"Towards Universal Health Coverage: Increasing Enrolment whilst Ensuring Sustainability"

NHIS
NATIONAL HEALTH INSURANCE SCHEME

National Health Insurance Scheme
10th Anniversary International Conference Report

International Conference Centre,
Accra, Ghana
November, 2013

Contents

Abbreviations

ANC	Antenatal Care
CHAG	Christian Health Association of Ghana
CHN	Community Health Nurse
CHO	Community Health Officer
CHPS	Community-based Health Planning and Services
DALY	Disability-Adjusted Life Years
DHIMS	District Health Information Management System
DHS	Demographic and Health Survey
DRG	Diagnosis-Related Group
FFS	Fee-For-Service
GHS	Ghana Health Service
GMA	Ghana Medical Association
HMO	Health Maintenance Organisation
HRH	Human Resources in Health
HTA	Health Technology Assessment
IGF	Internally Generated Funds
ISODEC	Integrated Social Development Centre
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MPI	Multi-Dimensional Poverty Index
MRI	Magnetic Resonance Imaging
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organisation
NHIA	National Health Insurance Authority
NHIC	National Health Insurance Council
NHIF	National Health Insurance Fund
NHIS	National Health Insurance Scheme
NTDs	Neglected Tropical Diseases
OOP	Out-of-Pocket
OPD	Out-Patient Department
PHC	Primary Health Care
PPI	Progress out of Poverty Index
PPP	Public-Private Partnership
QALY	Quality-Adjusted Life Years

RSH	Regional Specialist Hospital
SMTDP	Sector Medium-Term Development Plan
SSA	Sub-Saharan Africa
SVD	Spontaneous Vaginal Delivery
TB	Tuberculosis
TBAs	Traditional Birth Attendants
UHC	Universal Health Coverage
VAT	Value-Added Tax
WHO	World Health Organisation
WI	Wealth Index

Introduction

Ghana, like most African countries, aspired to provide free health care for its citizens at the time of independence through a tax funded health system. However, economic challenges faced by the country in the sixties and seventies meant that general tax revenues were inadequate to continue financing this laudable programme. In the face of these challenges, out-of-pocket user fees were introduced. Unfortunately, these out-of-pocket fees at the point of service delivery led to the inability of a significant portion of the population to seek the healthcare they needed without the risk of financial ruin. Often referred to as 'Cash and Carry', the Hospital Fees Policy led to a drop in outpatient attendance from approximately1.2 to about 0.35 per person per year by the late nineteen nineties, especially among the poor and vulnerable sections of the population.

In order to address this situation, the National Health Insurance Scheme (NHIS) was established by an Act of Parliament, Act 650, in 2003. The NHIS, a social protection initiative, aims among other things to provide financial risk protection against the cost of basic health care for residents of Ghana. Since its introduction, the Scheme has grown to become a major instrument for financing health care delivery in Ghana. The Scheme is credited with improvements in the health-seeking behaviour of a significant portion of the population, with membership and utilization of healthcare services growing significantly. Currently, NHIS covers 8.8 million active subscribers. The Scheme has enrolled over 3,500 healthcare providers, both public and private, and accounts for more than 85% of service delivery income of public and quasi-public health care facilities.

Ghana's NHIS has received both local and international goodwill and recognition over the years. Internationally, it has become a favoured subject of reference and study in social protection, especially as the global movement towards Universal Health Coverage (UHC) intensifies. It has at the same time also been the subject of critical scrutiny, especially with regards to its sustainability, slow growth and equity in membership coverage and quality of care, among other issues.

September 2010 marks ten (10) years since the passage of Act 650, which established the NHIS. Several activities have been held to commemorate this occasion, the climax being an international conference that brought together politicians, health financing experts, social development experts, healthcare practitioners, civil society representatives and other experts from over 26 countries to review the Scheme's progress, successes and challenges, to share experiences and lessons, and to help shape policy and direction for the Scheme as it enters the next decade.

Activities to commemorate 10th Anniversary

- Formal launching
- Public lectures
- Health walk
- School quiz competition
- Blood donation campaign
- International Conference

The conference was held from 4th to 5th November 2013 at the Accra International Conference Centre under the theme *"Universal Health Coverage: Increasing Enrolment while Ensuring Sustainability"*. There were moderated plenary and parallel sessions to review pertinent themes, systems and approaches related to relevant topics and issues. There was a poster exhibition throughout the conference, with concluding field visits on November 6, 2013.

This report presents highlights of the conference proceedings, presentations, discussions, lessons learnt, key outcomes and closing statements. The conference program with details on session moderators, presenters and panellists is included in the Annex.

Guests at the Opening Session: From left Dr. Kwabena Poku-Adusei, Hon. Omane Boamah, Sylvester A. Mensah, Rt. Hon. Edward Doe Adjaho, Hon. Sherry Ayittey, Hon. Emmanuel Adjei Anang, Hon. Mohammed Muntaka, Dr. Steve Ahiawordor, Dr. Monwabisi Gantsho, Hon. YilehChireh & Frank Adu Jnr.

Opening Session

There were addresses by the Speaker of Parliament - Rt. Hon. Edward Doe Adjaho, the Minister of Health - Hon. Sherry Ayittey, the Acting Board Chairman of the NHIA Board- Dr Steve Ahiawodor and the Chief Executive of the NHIA- Mr Sylvester A. Mensah. There were solidarity messages from the South Africa Council for Health Insurance Schemes and the Ghana Medical Association.

Highlights of the addresses are presented below.

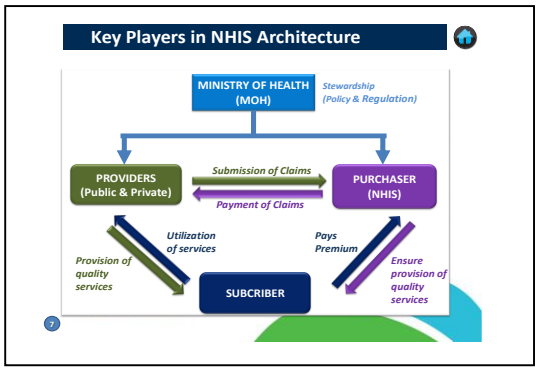
Dr. Steve Ahiawodor, Acting Chairman of the NHIA Board – There have been many opportunities and efforts to improve access to health care since independence. These efforts in recent years culminated in the establishment of the Community Health Insurance Schemes, which were consolidated into the National Health Insurance Scheme. Though the process has been fraught with challenges, all stakeholders have been committed to working hard to sustain the Scheme. Accreditation and clinical audits have helped improve quality of care, and initiatives such as the Free Maternal Care Programme have contributed to progress towards meeting the MDGs, particularly 4 and 5. In recent times, Ghana has embarked on legal and administrative reforms of the NHIS through the replacement of Act 650 with Act 852 in 2012. Some of the new focal areas of the reforms are equity of coverage and sustainability. There is need for stakeholders and partners to work together to strengthen the Scheme and position it as a global learning resource for improving access to healthcare.

Hon. Sherry Ayittey, Minister of Health - The Scheme has generated great interest and attention, particularly as regards its potential to catalyse the move towards Universal Health Coverage in Ghana. A key question that ought to be answered is how can we keep our population healthy in the most cost-effective way without compromising the ability of future generations to meet their health needs? It is in recognition of the need to draw on global experiences and best practices in answering this complex question that the MOH and the NHIA decided to bring together experts from all around the world to deliberate on the successes and challenges of the NHIS with a view to improving the Scheme. This is against the background that the Scheme has become critical in healthcare financing in Ghana, not mention its role in creating an expanded role for the private sector in healthcare delivery. The Scheme accounts for up to 85% of IGFs of public, faith-based healthcare facilities; and a significant number of private healthcare providers enrolled onto the Scheme. Conference participants should consider the following key questions in their deliberations:

1. What is the case for investing more in health care?
2. How much should healthcare cost and who should pay?
3. What type of global partnerships will be needed for improving healthcare outcomes?
4. What actions need to be taken to shape the institutional landscape for delivering healthcare?

Mr Sylvester Mensah, Chief Executive, NHIA - The NHIS is a government initiative to secure financial risk protection against the cost of healthcare services for Ghanaians. The Scheme covers 95% of disease conditions and features a unique model that pools funds from the National Health Insurance Levy, social security contributions, returns on investments as well as premiums based on the ability to pay. The MOH is responsible for overall governance and

regulation of public and private healthcare providers as well as the NHIA - the purchaser. The sum effect of the ministry's governance and regulation role is to facilitate effective interaction between providers and the purchaser is to ensure that the subscriber has access to quality health services.



The NHIS has contributed to Ghana's progress towards a number of MDGs – MDG 1 - poverty and hunger, MDG 4 - child mortality, MDG 5 - maternal mortality, and MDG 6 - HIV/AIDS, Malaria and TB; by providing financial access to healthcare. The NHIS exempts the following groups from paying premiums - persons under 18 years; persons 70 years and above; the indigent; SSNIT pensioners. Key achievements of the Scheme include promotion of community ownership through community participation, comprehensive credentialing and post-credentialing systems, involvement of both public and private health care providers and institutionalised systems for stakeholder engagement.

The Scheme has seen an increase in both outpatient and inpatient utilisation, with an attendant growth in claims payment. Despite its successes, the Scheme faces many challenges - financial sustainability, problems with identification of the poor, weak information systems, poor quality of care, high cost and poor availability of pharmaceutical products, low rate of subscriber reenrolment and slow and cumbersome enrolment and renewal processes.

Measures to contain costs and generate additional funding are continually being pursued to ensure the financial sustainability of the Scheme. New measures that will vigorously be pursued into the future to ensure the sustainability of the Scheme include intensification of clinical audits, scale up of instant ID card issuance to subscribers, improved systems for coverage of the poor, strengthening of ICT systems, shortening of the length of claims processing and payment times, reducing fraud and abuse by strengthening audit and risk management systems and roll out of capitation as a payment method. In order to strengthen knowledge and capacity building systems required for effective implementation of the Scheme, the NHIA will work with identified partners to establish a health insurance knowledge centre.

