Institute for Health Metrics and Evaluation (IHME) notes uncertainty intervals for data, but suggests a resumption of stronger progress from 2000, after a period of stagnation, especially in improving maternal mortality. The IHME's estimates (excluding the uncertainty intervals) are provided in Table 2.5. Annualised rates of decline in under-5 mortality of 2.2% per year between 1990 and 2000 and 2.4% between 2000 and 2008 may point to steady progress. However, some projections show that if the current trends in MMR and U5MR

continue it is unlikely that Ghana will meet the related MDG targets unless steps are taken to accelerate the pace of MCH interventions (UNDP 2010).

The following reasons have been given for relatively slow progress with regard to maternal health: lack of access to a skilled birth attendant; lack of hospital equipment; poor transport infrastructure; and low contraceptive prevalence, which causes an unmet need for family planning, leading to unwanted and mistimed pregnancies.

The Ghana MDG progress report (2010) credits policy interventions such as the Child Health Policy and Strategy, Infant and Young Child Feeding Strategy, Prevention of Mother-to-Child Transmission (PMTCT) Policy and Strategy, de-coupling children from their parents for NHIS coverage, and high vaccination coverage for the improvement in child health indicators.

3. Reforming service delivery and financing for results in Ghana

Ghana's health system has undergone several reform initiatives since the 1980s. Here we describe aspects of four sets of reforms: decentralisation; the movement away from vertical programmes; co-ordination of all sources of funding; and public financial management reforms. The reforms in decentralisation, organisation and financing are of particular relevance to planning and prioritisation processes in MCH.

3.1 Decentralisation

While allowing local organisations to decide about management and use of resources, decentralisation has been seen as a way of improving service delivery through increasing technical efficiencies (lower costs because of local solutions) and allocative efficiencies (provision of appropriate services due to local knowledge).

Decentralisation has been a key part of health sector reform in Ghana. This has involved the transfer of decision-making power and the management of health services away from the MoH to an agency, the GHS, and from there on to regional and district levels. Within this process the GHS, RHMTs and DHMTs are key actors. DHMTs, based on local level conditions, have the power to reallocate funds within budget lines for specific programmes and activities. In addition, DHMTs can mobilise extra funds from donors to support MCH activities.

However, despite the decentralised structures of co-ordination and service delivery, the health sector overall is often described as being 'partially decentralised'. This is because some centralised allocation systems remain. For example, staff are still paid through a centralised treasury system, while budgets for administration are allocated through a local treasury system; consequently, districts have little scope for making savings on staff to reallocate to other items. This process could undermine district ownership and flexibility in planning and implementation (Ensor & Ronoh 2005).

There is anecdotal evidence that capacity at district level remains generally weak, which undermines the planning and budgeting process. Ensor and Ronoh (2005) note that the benefits of decentralisation may be reduced when insufficient investment is made to build the capacity to manage complex planning and budgeting processes.

Given the split between funder (MoH) and service provider (GHS), communication and collaboration between agencies is necessary to ensure shared sector-wide priorities, policy objectives and goals, as well as to create the necessary synergies between agencies to enhance efficiency and effectiveness. An inter-agency leadership committee exists to achieve this end.

However, the effectiveness of the committee is said to have been impeded by, among other things, the lack of participation of key agencies such as the GHS and NHIS (MoH 2010).

3.2 Organisational reforms: Integration of service delivery

Another key element of the reform process has been the move from vertical to integrated programmes. Prior to the reforms, the health sector had 14 vertical programmes. Each programme worked from regional to national level with very little co-ordination. Programmes also had independent plans and budgets. However, under the reforms, management support systems (including systems for procurement and financial management) have also been reorganised functionally to support the integrated delivery of health services (UNFPA 2006).

The challenge of integration is ensuring that the required attention is given to the individual programmes (UNFPA 2006; Ensor & Ronoh 2005). However, in the case of maternal or reproductive health in Ghana, for example, the way in which service delivery is organised at service delivery points seems to minimise this threat for some components of the reproductive health package. For instance, all the public health facilities have maternal health units that provide family planning and safe motherhood services. This ensures continuous attention to these components of reproductive health in the planning and delivery of health services (UNFPA 2006).

3.3 Financing reforms

The health financing reforms aimed to ensure:

- increases in the overall resources to the health sector;
- equitable resource allocation;
- efficient resource utilisation;
- implementation of sustainable financing strategies that protect the poor; and
- a reduction in financial barriers to health services. (Addai 2005)

Key components of these financial reforms have included user fees, exemption policy, the NHIS, sector-wide approaches and, more recently, the move towards sector budget support.

3.3.1 User fees, exemptions and the NHIS

Aimed at narrowing the financing gap in providing adequate and quality health services, user fees covered all services except for pregnancies and family planning. To reduce the financial barriers to services, while maintaining the user-fee financing scheme, a series of exemptions was later instituted along with the user fees. Antenatal care, delivery services, family planning and immunisations were among the services to receive fee exemptions (Population Council et al. 2006).

With respect to the planning process within the health sector, although income from user fees is small, especially in poor districts, it can be seen as enhancing decentralised decision-making in that it remains under district and facility jurisdiction (Mayhew 2003).

Since 2004, Ghana has instituted the NHIS, which seeks to replace user fees (out-of-pocket payments) and, thereby end the need for an elaborate exemption system. Maternity services covered under the NHIS include antenatal care, delivery, caesarean sections, management of emergency obstetric conditions, and postnatal care (Population Council et al. 2006). The president of Ghana declared on 1 July 2008 that pregnant women would be exempt from paying NHIS premiums (Ghana Statistical Services 2009).

3.3.2 Financing arrangements: From SWAp to SBS

SWAps were adopted in the Ghana health sector in 1997, in order to introduce a method of working between the MoH and donors in which funding for the sector supported a single sector policy and programme of work, Accordingly, the government and donors worked towards a common programme of work (for 2002–2006) which spelt out the vision, priorities, strategies, targets, resource envelope and allocation criteria for the sector (UNFPA 2006). However, Ghana's key sexual and reproductive health donors, such as USAID and UNFPA, remained outside the SWAp and continued to disburse funds through separate earmarked channels. Indeed, Mayhew (n.d.) argues that the parallel existence of these two funding mechanisms can undermine co-ordinated planning, causing sexual and reproductive health to suffer if the field is seen as the preserve of a particular group of donors rather than as a mainstream health issue. The same arguments can be raised for child health issues.

In addition, under the SWAp, the 'health fund' through which donors channelled their funds was earmarked not by service allocations but by economic classifications (i.e. salaries, capital expenditure, administration and service related expenses). Districts could not reallocate between budget lines, although transfers could be made within a budget line, enabling greater flexibility in planning and prioritisation. However, each line came through a different disbursement mechanism, which created problems for district planners (Mayhew 2003).

In recent years, there has been a move towards budget support mechanisms for the sector. During discussions, SBS was praised for the flexibility, certainty and the degree of ownership it gives DHMTs in the planning and prioritisation process. SBS also puts the government in the driving seat, while improving the MoH's oversight of health sector resources. However, these positives are balanced by reservations regarding delays that are encountered when donor resources pass through the Ghanaian government's financial systems.

Box 3.1 The National Health Insurance Scheme

The Ghana NHIS was established with the *National Health Insurance Act* of 2003. The NHIS is regulated by the National Health Insurance Council. Regional and district offices of the NHIC are being set up to decentralise the operations of the scheme. The NHIC manages the National Health Insurance Fund (NHIF) through the collection, investment, disbursement and administration of the scheme's resources. The council also undertakes the licensing, regulation and accreditation of healthcare providers.