Rt. Hon. Edward Doe Adjaho, Speaker of Parliament – Members of Parliament are committed to supporting the health sector to improve delivery of healthcare to their constituents, who as a collective comprise the entire population of the country. Deliberations at the conference should therefore focus on delivery of cost effective quality healthcare services.

Dr. Monwabisi Gantsho, Chief Executive, South Africa Council for Health Insurance Schemes- Insurance is a necessary phenomenon in global health financing and a major determinant of economic growth and social development. It is a useful tool for promoting equity and efficiency in resource allocation. This can be done through establishment of the right financial incentives for providers with a focus on three key areas: (1) robust revenue collection; (2) pooling of resources; and, (3) effective and efficient purchase of healthcare interventions.

Dr. Kwabena Opoku-Adusei, President, Ghana Medical Association – The NHIS has had a significant impact on the health seeking behaviour of Ghana's population, and it is imperative

that the Scheme is sustained. The Ghana Medical Association wishes the NHIA well as it marks ten (10) years of the establishment of the NHIS. On behalf of healthcare providers in the country, the GMA expresses its commitment to working with the NHIA to find solutions to the challenges confronting the Scheme.

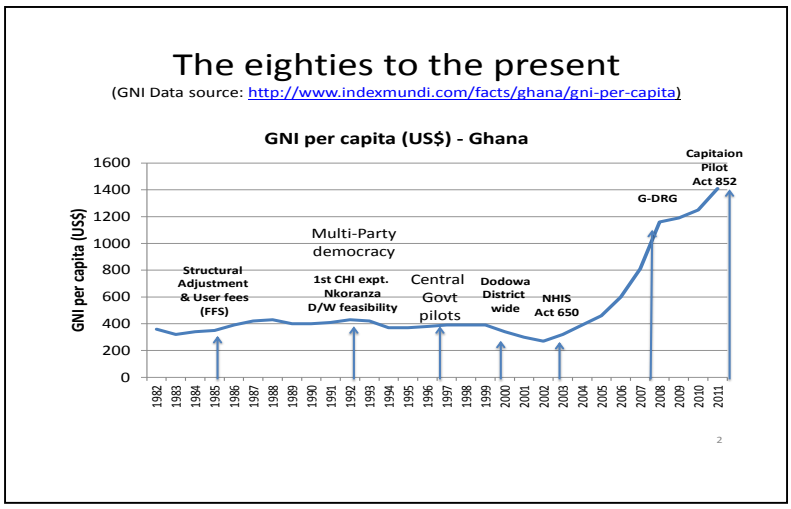
PLENARY SESSIONS

Session 1: Ghana's Journey to Universal Health Coverage so far – Successes and Challenges

Highlights of Presentation

'Ultimately, the vision of Government in instituting a health insurance scheme in the country is to ensure equitable access for all residents of Ghana to an acceptable quality package of essential healthcare'. '…every resident of Ghana shall belong to a health insurance scheme that adequately covers him or her against the need to pay out of pocket at the point of service use in order to obtain access to a defined package of acceptable quality of health service'. National Health Insurance Policy Framework for Ghana, Ministry of Health, 2002; 2004

During Ghana's pre-independence period, payment for health services was mostly private, out-of-pocket, with some public financing for expatriate civil servants. After independence, a tax-funded public system that provided health services free at the point of use was introduced. Access to healthcare was rapidly improved by expanding public infrastructure and investment in human resources. In the1970's Ghana was ushered into a decade of political instability and military governments. Financing healthcare delivery through taxes became increasingly difficult, as the economy failed to grow significantly and the country experienced increasing budget deficits. In response to this trend, user fees were introduced in the 80's. The country stabilised under multi-party democracy from 1992 onwards. With this came a dividend of declining levels of poverty, which brought in its wake the potential to improve financial access to healthcare. The establishment of Community Health Insurance Schemes was a response to this paucity of access to healthcare with an improved capacity for risk pooling acting as a catalyst. The first Community Health Insurance Scheme was established in the Nkoranza District. A number of district-wide schemes evolved thereafter – eventually culminating in the establishment of the NHIS in 2003.



Ghana has a small formal sector and a large informal sector. The formal sector is believed to be less than 10% of the population (only about 4% of the population is registered with SSNIT). The main challenge confronting the Scheme from the onset was therefore how to mobilise adequate taxes and premiums for universal insurance coverage. Widespread social discontent with the cash and carry system, combined with the desire to fulfill a popular election promise opened a window of opportunity for the establishment of the NHIS. Lessons from the previous decades of constrained financial access to healthcare informed the design of the

NHIS. During the design process, there were tensions between political expediency and technical propriety; diversity of opinions on who to cover, what services to cover and what proportion of costs to cover. These were often not based on rigorous analysis. Despite political differences and a skeptical donor community, there were enough committed politicians, bureaucrats and technical capacity to take the plunge of establishing the NHIS.

The governance arrangements under Act 650 comprised a Council (NHIC) with responsibility for registration, licensing and regulation. The Council worked with devolved payers - District Schemes; providers - both public and private; and clients to achieve the objects of Act 650. The devolved approach forced the local government structures and communities to actively engage on implementation of the Scheme in their respective localities. The reforms made in 2012 under Act 852 have however transformed the erstwhile NHIS into a single centralised payer. As regards funding flows for the provision of health services in Ghana broadly, funds come from the consolidated fund, donor resources, NHIF and client OOPs. The bulk of current public spending on health is on human resources.

Cumulative registered membership of the Scheme is over 20 million, but current active membership is less than half this number. The high non-renewal rate by subscribers is a major source of concern. Steep increases in utilisation of health services is also a major concern. Survey data from the SHINE project shows that insured individuals are 2.5 times more likely to use OPD services than non-insured individuals. The data shows equity in utilisation for the insured and inequities in utilisation for the uninsured. Trends observed in evaluation data also show providers shifting and referring cases, and in some instances undersupplying or reducing services because of perceived low tariffs, for example for laboratory tests. Perceived or actual low tariffs have particularly impacted the supply of medicines. Medicines are have become a significant portion of the Scheme's costs, particularly due to extremely high medicine prices in the country and irrational prescribing behaviour.

The achievements of the Scheme include a single pooled national fund, comprising value added taxes – a sustainable but not necessarily adequate source - deductions from SSNIT contributions and premiums payable by the informal sector for enrolment. Other achievements include stakeholder buy-in across the political divide, increased OPD utilization, protective effects for the insured poor, as well as a strong and continuing high-level government commitment to reforms.

Issues that need to be addressed going forward are the challenge of inadequate funds, how to increase enrolment and retain subscribers, how to reduce OOP fees and unintended cost-sharing, how to increase geographical access to services and how to improve quality of care.

There is the need to clearly define who regulates relationships between the payer, providers and subscribers. There is also the need to assess utilisation of healthcare services to determine whether demand is supplier-induced or based on increased awareness. Weaknesses in access to medicines and regulation need to be addressed, and consideration given to using the Scheme's resources to help build the capacity of prescribers and finance a change in service quality and improvement in service access.

Highlights from Panellists

Dr. Moses Adibo, Former Deputy Minister of Health - Health insurance was meant to support service delivery at the decentralised level, hence the initial approach with the establishment

ofmutual health insurance Schemes. There appears to be a disconnection between the current top down NHIS approach and the initial bottom-up community approach. In view of the fact that conventional health insurance does not work well with a small formal sector, innovations are required to ensure the success of the NHIS. Care should be taken for the curative approach of the NHIS not to muzzle focus on primary healthcare and public health.

Dr. Nii Ayittey Coleman, NHIA Focal Person for the MoH- Mutual health insurance Schemes that were the foundation of the NHIS were characterised by a social movement towards risk sharing, decentralisation and voluntary participation. Some of these characteristics were lost in the move to a centralised, national approach. These included indigenous solidarity and risk-sharing, competition among Schemes and leveraging the initial spirit to get citizens to participate. With the large informal sector there will always be a challenge of mobilisation of funds and the Scheme needs to focus on collection of premiums.

Hon. Mohammed Muntaka, Member of Parliament Health and Member of Select Committee on Health – Parliament is committed to the health sector and has passed several bills aimed strengthening the sector. During the legal reform of the NHIS culminating in the passage of Act 852, Parliament was united and dedicated in its approach. Remaining challenges to the NHIS which require further attention include the issues of equity and how to effectively identify the poor. Addressing the issue of who should regulate the NHIS was a key factor that delayed the legal reform of the NHIS. One aspect of the delay was how to provide effective governance and oversight structures without necessarily creating another layer of bureaucracy. The resultant bill accordingly provided for four Oversight Committees to limit the authority of the NHIA Board whilst ensuring checks and balances in the Scheme's operations. These are the Finance and Investment Committee, NHIS Oversight Committee, Private Health Insurance Oversight Committee and Dispute Adjudication Committee. The bill clearly spelt out roles, membership and lines of reporting for these Committees.

In its oversight role, Parliament has been committed to ensuring that the NHIA meets the legal obligation of presenting its resource allocation formula to Parliament within three months after passage of the Appropriation Act as legislated in Act 852. Progressive changes in the Scheme have includes expansion of exempt categories of members and the inclusion of family planning services in benefits package. The reforms whilst guaranteeing an opportunity to the MoH to leverage resources from the NHIF to fund selected programs such as vaccinations, infrastructural development and specific disease interventions such as cervical cancer screening, has placed a cap of 10% on such drawings to ensure the sustainability of the NHIS.

Regarding the issue of sustainability of the NHIS, there will be the need to increase the health insurance levy to facilitate the expansion of the Scheme and ensuring sustainability.

Hon.Matthew Poku-Prempeh, Member of Parliament and Member of Select Committee on Health - The Scheme's success depends on its accessibility, affordability and efficiency. To ensure the sustainability of the NHIS, all stakeholders will need to come together and advocate for an increase the 2.5 VAT that finances the Scheme. Complementary private insurance by selected sectors such as mining, petro-chemical and financial sectors should be pursued to provide an additional risk pool. Parliament's focus on the NHIS has been on effective targeting of the poor and vulnerable. The Scheme under Act 852 is required to report

to Parliament annually on how this being achieved. Premiums from the informal sector, which do not form a major source of revenues should be so structured that people pay according to their means.

Highlights from Discussion

Other feedback from conference participants and panellists were to-

- Facilitate improvements in quality of care at health facilities to ensure better outcomes.
- Increase client education on disease prevention and environmental hygiene to ensure a healthier population.
- Encourage involvement in the implementation of the NHIS at the decentralised level in the areas of risk pooling and coverage. Centralisation of the Scheme should not put a stop to local participation and competition among districts.
- Focus on effective collection of VAT rather than rate increase to avoid overburdening tax payers.
- Maximise collection of premiums without ignoring differences in communities by taking account of economic seasons and timing of economic activities.
- Put mechanisms in place to make health insurance mandatory for school enrollees.
- Find ways to reduce utilisation of healthcare services by providing more efficient services whilst discouraging co-payment because of its potential to exacerbate out-of-pocket payments.
- Asymmetry of information between providers and patients should be managed through better education. Providers should be empowered to effectively keep the gate to ensure effective utilisation of services.
- Involve patients and consumers in decision-making to improve the quality of services.
- Utilise services of private providers in the community to increase access.
- Implement policy changes that combine access to care with provision of quality care.
- Promote separation of services - prescription and dispensing – to deal with perverse incentives in patient care.

Session 2: Towards Innovative Healthcare Financing: Experiences from the World

Highlights of presentation

The emergence of UHC as a topical issue in recent times is leading to a convergence in approaches to health financing - revenue collection, pooling of funds and purchasing of services. Revenue collection deals with sources and adequacy of funds; pooling is the accumulation of prepaid revenues on behalf of a population; and purchasing is the transfer of pooled funds to providers on behalf of a population. The convergence in these approaches is reflected in the World Health Report 2010 which stresses that financing systems need to be specifically designed to provide all people with access to needed health services (including prevention, promotion, treatment and rehabilitation) of sufficient quality that are effectively delivered and ensures that use does not expose the user to financial hardship'.

There is strong consensus that efficiency gains are needed to move health systems towards UHC, but there is less strong consensus on how to achieve efficiency gains. It is however clear that innovative health financing systems are those that maximize efficiencies in the relationships between the three health financing functions and their intersection with health service delivery. Revenue sources for health financing range from the national budgets to payroll taxes, donor funds, to private funds. Separate or vertical pooling and purchasing arrangements by revenue source leads to health financing fragmentation and inefficiencies, undermining progress to UHC.

Use of input-based line item budgets for funding public facilities can be problematic if low budget levels don't fund all the services provided in a health facility. Here it is not clear to the provider what services are funded and what services are not funded. Health budget purchasing enables better targeting or matching of priority services to poor populations. Such an approach should have as its salient feature an output-based provider payment system with financial incentives for desired service delivery improvements, as well as clarity and space for private financing. A clear institutional structure for healthcare purchasing that clarifies roles and relationships, and coordinates provider payment systems across revenue sources reduces avoids conflicting financial incentives at the provider level. This stimulates development of health system structures, facilitates service delivery improvements and makes it easier for people to get access to covered and appropriate services.

Ghana is making good progress in moving towards UHC. To accelerate this process, innovations to consider include better coordination of MoH services/programs and the NHIS benefit package. The potential for efficiency gains through reduction of conflicting financial incentives in payment systems should be exploited, especially where variable costs of direct patient care paid through input-based line item budgets, fee-for-service, DRGs, per capita, and other mechanisms are being used. Health purchasing and financial incentives should drive desired service delivery improvements.

Highlights of Discussion

Key issues for consideration by the Scheme include:

a. Raising more revenues from the informal sector.
b. Striking the right balance between incentives and disincentives that encourage desired provider behaviour.
c. Ensuring quality of health services through strategic purchasing.
d. Covering and ensuring the provision of the most cost-effective benefits and treatments within benefit package – medicines may require extra effort to manage because of the fragmented environment.
e. Dealing with complexities in the administration of the NHIS, including how to integrate the private sector and strengthen information systems.

A key goal of the Scheme is to target and cover the poor. While the Scheme has improved access to healthcare, this has fallen short of the expected equity goals as inequities in enrolment exist. There is the need to find innovative ways of identifying the poor and covering them. Issues to consider here include the cost of identification of the poor, difficulty of identifying incomes, errors of exclusion in coverage, and financial implications of the huge exempt population. Different approaches to targeting the poor can be adopted. The selection of an approach should be based on cost and administrative capacity. The NHIA is working with other social protection programs to identify the poor and to build a national database of the poor and vulnerable.

The Vision of the Scheme over the next 15 years should include ensuring transparency in governance, considering that the country has opted to use the mechanism of oversight committees instead of establishment of an independent regulatory body. This will come through regular annual reports, submission of reports to Parliament, making implementation issues transparent to the public and providing opportunities to different stakeholders to have access to information to enable them make constructive inputs for strengthening the Scheme.

There is the need to strengthen the Board and its functions. Bi-partisan politics should be overcome, cross-party representation on the Board of the NHIA should be encouraged and the Scheme should be viewed as a national asset. Debating issues at the political and technical level will help strengthen the Scheme. In the meantime, considering the inadequacy of revenues, the focus should be on minimising costs and strengthening information systems to facilitate evidence based decision making.

The role of public health programmes in facilitating preventive health should be emphasised as a cost containment strategy. Innovative approaches to identifying the poor should also be adopted. Health infrastructure should be improved to ensure access to good quality services, particularly in rural areas where a majority of the population do not have access to good health facilities. There is no point having an NHIS card when facilities are not accessible.

There is also the need to address inequities in the payment of premiums by ensuring that premiums are paid based on ability. Broadening the base of the number of people paying premiums, such as requiring SSNIT contributors and relatively wealthier categories of the population to pay premiums has the potential to increase revenues for the Scheme.

Session 3: Shaping UHC Policy for Post 2015 - Opportunities and Risks

Highlights of Presentation

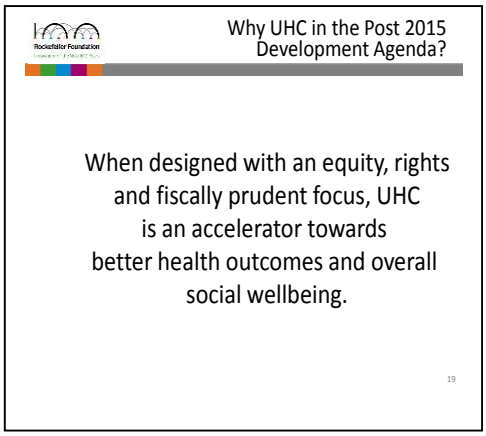
It is inevitable that implementation of UHC strategies by a country has the potential to help it accelerate its progress towards achievement of the health-related MDGs. A key reason for non-achievement of the health-related MDGs in many countries is the absence of systems that assure UHC as well as ensure social wellbeing. UHC is a recommitment to health as a human right. It reflects the health sector's inherent responsibility to provide universal and equitable access to health that ensures improved health outcomes and ensures risk protection. UHC links to the broader social and economic sectors to provide the basis for sustainable development. UHC is defined as a situation where all people can access the health services they need without incurring financial hardship. The two main indicators are financial protection and access.

Under UHC, the entire population of a country has access to good quality health services according to needs and preferences, regardless of income level, social status or residency, obviously stressing the importance of PHC. Policy options for funding UHC include:

a. Funding coverage for everyone secured from general budget revenues providing automatic non-contributory entitlements.
b. Mandatory contributions.
c. A guarantee (fund from budget) for certain services for all – entitlement to full package requires contribution – leverages complementarities between direct contribution and government subsidies for coverage expansion.
d. Subsidized participation with strong public commitment to universality.

The two conditions for financing UHC when using contributory arrangements are subsidization (because some will be too poor or too sick to be able to afford coverage and compulsory contribution because those who can afford it may be unwilling to pay for it). Some broad lessons on health financing policy are - no country gets to UHC with voluntary health insurance. All countries with UHC rely in whole or in part on general budget revenues. To ensure sustainability of UHC programmes, there is the need to manage resources efficiently and purchase services strategically. The few countries that have high coverage with voluntary contributory Schemes have common elements such as - cost of premiums being much less than the perceived value of the benefit thereby stimulating demand or a strong role of governments both national and local (sometimes authoritarian) that are able to implement these measures.

UHC requires action beyond the health sector. This is because some determinants of health are outside the health sector. Some of the areas to which attention should be paid are education and employment. In terms of contributory systems, subsidies have to be put in place for the poor. Compulsory contributions should not be linked to employment status. Lessons from around the world indicate that no country has successfully used voluntary contributions to finance UHC. UHC funding is mainly derived from the budget and managed strategically to achieve desired objectives.



The key issue then is how to increase the health budget as a priority. Where premiums are very low, subsidies tend to be high. In Rwanda where good progress has been made for example, enrolment is enforced. Hence if Ghana also enforces enrolment and puts institutional systems in place for this purpose, UHC will not be too distant. Without such a system, accelerating enrolment will remain a major challenge. Other challenges of Ghana's NHIS include how to protect the financial sustainability of the Scheme, how to ensure rational and prudent use of drugs, improving access through infrastructural development and availability of appropriate skill mix, as well as how to improve awareness about the Scheme among the population (raising campaigns to educate the public on the benefits of the Scheme). All stakeholders need to help strengthen the Scheme so as to increase uptake and retention.