NHIS premiums are generally based on a client's ability to pay. DHICs identify and categorise residents into four main social groups – the core poor or the indigent; the poor and very poor; the middle class; and the rich and very rich – and vary their respective contributions accordingly. The core poor or indigent, people over 70 years of age, and former Social Security and National Insurance Trust (SSNIT) contributors who already are in retirement are exempted from premium payments.

While premiums vary slightly from district to district, generally members pay no less than GH¢7.2 (US$8.00), per annum. For members in the formal sector, 2.5% of their contribution to the SSNIT is deducted monthly as their health insurance premium. Workers in the formal sector are members of the NHIS automatically, but they still have to register with their respective District Health Insurance Schemes. Those in the informal sector, as well as the self-employed, pay between GH¢7.2 and GH¢48.0 yearly, depending on their income. All contributors' premiums cover their children and dependents below age 18.

In 2004, the government introduced a 2.5% sales tax (i.e. a health insurance levy) on selected goods and services to help fund the NHIS. Other notable sources of funding for the scheme include money from the government's budget and donor contributions The benefits package includes general out-patient and in-patient services, oral health, eye care, emergencies and maternity care, including prenatal care, normal delivery and some complicated deliveries. Diseases covered include malaria, diarrhoea, upper respiratory tract infections, skin diseases, hypertension, asthma and diabetes – in all, about 95% of the common health problems in Ghana are covered.

By the middle of 2007, some 47% of the total national population had registered with the NHIS. The largest numbers of enrolees were in the Ashanti Region (2.0 million).

Source: Mensah, Oppong & Schmidt (2009)

3.4 Public financial management reform

In the last decade Ghana has undergone a series of public financial management (PFM) reforms. Key elements around budget preparation and formulation have been:

- a change from line-item and incremental budgeting to a medium-term expenditure framework;
- a shift to medium-term sector plans (moving from an annual to a three-year perspective);
- a more analytical basis for resource allocation; and
- the inclusion of donor and internally generated funds. (Adjei-Mensah 2007)

Typical objectives of such PFM reforms are: more collaboration between different players (such as health and finance departments) in the formulation of budgets; comprehensiveness of the budget (including all funding sources); aligning budgets with priorities; and providing more certainty for forward planning.

The budget process in Ghana is now a tightly managed annual process aimed at the top-down setting of ceilings and broad priorities and bottom-up prioritisation and allocation. Key steps in the process include:

1. A request for inputs from the general public, including civil society and private sector groups.
2. Updating the macroeconomic framework, including overall spending ceilings and the distribution of government and donor funds.
3. An early policy review by ministries, departments and agencies (MDAs). During this review, the MoH looks at its objectives, policies and activities to come up with their expenditure requirements in the light of policies and priorities.
4. Cross-sectoral meetings (led by MoFEP) to identify: areas of overlap and duplication in outcomes, objectives and key outputs; areas where cross-MDA collaboration and co-ordination are required in the planning and implementation of activities; and comments and feedback on prioritisation of objectives between MDAs within the same broad sector.
5. Review and finalisation of ceilings by the MoFEP comprising forecasts of service expenses, investment and personnel and administrative expenses.
6. Issuing through budget guidelines of final ceilings to MDAs after approval by Cabinet.

7. Development of MDA proposals and more detailed first-year operational plans, which are discussed in policy and technical hearings with the MoFEP. After finalisation the MoFEP consolidates the national budget.
8. Final allocation by MDAs of ceilings between cost centres and objectives. (Adjei-Mensah 2007).

The issuing of initial indicative ceilings by the MoFEP triggers an intense planning process in health organisations. For example, the GHS issues planning and policy guidelines to districts. The guidelines are intended to assist in the preparation of the various regional and district plans focusing on the policies and priorities of the health sector. They reflect the policy direction and priorities of the GHS (and the health sector as a whole), as indicated in the GHS Strategic Plan 2007–2011. These guidelines include the relevant budget allocation formula for sources of funding.