There are several reasons why UHC has become important in the Post 2015 Development Agenda. When designed on the basis of equity, rights and a fiscally prudence, UHC can become an accelerator for better health outcomes and overall social wellbeing. The emerging consensus therefore on UHC in the Post 2015 Development Agenda is that:

a. With adoption of UHC, MDGs will have more ambitious health outcome targets.
b. UHC is the health sector's contribution to sustainable development.
c. UHC is based on equity – realizing the right to health for all.
d. Achieving UHC requires actions beyond the health sector (the determinants of health).

Considerations going forward for Ghana will include how to push the envelope on all sides of the UHC journey during the Post 2015 era, including how to leverage indigenous solidarity and risk sharing experiences. There will be the need for concrete steps to maximize the efficiency of risk pools and for the implementation of a good gate-keeping system as the country moves toward a full-scale universal health system.

Highlights of Discussions

The main issue is how to minimize risks while leveraging opportunities. With governments facing so many pressing challenges in the midst of limited resources, it is important to keep the NHIS on the national agenda. This requires strong and consistent policy advocacy. In shaping Ghana's UHC policy for Post 2015, the health system in deprived communities will have to be strengthened. This is because the health system in most parts of rural Ghana is a vicious cycle of low trust, low demand, low investment and low quality supply. In most rural districts, health facilities are only found in district capitals, making accessibility and utilization of health services more rhetoric than reality.

There is the need for new approaches in regulation and supervision. Health enhancing social policies in the areas of housing, clean water, sanitation systems and nutrition are relevant for shaping UHC policy for the Post 2015 Agenda. Various dimensions of access must also be considered. A key lesson is that where the private sector plays an increasingly prominent role in service delivery. It is also pertinent that strong political will and effective governance will be

needed to secure adequate risk pools, strengthen sustainable financing, support cost containment, ensure equitable resource allocation and assure quality of services.

Summary and Conclusions

There are two critical issues that need to be addressed to increase financial access to healthcare. These are how to advance towards pre-paid universal financial coverage and how to increase overall fiscal space for health financing. This requires the featuring of health as a priority in the general budget. The history of the evolution of large welfare states shows that their large collective systems that provide for universal health coverage grew incrementally over long periods of time.

Their experiences cannot be simply transplanted into low-income countries, since development is path-dependent. Judgments on fiscal space are country specific, requiring detailed assessment of a government's fiscal position, its revenue and expenditure structure, the characteristics of its outstanding debt obligations, the underlying structure of the economy, the prospects for enhanced external resource inflows and a perspective on the underlying external conditions facing the economy. Competition for fiscal space is a given as a country confronts many urgent needs across sectors.

Ghana should adopt viable strategies to overcome the risks posed to the NHIS. These should be instituted as soon as practicable with all key players playing a role to help strengthen the Scheme through regular stakeholder engagements values the inputs of all stakeholders. Equity needs to be emphasized and the poor protected. Coverage has to be increased and financial risk protection expanded.

Session 4: Improving Health Outcomes - New Trends in Patient Safety

Highlights of Presentation

Patient safety is an important concept that highlights the need to avoid and prevent adverse outcomes as a result of seeking healthcare. It is estimated that one in ten patients have an adverse medical outcome. This fact resulted in a World Health Assembly resolution on the importance of patient safety in 2002. Patient safety is important for UHC, as there is no point in offering UHC if the quality of available healthcare is poor.

There are systemic problems that prevent individual clinicians from being able to treat patients effectively. A growing global-to-local-to-global trend in learning about and dealing with patient safety has become a critical tool for awareness creation and adoption of patient safety best practices. Each region must adapt global polices and initiatives to fit their local contexts. In Africa, the WHO AFRO Regional Committee met in 2008 and came up with a Patient Safety Framework that specifies 12 action areas for patient safety. Additionally, the African Partnership for Patient Safety is an initiative linking African hospitals with European hospitals in bi-directional learning partnerships.

The WHO has launched patient safety initiatives in the areas of hand hygiene and surgical safety. Hand hygiene initiatives serve to reduce hospital-associated infections while a surgical safety checklist has been implemented to reduce complications and surgical site infections. These initiatives utilize a multimodal strategy, which involves system change, training and education, evaluation and feedback and reminders in the workplace that need to be adapted to fit the local context. For example, at a faith-based hospital in Uganda, praying for the patient was added to the surgical checklist. Successes in patient safety will contribute to accelerating achievement in all the health related MDGs. The future of patient safety includes a people-centered design of integrated care, moving patient safety concerns upstream, preparing the future health workforce, creating a model for change that lasts and developing quality measures and matrices.

In 2008, Ghana hosted a conference on patient safety. Since the conference, problems in patient safety have been identified and some initiatives to resolve them implemented. In Ghana, key areas of concern with regards to patient safety include the quality of medical products and medicines. Ghana's pharmaco-vigilance system as a result is being strengthened and standard protocols and guidelines are being introduced. However there are no structured systems for learning about non-drug adverse effects of patient safety e.g. falling off a bed.

Although there is an increasing interest in patient safety among professional associations and intensive education on some aspects of patient safety, funds for running systematic awareness creation and training programmes is sometimes a challenge. Alcohol-based hand rub is increasingly being used at health facilities, but ensuring a regular supply is a challenge in Ghana. Another issue in Ghana regarding patient safety is healthcare waste management. There are a number of initiatives to provide incinerators to facilities, but open dumping is still common.

In rural areas in Ghana the biggest patient safety issues include inadequate staffing of healthcare facilities and an unreliable supplies of running water and electricity. The ever increasing number of patients puts a strain on already limited logistics. Contrasting with the context of the United States, a holistic view of the patient is the centre of patient safety initiatives. Drug interactions as well as antibiotic resistance are current threats to patient safety in the US. Protocols are the basis of patient care. These are modified by healthcare providers for individual patients. Important aspects of patient safety are educating the patient and empowering the patient. This means involving the family in care and allowing the patients to ask questions.

In South Africa, a good example of a successful patient safety campaign is the "best care always" campaign. It relies on five important factors:

- A clear aim.
- Ownership and participation of all stakeholders and senior leaders.
- Clear and robust evidence-based clinical change concepts.
- Capability at the front lines of service delivery for system improvement.
- Measurement and feedback for those working at the front line.

Highlights of Discussion

Several concerns were voiced about patient safety in Ghana. The audience brought up issues of how health care professionals are being trained to improve patient safety, task shifting and how to leverage technology for patient safety. The need for a systemic quality improvement continuum, which will in turn improve patient safety, was emphasized.

Summary and Conclusion

Patient safety is critical for ensuring that quality health care is provided to the people of Ghana. There have been successful patient safety initiatives introduced by the WHO concerning hand hygiene and surgical safety checklists. Modifying global initiatives to fit local contexts is important in patient safety and contributes to global-to-local-to-global and bi-directional learning. The most common patient safety concerns in Ghana are inadequate staff and resources such as running water and electricity. Ghana should concentrate on system changes that integrate patient safety, with particular emphasis on training of healthcare workers to be aware of patient safety concerns.

Some recommendations

a. Include patient safety in pre-service training curriculum.
b. Maintain a holistic knowledge-based view of patients and keep them as the focus of care.
c. Make healthcare workers and receivers of care an integral part of patient safety programmes. Safe care should be seen as a fundamental right for people.
d. Make an economic case for patient safety based on the principle that errors cost money.
e. Implement a systemic response to quality improvement – use of checklists, adherence to clinical guidelines and protocols, use of resource transfer incentives etc.
f. Explore options for an electronic medical records system to increase efficiency.

g. Promote a culture where health workers are confident to discharge their duties and share their experiences, both positive and negative, to facilitate learning.

Session 5: Effective Resource Management - The Optimal Provider-Payment Mix

Highlights of Presentation

UHC requires a right balance between revenues and expenditures. The focus of revenue generation is obtaining adequate resources for expanding and sustaining effective coverage. The focus on expenditure is to design appropriate benefits packages that are strategically and effectively purchased. A key question to be considered is whether revenue generation gets more attention than expenditure management. Raising revenue for UHC is not enough. Evidence shows that Ghana's NHIA has achieved a growing and diversified revenue base – VAT, SSNIT contributions, investment income and premiums, but the gap between revenue per member and claims per member is becoming adverse.

Provider payment methods - the way providers are paid to deliver the covered package of services - are an important strategic lever in UHC. Provider payment methods help balance system revenues and costs and create incentives for providers to improve quality and deliver services more efficiently. This ultimately makes it possible to expand coverage with limited funds. The main provider payment methods are line-item budget, global budget, per diem, DRG, fee-for-service and capitation. There is no perfect payment method. They all have strengths and weaknesses. They can all create undesirable incentives and adverse consequences. They can all be useful at different times depending on the objectives. There are compromises and trade-offs to be made in deciding on a provider payment method or mix. Lessons have emerged from country case studies to guide in the process.

Options selected can be assessed on whether they are coverage-enhancing or coverage eroding. Coverage-enhancing expenditure management frees up resources to expand coverage, while coverage-eroding expenditure management controls expenditure by limiting benefits, increasing cost-sharing or underpaying providers, thereby reducing access to necessary services and financial protection. Countries that have achieved UHC and financial protection have balanced revenue-generation efforts with coverage-enhancing expenditure management.

The case studies show that, with the exception of Japan, countries relying on fee-for-service payment face coverage-eroding cost escalation and inefficiencies. The factors that make Japan different are a strong governance system with biennial revision of the fee schedule, tight conditions for billing and payment, strict enforcement of cost-containment measures and a unified payment system across providers and insurers. Coverage-eroding approaches found in country case studies include underpaying for services, supply-side constraints - with attendant implicit access restricting effects, shifting of financial risk to providers, increased cost-sharing - attendant with excessive shifting of financial risk to patients, and creation of access barriers - through rationing.

Coverage-enhancing expenditure management approaches include setting of expenditure targets - at the global, system-level and sub-level, closed-ended provider payment methods - with performance-based components, fee-schedule revision - as a cost-containment tool, strong primary care gate-keeping, tough negotiation with pharmaceutical companies, priority-setting for expansion of benefits, and monitoring and early-warning systems.