At the district level, planning workshops are then organised to orientate managers regarding priorities for the year and the tools and processes for planning. The districts compile their plans and budgets to link up with their respective regional programme of work. During the planning process, districts review the various components of service delivery, such as clinical care, public health services, including reproductive health, and essential support services. Districts also review the progress and challenges of the previous year, define district targets in the light of national priorities and targets, identify activities to be implemented and cost these activities.

After these sectoral processes, the MoH consolidates the plans and budgets for the entire sector and submits it to the MoFEP (step 7 above).

4. Reform issues

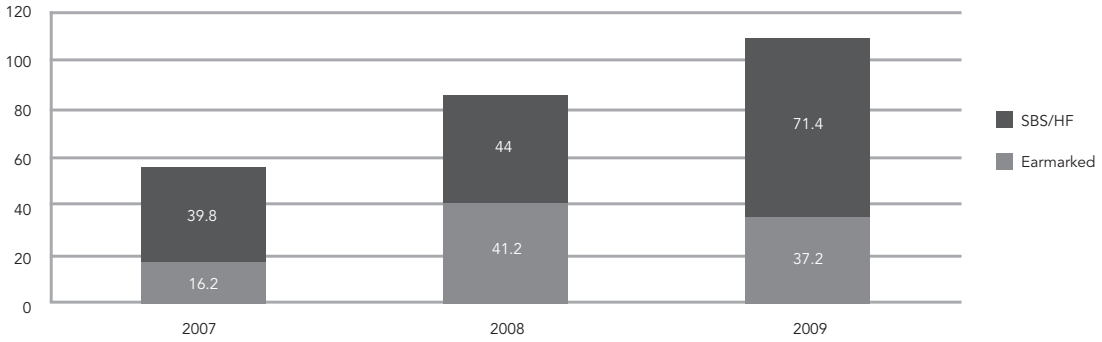
4.1 Autonomy and comprehensiveness

In at least two of the reform areas – decentralisation and increased co-ordination (or comprehensiveness of budget processes) – there is a perception that despite reform having come a long way, it is incomplete, and this limits its impact.

This is so for decentralisation where the effective discretion of regional and local authorities remains limited by central allocation mechanisms (such as that for personnel). Therefore, autonomy and flexibility may be more illusory than real.

In the area of co-ordination between different funders (including the different arms of government, such as the MoH and the NHIS, and donors) many commentators refer to the budget process as being less than comprehensive, in spite of Ghana's long experience of SWAps and the move to SBS.

Figure 4.1: SBS gaining prominence in Ghana health sector (development partner payments in GH¢ million)



Source: MOH (2009b)

Bempah (2007) indicates that funding contributions from some sources are not known at the budget formulation stage and, hence, are not included in budget formulation and analysis (Bempah 2007). In addition, some funds are sent directly from the MoFEP to regions and districts. This affects transparency and accountability of service units, as it becomes difficult for the MoH to monitor the use of such funds. It also negates the principles of budget comprehensiveness and allocative efficiency (Bempah 2007). Abekah-Nkrumah, Dinklo and Abor (2009) argue that the MoH, without recourse to MoFEP, can obtain from its development partners the extra funding needed to provide services and that, as a result, the MoH communicates more with the development partners than with the MoFEP.

4.2 Effects of reforms on prioritisation

While there has been substantial progress in Ghana with SWAps and SBS, substantial earmarked allocations persist, as can be seen in the funding of MCH, which limits the power of the budget process and also the ability of regions and districts to respond to perceived needs and to chase efficiencies.

The 2008 Independent Health Sector Review (MoH 2009a) confirms that health sector financing is changing in two respects: the relative shares of different sources are changing, and the ease of access to those sources is also changing. In terms of sources, financing is characterised by a levelling off of the share of government funding, and a significant increase in share of national health insurance. It is not clear what the effect of increased NHIS funding will be on different priority areas, but the fear has been expressed that this could have a negative effect on funding of preventive services relative to curative services, as the NHIS funding would be driven by health-seeking activities of patients rather than evidence of the impact of preventive measures. Alfers (2009) points out that 'there is a notable emphasis on female reproductive health in the benefit package' (of the NHIS).