While the optimal payment mix ultimately depends on the objectives and context, common features of an optimal mix are:

a. Closed-ended payment methods that impose a cap at some level e.g. capitation or DRG with global budget/volume targets.
b. Incentives to limit high-cost services e.g. paying providers below cost for some high-cost/low priority services e.g. MRI, limiting volume, higher cost-sharing for self-referral.
c. Emphasis on primary care, e.g. primary care gate-keeping, ring-fencing or setting targets for sharing of expenditure for primary care, paying relatively higher rates for primary care.
d. Negotiation of drug prices e.g. reference-pricing, budget caps, mandatory rebates and discounts, health technology assessment to expand medicines covered.

Determining an optimal provider payment mix is an ongoing process of analysis, revision and response. Good provider payment requires a high degree of institutional capacity and information, which takes time to build. Involvement and negotiation with providers is critical. Some coverage-enhancing expenditure management strategies can eventually put too much pressure on the system and begin to erode coverage. Countries take steps, gain experience, analyze results and revise. Learning from other countries can help make better technical decisions, provide innovative ideas, avoid pitfalls and navigate real-world implementation challenges. The Joint Learning Network is an example of a mechanism that helps to facilitate this.

Highlights of Discussion

A provider payment mechanism should sustain the NHIS. There is the need to review the challenges and solutions in each mix, listen to and involve stakeholders and educate them on whatever payment mechanism is used e.g. DRG. Providers and patients alike need to be well educated to ensure level understanding of payment mechanisms. Co-payments should not be encouraged due to their potential to increase financial risk. The possibility that medicines will be included in the NHIS capitation basket should be well considered since medicines are not always available. In such a situation, providers may take the money and not provide the medicines thereby leading to dissatisfied subscribers.

Providers need to recover their costs to be financially sustainable into the future. Recovering costs will enable them improve quality of services and enhance access. The view is held that NHIA's strategies have been coverage eroding as tariffs are not reflective of cost and payments not timely and regular - not taking into account credit cycles of suppliers which are 90-days compared to NHIA reimbursement of 180days. Who provides the difference in costs? Inflation and foreign-exchange rates erode tariff levels making it imperative to regularly review tariffs. Providers have resort to writing prescriptions for patients instead of supplying when they cannot recover costs. Providers should be involved in costing of healthcare services. In response to this challenge, the NHIA has set-up a multi-stakeholder team to monitor tariffs and to bring feedback to inform tariff revision exercises. Providers are therefore being engaged in monitoring right from the time when tariffs are released. The issue of eroding tariff levels however remains a serious challenge to the NHIS.

The perspective of Malaysia regarding funding of healthcare is that it adopted the British public general tax system for funding of healthcare. The key reason for going this route was a strong

social development agenda - with a strong focus on equity and rural development - geared towards improvement of the social determinants of health namely education, housing, clean water, sanitation etc.. all factors that have an impact on the health of communities. Resource allocation went into PHC, maternal and childcare and basic health needs. Malaysia also adopted cost-effective measures, such as use of line-item budgets to push efficiencies within the public sector. It also used performance contracts, targets, quality improvement programmes, patient safety initiatives, accreditation of facilities, central negotiation and purchasing of drugs to capitalise on economies of scale. Malaysia focuses on buying generic drugs and cost-sharing for high levels of care.

Conclusions and Recommendations

There is a need to educate subscribers about the Scheme's benefits thereby empowering them to know their rights and responsibilities. This can be achieved through developing subscriber handbooks, making medicines lists more accessible and encouraging subscribers to call the complaints centre. With particular reference to capitation, successful implementation will depend, among other things, on effective communication and education of stakeholders thereby helping them to understand what capitation means. When this is effectively done, providers for example can restructure their systems of care delivery to increase efficiencies in order to accommodate the new payment method.

There is the need for an in-depth scientific enquiry and cost analysis to assess the real cost of providing services. Effective regulation of both the supply and demand-side of healthcare will also help to contain costs.

The private sector should be engaged in providing primary healthcare and in forming provider networks to be able to deliver service packages.

Ghana Capitation Lessons

The NHIA's challenges piloting capitation are not uncommon; as long as the objectives of capitation were clearly identified, implementers should know that implementation challenges will always arise. The experience gained should be used to revise and adapt the approach.

Session 6: Improving Targeting of the Poor and Ensuring Equity - Emerging Systems and Approaches

Highlights of Presentation

Various studies have shown that many people in the world have been pushed below the poverty line of US$1.25/day due to out-of-pocket health payments. Providing protection from catastrophic health-related expenditure is critical not only for the poor, it also ensures that people in all wealth categories do not become impoverished due to sudden ill-health. Above all, it very important to provide cover to protect poor and vulnerable families from health-related shocks. However, this is easier said than done as designing systems for effectively covering poor and vulnerable populations is a challenge facing many countries as they strive to move towards UHC. The poor and vulnerable are defined in a number of different ways. There are also several reasons in different countries for wanting to reach the poor. Despite this, equity as a rationale for targeting the poor and vulnerable is supported by many country examples, such as those of Thailand, Columbia, Mexico and India.

The universal approach to coverage, which is the human rights' approach and the targeted approach are the two main approaches to coverage of poor and vulnerable populations for UHC. A key challenge with the targeted approach is with its inclusion criteria and inadvertent exclusion of those in hard-to-reach areas. Criteria for identifying the poor and vulnerable tend to be diverse, but in all systems, the absence of a robust national identification system leads to duplications. Effective coverage is facilitated by the use of unique IDs to identify beneficiaries in targeted programmes. Successful implementation of targeting programmes requires a competent administration that defines the scope of the benefit package and enforces a means-testing system. Where such capacity is lacking, many implementation challenges arise. The significance of targeting from the political economy perspective is very different from the technical perspective. The question that arises is whether public programmes should attempt to target the poor through means-testing or if this effort is more costly and much less effective than simply making services available to all households.

From the political economy perspective of targeting, the important question is not how to better target the poor, but rather who gets targeted and why. In all these processes, enrolment is very critical, hence the need to build in incentive systems and employ technology to improve the efficiency of the process. It is also important to improve the demand side by making health services available and accessible (financially, geographically and culturally). This requires a good legal and governance framework that is realistic and ensures accountability.

Highlights of Discussion

In Ghana, social protection programmes such as the Livelihood Empowerment Against Poverty (LEAP) and the School Feeding Programme were introduced as targeted programmes. Experience however showed that where there is low awareness about targeted programmes of this nature, their uptake is low.

There are economic advantages and disadvantages in both approaches to coverage. There are also technical, social and political consequences for each approach adopted. This is supported by global and African regional experiences. The use of tested systems such as use

of poverty maps and special surveys such as the Ghana Living Standards Survey should be increasingly employed in designing targeted programmes. A key issue with regards to targeting, however, is whether the poor remain poor forever, and whether there are exit strategies for beneficiaries who no longer qualify for such programmes and entry points for those who were hitherto non-beneficiaries. Numerous strategies have been used globally and regionally to ensure that the poor and vulnerable are not denied access to healthcare. These experiences provide opportunities for learning lessons as regards to how poor and vulnerable populations can be effectively targeted.

Conclusions and Recommendations

How to effectively identify the poor and vulnerable is a big challenge for most social protection programmes. Available evidence shows that improving systems for identification of the poor is necessary for effective targeting. This involves dealing with duplications and ensuring minimization of errors of inclusion and exclusion. Effective identification of the poor and vulnerable is often fraught with challenges. On the other hand, adoption of the universal approach in most cases benefits rich urban dwellers because of the concentration of health facilities in the urban areas. A decision has to be made as to whether NHIS premiums should be partially or fully subsidized. In an environment of scarce resources, an effective way of targeting will yield greater dividends than the universal approach, notwithstanding the fact that health is a human rights. While it is well known that formulating, adopting and implementing social policies occur through political processes, sound economic and technical designs of such policies is important. Effective monitoring and evaluation systems should be put in place to ensure continuous improvement of the policy and implementation framework for poverty targeting.

PARALLEL SESSION A

A1: Improving Health Infrastructure

Health infrastructure has been defined in a limited context to mean brick and mortar. This definition provides a distorted meaning about health infrastructure hence the need to define the concept in a more broad sense. Health infrastructure properly defined should be broadened to include medical equipment and staffing in their right proportions to achieve economic efficiency and technical healthcare quality, whilst at the same time ensuring comfort and healing in an environment conducive both for workers and client care.

Apart from Europe, which has 60 beds for every 10,000 patients, the rest of the world is in deficit as follows: America has 24 beds per 10,000 patients; South East Asia has 10 beds for every 10,000 patients; and Africa has less than 10 beds for every 10,000 patients. A global estimate of required investment in health infrastructure by 2030 is 175 billion US Dollars, of which Africa as a whole will require 72.5 billion US Dollars to meet health infrastructure standards for its population, whilst Ghana will require an estimated 1.6 billion US Dollars investment in health infrastructure by 2030 to meet the standard. Whilst by no means the only indicator of access to healthcare, the availability of hospital beds is a mirror of the dire need of health infrastructure in Africa, Ghana being no exception.

UHC requires that nations prepare to make significant investments in health infrastructure to meet global standards of healthcare thereby ensuring the provision of quality care and geographical coverage. Increasing populations and demographic changes fuel demand for healthcare, and Ghana's population growth of 2.3%, increasing life expectancy and demographic changes and shifts in disease burden will mean demand for more beds and other infrastructure. With such a huge infrastructural gap, and with public spending currently unable to meet the growing needs, the private sector's participation in health infrastructure investment will need to be stimulated.

To meet global health infrastructure standards, efforts should be made to engage the right design, specification, tendering, construction, operation and maintenance processes. Waste should be reduced at every point along this chain. Countries in conjunction with acquiring physical infrastructure also develop the appropriate human resource capacity for effective procurement, operation and management of health infrastructure. Monitoring and evaluation systems also need to be strengthened. Poor maintenance quality assurance cultures which are the key causes of the health sector's inability to meet global standards for health infrastructure should be overcome.