Earlier fears that decentralisation and a focus on burden of disease might affect the relative priority of reproductive health and child health services seem not to have materialised, primarily because of the entrenched nature of these services in policies and in district health structures.

4.3 Budget execution and transfers

Comments in the literature and interviews about delays in the release of sector funds by MoFEP, and certain institutions being privileged in term of release of funding, may point to some aspects of budget execution that could hamper implementation according to plan.

The increase in development partner's contributions to the sector is accompanied by SBS regaining prominence over earmarked funds (see Figure 4.1). This is encouraging and in line with the Paris Declaration principles, and allows greater comprehensiveness and flexibility in the planning process. However, as SBS funds are channelled through the government's systems, the view has been expressed that there could be more delays in the release of funds needed for the implementation of key interventions, compared with when they were channelled through parallel structures. Untimely disbursement can also create negative planning and undermine the credibility of the budget, as well as hindering the institution of performance contracts for monitoring.

4.4 Capacity and incentives

The view has been expressed that although the reformed budget process in Ghana 'provides the necessary instruments for departments to take the vital step towards an increasingly realistic set of budget year allocations and better forward planning…the take-up of the opportunity has differed among MDAs. Some MDAs have very detailed costed, sequenced and prioritised strategic plan documents. Others have not. (Adjei-Mensah 2007)

Previous reviews point to that fact that the MoH is not always able to argue its case effectively to MoFEP and Cabinet (Abekah-Nkrumah et al. 2009; MacCarthy 2009). Others have asserted that the MoH needs extra capacity to develop the instruments needed to make a strong case in interaction with the MoFEP. The budget is a key instrument used by MDAs to engage MoFEP on issues of policy and resource allocation, especially during the budget hearing process. Some argue that this requires better qualified staff in order to make a strong case during budget processes.

While this case study does not look in detail at the tools used to cost programmes and the methods for assessing effectiveness or benefits of programmes, there have been suggestions that some of these activities may be too 'consultant-driven' (with insufficient ownership by departments), and an appropriate 'box of tools' is generally not available.

Specifically for planning and budgeting within MCH, Ghana adopted the High Impact Rapid Delivery (HIRD) approach in 2005. The HIRD approach is a strategy or tool to reduce maternal and child mortality. It helps in the identification of the key priorities and cost effective interventions for achieving MDGs 4 and 5 (GHS 2007). Box 4.1 shows the processes involved in planning and identifying priorities under HIRD.

Following a review of Ghana's experience with using the HIRD approach, Aboagye (2008) identified several limitations to its effectiveness, including: inadequate data for planning and target-setting due to lack of baselines, particularly district-specific baseline data for key indicators; inadequate and late release of funds for implementation; limited involvement of relevant stakeholders in planning and advocacy meetings, as well as in the implementation of activities; and delays in the procurement of emergency obstetric care equipment. Discussions with key informants also pointed to the loss of institutional memory and limited involvement of other social sector stakeholders.

Box 4.1 Nine steps for developing HIRD plans

- State vision of the region / district for maternal and child health.
- Compare the current coverage levels of MCH interventions with stated targets.
- List the interventions which have current coverage levels below the set targets.
- Identify bottlenecks that hamper the achievement of set targets, list the underlying causes of the bottlenecks.
- Formulate strategies to remove the underlying causes of the bottlenecks.
- Identify potential resources within and outside the health sector.
- Develop a plan for implementing the strategies.
- Estimate the extra cost required to implement the plan.
- Develop the monitoring and evaluation framework for tracking performance.

Source: GHS (2007)

Understanding of the budget process and its different components may also be an issue. For example, mid-term planning is meant to give a rough indication of the availability of funding for priorities. A further process of reprioritisation and detailed planning takes place once final ceilings are received. However, during the discussions, it was found that this later process of 're-budgeting' is often seen as duplication. BMCs 'know' that the 'real' budget is to be made at a later stage, once final ceilings are approved. The initial indicative ceilings, therefore, are not credible to them (in aggregate and in terms of distribution) and, over time, it has become an exercise of filling in budgeting templates, rather than a real strategic planning process.

Officials in the health sector pointed to a general lack of understanding of how ceilings are derived and how they relate to the sector's needs and challenges. This process was seen by the health sector officials as 'top-down'. Related to the guidelines and ceilings, health sector officials also saw this as undermining ownership, particularly at district level, as the pursuit of national priorities can sometimes overshadow district-level priorities. With respect to budget hearings, sector officials perceived this process as a formality rather than a real negotiation opportunity.

4.5 Co-operation

Abekah-Nkrumah et al. (2009) describe the relationship between the health and finance ministries as follows: 'The MoH sees MoFEP as a very powerful body that sets ceilings and will not change those ceilings irrespective of what MoH does. On the other hand, MoFEP also sees MoH as not being interested in dialogue.' The authors argue that the incentives for the MoH to dialogue with MoFEP are almost non-existent, because about 80% of funding that comes from MoFEP goes into personal emoluments and investments, over which the MoH has no control.

This review raised several important related points with respect to the level of co-operation between the MoH and MoFEP. Relations between the two ministries are said to have improved over the years due to the move away from pooled funding to SBS, which forces the two ministries to dialogue. Where districts receive off-budget support, they are encouraged to report this. In addition, a recently installed health schedule officer in the ministry of finance was said to have improved dialogue between the two ministries.

In addition to the improved co-operation between the MoH and MoFEP, respondents pointed to the need for better dialogue between the MoH and its own agencies. Decentralisation may

make sectoral co-ordination more difficult. Most of the respondents interviewed for this case study felt that an opportunity still exists for the sector to dialogue amongst itself in a more beneficial way than is the case at present.

Another level of dialogue was deemed necessary, namely between the MoH and other social sectors. It would seem that the process of identifying duplication and areas of cross-sectoral collaboration is limited in practice. During discussion with officials at the GHS and key donors, it emerged that the progress towards the achievement of MDGs 4 and 5 is hampered by weak cross-sectoral planning between the health sector and other social sectors, such as education and transport, leading to an unco-ordinated priority-setting process. For example, the health sector's collaboration with the transport sector could help to overcome a core barrier to accessing skilled birth attendants.

Finally, a level of dialogue in the budget planning and preparation process that was said to be weak is that between the sector and the decentralised political administration in the regions and districts (Abekah-Nkrumah et al. 2009).

4.6 Information and data

The capacity to prioritise and cost activities effectively is often limited by lack of data. This is particularly so for maternal health at the district level, with lack of access to indicators for tracking progress and identifying bottlenecks. Current sources of data, such as the Demographic Health Survey (DHS) and the Maternal Health Survey (MHS), do not offer a district level perspective. Weak financial management capacity also limits analysis of cost-effectiveness of alternative options for meeting policy objectives.

5. Key questions for discussion

1. The planning and budgeting process: Does the decentralised structure engender optimal health outcomes? What can be improved?
2. Financing for reforms: Has the Ghana MoF adequately explored financing for health, taking into account user fees, NHIS, etc? Are these mechanisms appropriate? What lessons can be learned from other countries?
3. Allocative efficiency: Is the MoH spending on priority areas? What can we say about the MCH indicators in the context of the health sector receiving 14.4% of the budget?
4. What are the pros and cons of donor/off-budget support? How do other countries manage this?
5. Planning processes, costing and the analysis of options (such as cost-effectiveness analysis) are often driven by external consultants. What are the options for creating more capacity and ownership in the MDAs? Do finance ministries allow sufficient resources for planning? Are there any guidelines in this regard?
6. Data for costing, planning and prioritisation are often a problem, especially for planning at a decentralised level. What can be done to address this problem? Have some countries found solutions?

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