Most of the health infrastructure in developing countries is located in the urban areas. Urban areas typically have about a third of the populations of these countries compared with the two thirds that live in sub-urban and rural areas. Emphasis on providing infrastructure should therefore be on provision of smaller primary healthcare infrastructure that are closer to majority of the people. Ghana's policy of prioritizing the provision of standard basic health infrastructure to lower level Community-based Health Planning and Services (CHPS) and PHC facilities, whilst providing more sophisticated infrastructure and equipment to bigger and higher level facilities, appears to be the right policies for attaining UHC and should be pursued. It is however pertinent to note that insufficient funding has dogged Ghana's health

infrastructure delivery efforts over the years due to ever growing demand. For the policy on health infrastructure provision to work effectively, there is an urgent need to map existing health infrastructure, identify gaps and develop a geographical health infrastructure database. Health infrastructure development should go hand in hand with production and deployment of requisite human resources in order to be meaningful. In a context of serious financial constraints, Public-Private Partnerships should be vigorously explored.

A2: Developing and Deploying HRH

Highlights of Presentation were:

a. The PHC experience and emerging concerns about inequalities in health outcomes.
b. The case for a new direction in Human Resources for Health (HRH).
c. The need for new thinking and effort in Human Resource development.
d. The need for competency-based health education.

UHC is a means for dealing with inequalities in access to healthcare. Dealing with inequalities in health access on the journey towards universal coverage requires three basic steps. These are extending healthcare networks (infrastructure) to where they are not available, shifting from reliance on user fees levied on the sick to solidarity and protection provided through pooling and prepayment and developing mechanisms for social health protection. Achieving these three ends requires human resources in the right numbers and with the right skill mixes. Available evidence indicates a 4.3 million global shortage of health workers. On the African continent, there is a shortage of 1million health workers. The reality of health human resources today is a globalized and inter-connected market with inequities, tensions within the working environment, a delicate balancing of health professionals versus population expectations, distribution, commercialization, changing nature of vocations or jobs, changing scope of practice, unmet skill needs, task shifting and the evolution of needs-based training among other things.

The new direction for building effective partnerships for medical education is towards competency-based education - as indicated in the 2008 WHO report on skills gap and skills mix- as well as revitalizing primary health care. UHC as a means to obtaining better equity implies improvement of healthcare in three dimensions. These are service delivery systems - infrastructure/drugs/supplies - financing and mechanisms for social protection. These three aspects are vital for the design of comprehensive and responsive systems for attaining UHC in an equitable way.

In terms of the human resources needed for UHC, staff numbers, quality and skill mix tend to be very critical. It is worth noting that some efforts have been made on the African continent in response to this need. There is the African Union/WHO Strategies/Scale-up Framework and Roadmap for Health Workforce in Africa. With political, technical and social commitment, evidence-based information for HRH can be fed into policy to address the needs of the health workforce for the 21st century.

As part of strategies to beef up human resources for health, selection criteria for admission into health training schools should not be based only on good grades but a combination of other competencies. It is important to link education and training to population dynamics and the ongoing epidemiological transition. As the population ages, many more professionals would have to be trained in geriatric care (care for the elderly) so that the healthcare delivery system can effectively respond to the needs of the beneficiaries. Special incentives should also be built into the system so that health professionals will be willing to live and work where the need is greatest.

Disease burdens in areas deprived of health professionals is very high due lack of advocates. Advocacy is therefore a strong tool for ensuring availability of human resources. Human resources policies and strategies should be constantly reviewed to make them relevant and applicable to the achievement of UHC. Best practices from other countries can be used to improve productivity. This should include staffing norms that help attract and retain staff. Where attrition is high, more people should be trained and mechanisms should be built in for higher retention.

Highlights of Discussion

Underlying the global health work force crisis is the failure to train and retain adequate staff. Competency-based education with initiative and drive is the type of health workforce training required for the 21st Century. Effective human resource strategies should consider the need to correct the current dominance of hospital care over primary care, labor market imbalances in low resource settings, importance of teamwork and gender stratification, and the need to align competencies to needs. Indeed, this calls for evidence-based HR policies and strategies. The health workforce should be fit-for-purpose in terms of being appropriate for assigned jobs, possess attributes required to achieve intended work objectives and be conducive to developing experts/leaders/professionals. Lessons should be drawn from the African Union Health Strategy, the WHO Road Map, as well as the Kampala Declaration and Agenda for Global Action, which not only dwells on numbers of available staff but on appropriate skill mixes and quality.

Conclusions and Recommendations

With competency-based education, health workers can become change agents who lead the processes they profess. Achieving such competencies demand that the right people are trained, selected and recruited. In this regard, it is important to link education and training to population dynamics. Health worker training should be in real life practice environments where there is mentorship and team-based learning, as well as strong linkages with communities. Countries need to prioritize education and training of their health work force by linking it to their national development plans.

It is important 'to plan long term, act short term and review frequently'. Health worker education and training should be linked to population health needs and the health system. Country multi-stakeholder alliances should be created and health work force information systems (observatories) established. Adequate numbers of health workers should be trained in order to be responsive to demand for services. Human resources gaps should be filled with the correct mix of health workers. Health Boards should be created for recruiting and distributing staff. Such boards should ensure that opportunities for career development are enhanced.

Challenges to that have to be addressed to ensure effective human resources for health including inadequate capacity to manage human resources, poorly defined HR needs, inequity in staff distribution, lack of political, social and technical commitment, and inability to provide attractive packages to retain health workers in rural communities. HR needs should be well defined, recruitment procedures streamlined and, special incentives such as additional allowances and early promotion for staff in deprived areas institutionalized. Development of capacity for managing human resources should be well planned and executed, in addition to

the development of evidence-based information systems that feed into human resources policies and strategies that can be translated into meaningful action on the ground.

A3: Mainstreaming Monitoring and Evaluation

Highlights of Presentation

Ghana generally does not have a good culture of monitoring and evaluation (M&E). To a large extent, M&E policies and activities have often been driven by donors. Despite the low attention paid to it in Ghana, M&E has a key role in guiding policy and decision-making in a health system. In Ghana, there are generally major gaps in data availability which presents challenges in tracking program implementation. Based on this background, it is interesting that the new NHIS law has taken some steps to mainstream M&E. The new legislative regime requires that results chains for the Scheme should establish the link between inputs and outcome/impact, utilization, patient satisfaction etc. The serious challenge of sustainability facing the Scheme could have been addressed differently if M&E had been a critical component of implementation from the onset. M&E allows for regular feedback to front line workers and helps to educate and guide them on program relevance, effectiveness and impact.

Highlights of Discussion

M&E should be mainstreamed so that it becomes the norm and results in appropriate resources being allocated. The cost of M&E activities should be built into every project and programme that is undertaken. Effective M&E should produce evidence. This evidence must be 'pushed' (demand strict and regular reporting) or 'pulled' (use evidence to make decisions). Some major reforms in Ghana's health sector over the years have helped to emphasize and structure M&E. Some monitoring processes that have evolved through these reforms include the MoH/GHS series of Performance Reviews, Senior Management Meetings, Health Summits, Inter-Agency Meetings and Independent Reviews. Despite these strides there continues to be a lack of a sustained effort to establish posts for M&E in the health sector.

M&E is mostly fragmented at the level of service delivery and programme implementation. The various major constituencies of the health sector implement vertical and parallel M&E systems based on their respective programmes, instead of a coordinated M&E system based on the sector medium-term plan. A web based Ghana District Health Information Management System (DHIMS2) system that allows easy access and permits managers at the national level to view directly how responsible officers at the decentralized level are inputting and monitoring data has been developed. But this has no direct linkage to other information systems within the sector.

Linkages and partnerships with academic institutions can help address gaps in M&E through capacity building and in triangulation of findings. Fear of M&E can be eliminated by introducing M&E as a course in tertiary training institutions to make M&E a normal practice in the country.

M&E systems need to be strengthened for effective programme delivery. Collaborative monitoring and review arrangements with industry, civil society and academia should be encouraged to facilitate broad buy-in and understanding about programs and minimize dissension when results of M&E are made public e.g. the Oxfam report on the Scheme.

Conclusions and Recommendations

M&E is effective only if it is transparent and open. To make this possible, M&E should be built into program design. Partners and stakeholders should work together to develop a credible data system that has minimal bias. They should share and review M&E reports with each other. Staff responsible for collecting and analyzing data need to understand the rationale for the collection and analysis. This will motivate them to collect and analyze data accurately. Dashboards could be created to enable data generators and managers use the information to improve performance.

Monitoring and Evaluation should be coordinated with top management championing an M&E culture in their organization. Feedback should be provided to those on whom data is collected to guide and influence their work. Efforts should be made to avoid duplication in data collection and confirm data from their sources. Data should not only be collected on activities but also on the impact of activities from the point of view of beneficiaries.

A4: Expanding Primary Healthcare

Highlights of Presentation

Ghana's health delivery system has evolved in 20-year cycles from independence. From an initial focus on infrastructure, to rapid expansion of services based on PHC, to health systems strengthening and the MDGs. The WHO defines PHC as essential health care based on practical, scientifically sound, and socially acceptable methods and technology, universally accessible to all in the community through their full participation at an affordable cost and geared toward self-reliance and self-determination. In 1978, the Alma Ata Declaration recognized PHC as an essential right and committed governments to launching and sustaining PHC as part of their national health systems.

Ghana's PHC goal, objectives and strategies

Goal: Maximise total life of Ghanaians

Objectives:

1) Achieve basic and primary health care

2) Effectively attack the diseases problems that contribute to morbidity and mortality

Strategies:

- **Improve accessibility-coverage of services**
- **Improve quality of PHC**
- **Improve and strengthen management**

The objectives of Ghana's PHC are to achieve basic and primary health care for 80% of the people and to effectively deal with the disease problems that contribute to 80% of morbidity and mortality. The strategies for PHC are to improve quality, accessibility and coverage of services and to improve and strengthen management capacity to support the primary level of healthcare service provision. Primary Healthcare is organised at the district level, with graduated skills and capacity from the community to the sub-district and district level e.g. use of TBAs at the community level.

With little evidence that training and deployment of semi-skilled health workers at the community level was having an effective impact on morbidity and mortality, MoH took a decision to replace them with trained staff, leading to the CHPS initiative. CHPS involves locating a CHN (CHO) in a community with a defined population (zone). A CHPS works with volunteers supported by the community through Community Health Committees, with a set of functions to perform, and supervised by a sub-district team.

Priority interventions in PHC have evolved over the years. These interventions have mostly focused on disease prevention and control, immunisation, health promotion and family planning services. Government resource allocation to PHC in Ghana has seen steady increases over the years, but the complex funding flow from many different sources has caused fragmentation. The NHIS has become a significant source of funding to the health sector, contributing over 80% of facility IGF in most cases. The NHIS currently uses capitation for reimbursing PHC services in a pilot region, but the potential of capitation for preventive healthcare is yet to be explored.

Data sources and structures for measuring performance in the health sector includes data on PHC. Performance measurement could be improved to include a league table of districts. The

major challenges in implementing PHC include inadequate capacity at the decentralised level, lack of partnerships with the private sector, challenges of defining a package of interventions, slow pace of decentralisation of health services and mainstreaming of M&E to provide an evidence base for decision making and programme improvement. Since the days of Alma Ata, there have been changes in Ghana's landscape that will influence the way forward for PHC. These include urbanisation, improving economic status, changing disease burden and the financing landscape provided by the NHIS. Opportunities provided by improvements in information technology is also an important change that can be leveraged to improve PHC. This calls for a consistent strategy to use ICT to enhance efficiency in PHC in areas such as mobile health, electronic blood banks, community-based electronic registration, electronic claims etc.

Highlights of Discussion

The package of PHC services would need to be reviewed in the midst of the ongoing transition of the NHIS to reflect the changing disease burden towards non-communicable diseases (NCDs) – stroke, hypertension, and diabetes etc. NCDs are disproportionately affecting poor people and there is the need for a multi-sectoral approach and engagement of communities in preventive strategies which direct resources as appropriate. PHC must also deal with infectious and chronic diseases - TB, AIDS, NTDs, as the double burden of disease affects both households and individuals.

Classification of health facilities in Ghana has not adequately captured the private sector as an agent for PHC scale-up. Task shifting – drawing on capacity of a large number of lower trained health workers should be integrated in PHC delivery.

Experiences and challenges shared with regard to Malaysia's PHC its delivery are as follows:

a. Challenges in expanding public infrastructure for PHC delivery and expansion of PHC services in existing primary facilities.
b. How to rope in the vast resources in the private sector for PHC thereby optimizing use of resources in the country.
c. The fact of private sector facilities being predominantly in urban areas.
d. Strengthening of the district health system to offer PHC through a network of community nurses in rural and remote areas. This level escalates to health clinics with physicians and multi-disciplinary teams where physicians handle complex cases while nurses provide continuity of care for chronic diseases.

PHC is mostly used by the poor. PHC has a significant impact on reducing the burden of disease. However, since Alma Ata, PHC has under-delivered on its promises. PHC was expected to help attain the MDGs but this has not been possible in many countries despite enormous efforts. Challenges to PHC include insufficient facilities close to populations, low quality of care supplied at primary facilities especially in poor areas, broken equipment, inadequate supplies, as well as poor customer service by primary care workers. Consumers compound this challenge by delays in seeking care, seeking alternative care or skipping the primary level of care and going to the secondary or tertiary level for services.

Recommendations

The following recommendations were made:

a. Encourage greater involvement of the private sector in delivery of PHC and preventive services.
b. Use innovative financial incentives to stimulate better supply of services.
c. Help consumers make better use of PHC through innovative financial incentives and similar programs – transportation, immunisation cash transfer etc.
d. Mobilise increased funding for PHC - taxation and earmarked taxes and user co-payment of fees.
e. Encourage greater role of development partners in PHC.
f. Increase efficiency in how funds are utilised to encourage increased mobilisation from all sources - taxpayers, Ministries of Health, the global community, donors, consumers etc.
g. Shift to large public funding and increased use of performance and results-based funding modalities.
h. Utilise resources to achieve results in preventive care to reduce the focus on curative care.
i. Use the purchasing power of the pooled funds to involve the private sector in order to reduce the focus and pressure on the public sector e.g. increase skilled delivery by training private midwives to work with CHOs.
j. Accreditation of health facilities should promote situating of health facilities in deprived areas. Accreditation processes should minimize delays.
k. PHC performance indicators should cover access, quality, efficiency, partnerships and collaborations, equity and financing.
l. Performance systems should encourage country comparisons to motivate improvements.

A5: Dissemination of Study and Survey Results

A5.1 The Challenge of Non-Communicable Diseases in Sub-Saharan Africa

Sub-Saharan Africa is experiencing a changing health profile (changes in epidemiology). It is at the same time witnessing increases in economic growth. The changing context could be easily misconstrued as an indicator of equity in distribution of wealth. However, the trend does not necessarily imply that the numbers of the poor are decreasing. Strategies to eradicate poverty should include an effort to ensure a healthy population by attending to their health needs. A healthy population, though not sufficient, is necessary for increased productivity, which in turn strengthens the extent and sustainability of growth. In Africa, deaths from communicable diseases are still high, despite the progress made in reducing its incidence. However, in the wake of these difficulties, NCDs have emerged as the leading cause of loss of lives. The highest death rates from NCDs occur in Africa. NCDs have economic, social and demographic dimensions in addition to biological ones.

The question of how to effectively address NCDs in SSA in a context of limited resources therefore arises. Financial protection and access to quality services can be offered with limited resources by strategizing to avoid the introduction of vertical programmes. Integration is key to fully utilising extremely limited resources. Ways of achieving effective use of limited resources include:

a. Taking advantage of the links that exist between health conditions, treatment approaches and their common determinants using existing resource capacity. For example, cross-fertilization of cure approaches between communicable diseases and NCDs, such as the case of integrating HIV and cervical cancer control, can cut huge costs.
b. Treating a person holistically - this could mean checking blood pressure while primarily checking HIV status.
c. Taking advantage of proven interventions that are cost effective -by adaptation of global experiences from mobilized knowledge.

Strong systems need to be established to make the implementation of interventions cost-effective. Integration of vertical programmes and systems interventions is cost-effective. Donors who insist that funds should be used solely for a particular disease stifle the attainment of a well-integrated system. Encouraging the unitary folder system can be helpful in this regard. Organisations should invest in the health of their workers since everyone has a role to play in dealing with NCDs. Learning from the global village can be enhanced through mobilizing relevant knowledge from country experiences.

In order to effectively deal with NCDs that are caused by lifestyle, it should be possible for the Ministry of Health to engage the Ministry of Education to educate the general public. The particular instance of educating people on the risks of alcohol and tobacco consumption can be comprehensively through such partnerships.

Improving the health condition of the people is an essential pre-requisite for sustainable growth and social transformation. A well-integrated health system that is multi-sectoral in outlook

improves access to quality health services for all. Efforts should also be made to invest in prevention as much as cure.

A5.2 Analysis of Survey Results of the Performance of Health Facilities in NHIS Accreditation

Accreditation of health facilities in Ghana was first legislated in National Health Insurance Act 2003, Act 650. Implementation of the NHIS from 2005 started with a system of blanket accreditation of all public facilities and provisional accreditation of private facilities based on their standing with their licensing bodies. In 2006, efforts got underway to develop a system of accreditation of health facilities under the NHIS. This finally culminated in the implementation of a full-fledged accreditation system in 2009. The accreditation process, which started in 2009, has generated significant evidence that would be useful for improving policy and programmes on quality of care.

Preliminary findings of a survey undertaken to assess the nationwide performance of all NHIS accredited facilities, was presented during the session. The survey measured performance of health facilities by region, facility type and ownership, to determine the forces driving facility performance. Following accreditation, facilities are graded based on their performance. Grades range from A+ to E. A grade of A+ is the highest grade a facility can score and represents a score of 90-100%. A grade of E represents a score of less than 50% which represents failure by a facility. The survey was carried out on 3701 facilities accredited between July 2009 and December 2012.

On the whole the pass rate was high (at 95%) but the quality of passes was not impressive, considering that 77% of the facilities passed with grades C and D. The Eastern Region was identified as the best performing region with the Brong Ahafo, Volta and Greater Accra performing poorly in the respective order. Central Region, Upper East and Upper West Regions had the best quality of passes. It was observed that the least endowed regions put up the best of performances. By facility type, primary health facilities mostly characterised by CHPS performed better than clinics. Chemical sellers as a group posted the worst performance. By ownership, private clinics had the highest failure rates. Mission health centres performed better than both private and public health centres.

Highlights of Discussion

Concerns about the views of the patients contradicting conclusions from the survey were raised. Patients are generally of the view that private hospitals give services of better quality but the survey proved otherwise. The good performance projected by the survey might not necessarily mean services are of good quality but may rather imply poor infrastructure. However, accreditation as a tool for assuring quality is critical and should be strengthened in Ghana. As a country aspiring to UHC, Ghana should use the process of accreditation to assure quality of services to all.

PARALLEL SESSION B

B1: Country Case South Korea - Contracting for Medicines

The importance and influence of medicines and the pharmaceutical industry in determining the cost of healthcare cannot be underestimated. Medicines cost between 34-53% of patient treatment costs across the globe. The pharmaceutical industry accounts for 1.3% of global GDP and 7.5% of GDP in well regulated countries like Korea, which is considered relatively low when compared to other developed countries. In Ghana, over 50% of NHIS expenditure is on medicines, with the cost of outpatient medicine prescriptions accounting for 80% of total spending. Medicine prices in Ghana have grown rapidly since the introduction of health insurance, particularly between 2008 and 2013, reaching up to over 300% of initially negotiated prices at the start of the NHIS.

In Korea where about 97% of the population is covered by national health insurance, it took the introduction of an independent Health Insurance Review and Assessment Service to review medical claims and evaluate the appropriateness of the care provided by medical institutions to reduce medicine volume and prices. It is generally agreed that when medicine prescription and dispensing are not separated, particularly when it is possible for both physicians and pharmacists to prescribe and dispense medicines, the cost of medicines to an insurer rise considerably within a short period because of the incentives inherent in such a practice. For medicine dispensing patterns to be rationalised and price escalations contained, there is the need to introduce measures that influence supply price negotiation alongside regular price adjustment, with reimbursement incentives to providers who conform.

Regularly reviewing decisions on what medicines to add to a country's national health insurance medicines list has to be carefully and scientifically evaluated. This has to be done alongside parameters such as availability, effectiveness of existing alternatives, and volume and budget share of each medicine or group of medicines before adding or removing them from the list. Additional considerations should include the cost effectiveness and the therapeutic benefits linked with their necessity and severity of the diseases they treat, with status assessed regularly.

There is the need to set up a system to monitor and provide regular feedback on the way medicine prescription is carried out, in terms of numbers per prescription as well as injections and antibiotics prescribed. The results from such monitoring and evaluation should be shared with the prescribers and dispensers. There is evidence from the field of practice to suggest that posting the monitoring results of negative findings on the website for all to access has influenced behaviour change among prescribers and dispensers. It has been widely acknowledged that the asymmetric influence of physicians and pharmacists within the medical and pharmaceutical industry in dictating which diseases to treat and which medicines to use remains the strong determinant of medicine use and prices. Their support is therefore very essential in the choice and use of medicines in NHIS and should be engaged to help bring prices down.

If Ghana's NHIS is to make an impact in controlling healthcare expenditure, particularly in the area of medicines, then there is the need to lobby government, while seeking the

understanding of physicians and pharmacists, to accept the introduction of polices that will influence the demand and supply of healthcare and medicines to be used. Policies should include setting up of an independent body to be responsible for the negotiation of medicine prices with the companies. There should be strong enforcement and compliance with standard treatment protocols and guidelines, to ensure that patients who have no access to qualified physicians and pharmacists do not suffer.

The NHIS should sponsor research into medicine prescription to determine the most effective cost containment measures without compromising access, quality and efficacy of medicines. The local pharmaceutical industry should be empowered and encouraged to undertake large local production as a way to control prices. Government should work on the demand side by investing in medical technology like the Koreans have done, setting up a team to study Korean medicine policy and to adopt those that can be applied in Ghana.

There was no consensus between participants on the issue of introduction of co-payment into the NHIS as a way of controlling abuse of medicine prices and use.

B2: 50 years of UHC in Japan - A Lesson in Sustainability

Highlights of presentation

UHC in Japan has led to good health outcomes at a low cost. By law, all Japanese citizens are required to belong to an insurance Scheme. Japan's UHC system uses a well-managed fee for service system, which covers basically all health services. The system is financed through taxes, co-payment, and employer and employee contributions. There are four separate Schemes with different premium rates, which are based on employment status.

There is one fee schedule that unifies all of the Schemes. The government bi-annually reviews the fee schedule which is the only source of income for the majority of providers. The government also uses its purchasing power to negotiate lower prices for pharmaceuticals. The government sets the prices of pharmaceuticals and medical services, and providers must abide by these prices or they will not receive any money from the government. There are strict regulations on what hospitals can and cannot charge for. Over-billing is prohibited.

Increasingly, the aging population of Japan is putting pressure on Japan's UHC system. A guaranteed 0% co-payment has been introduced for the elderly and a new Scheme created for them. The economic growth of Japan is not keeping pace with the rate of increase in spending on social security. This is putting pressure on funding of the UHC system.

Highlights of discussion

Political commitment has been critical for the success of Japan's UHC program. So also has the country's impressive primary healthcare system. For Japan, UHC is not a final goal. The country's long-term goal is to provide quality healthcare to ensure a healthy population. The main challenge in Japan is the strain the aging population puts on the system. The complexity of the health insurance system, with its fee schedule that changes every two years, can make working within this system quite challenging. There is however robust data collection and regular analysis which is used to inform the development of health insurance schemes.

In Japan, the guarantee that elderly people will be given quality care with 0% co-payments makes the working class willing to contribute to the health insurance scheme as they know it will take care of them later on in life. Japan's current UHC issues involve developing quality control mechanisms and providing a mechanism for incorporating patient views and perspectives into the development of the health insurance scheme. As its contribution to the global movement towards UHC, the Japanese government has partnered with the World Bank to share Japanese expertise and knowledge in UHC with the rest of the world. Additionally, financial commitment has been made to assist developing countries with capacity building and training of health care workers.

Summary and conclusions

The Japanese health insurance scheme is actually four separate schemes with one common fee schedule and payment system. The law requires all Japanese citizens to be insured. Which system each person is enrolled in depends on their employment status. Factors that have been important to the success of Japan's UHC include political commitment, regular monitoring and evaluation, focus on PHC, and the development and strict management of the

fee schedule. Japanese expertise is being used to inform the development of health insurance schemes around the world. It is important to remember that UHC is not the ultimate goal of the Japanese system. The Japanese system is designed on the premise that there is the need to change and adapt to ensure quality health care and coverage available to all to improve population health.

B3: Generating Evidence for Benefit Package Design - Role of Health Technology Assessment

Highlights of Presentation

Health systems everywhere are under pressure due to finite budgets and competing priorities. These pressures stem from increasing chronic burdens of diseases, ageing, high user expectations, the aspiration to make healthcare of acceptable quality available to all, improvements in technology as well as expanding possibilities for care in the market place. This situation calls for evidence in decision making. Evidence based decision-making starts from the premise that not everything that is clinically effective is affordable. Public expectations about healthcare are always increasing, in part due to political promises; a situation not helped by the break-neck speed of healthcare innovation. However accumulating debt to offer all possibilities available in healthcare is not prudent.

Health Technology Assessment (HTA) offers a way to make these difficult choices based on scientific evidence. HTA is a multi-disciplinary field of policy analysis that studies the medical, social, ethical, and economic implications of development as well as the diffusion and use of health technology. It is the systematic evaluation of the properties and effects of a health technology which addresses the direct and intended effects of a technology in addition to its indirect and unintended consequences. It is aimed mainly at informing decision-making regarding health technologies.

HTA is a tool to help policy makers make consistent decisions, reduce inappropriate variations and signal value to industry. It is not a cure for all system inefficiencies and problems, but it is intended to provide a bridge between the world of research and the world of decision-making. The audience for HTA includes policy makers, payers, medical product developers, industry, healthcare professionals, academic community, researchers, general public, taxpayers, insured population, informal sector, patients and their families NGOs, and donors.

HTA is an innovative program that determines whether health services approved for use by states/governments are safe and effective. The primary goal of HTA is to make healthcare safer by relying on scientific evidence and ensuring that healthcare coverage decisions are consistent and cost effective, and lead to payment for medical tools, inputs and procedures that are proven to work. Ultimately, the goal of HTA is to make the healthcare coverage decision process more open and inclusive by sharing information, holding public meetings, and publishing decision criteria and outcomes.

Health Technology is defined as any intervention that may be used to promote wellness, prevent, diagnose or treat disease, or for rehabilitation or long-term care. This includes pharmaceuticals, devices, procedures and organizational systems used in health care. The Paris Declaration on Aid Effectiveness (2005) and the Accra Agenda for Action (2008) state that ‘successful development depends to a large extent on a government’s capacity to implement its policies and manage public resources through its own institutions and systems’.

Locally led HTA-informed decision making requires strengthening and empowering local institutions to develop technical capacity to do the needed systematic reviews/meta-analysis, health economics analyses, and to secure the political backing of these endeavours. When

well conceived and structured, HTA can become a means for building and reinforcing capacity for the implementation of new initiatives in the NHIA.

HTA is a useful tool for policy makers to assess the value of a range of health technologies, including drugs, medical devices and disease prevention interventions, thereby helping to maximise the impact of finite healthcare budgets. It is a means of legitimising disinvestment decisions and saving money to reinvest in expanding coverage. Countries starting out in HTA should not wait for 'full' capacity to do HTA, but rather concentrate on using the policy need to drive capacity building. Inclusive and transparent processes will be important in managing political tensions and ensuring the legitimacy of decisions. Ghana has well-developed institutions that can inform and contribute to such activities and it is important to build on these.

There is the need to consider who should convene and drive the HTA institutionalization process. As is evident from Thailand, a systematic approach to introducing HTA is highly recommended. In Thailand the development process was motivated by a scientific publication in 1992. This led to the establishment of a Centre for Health Economics and subsequently to the establishment of HTA procedures in the Ministry of Health. Eventually a Health Interventions and Technology Program (HITAP) was set up to formalize the concept and practice. The program produced guidelines and a database to guide and document health interventions as a basis decision-making. The concept was also introduced into curricula for schools of pharmacy.

Highlights of Discussion

HTA may be a useful tool for decision-makers in Ghana in achieving their joint aims of expanding coverage, increasing quality of care, and ensuring financial sustainability. There are many interventions in Ghana that will benefit from scientific evidence of cost effectiveness. The lessons from Thailand and UK indicate clearly the need to do things differently. Ghana has a double burden of communicable and non-communicable diseases. It has a health insurance Scheme with a generous benefit package that continues to expand. What process was used to generate evidence on which the package based? It is obvious that given limited resources at hand, HTA would important for rationalizing the benefit package.

The Ouagadougou Declaration of 2008 should underpin the need to use HTA as a tool for expanding expand coverage. Interventions should be implemented in a timely manner and be based on scientific rigor. Collaboration with academic institutions will help link research, policy and industry together providing convergence and collaboration for better healthcare. Research by academia can inform and guide policy decisions. Meta-analysis should also be undertaken more regularly.

Conclusions and recommendations

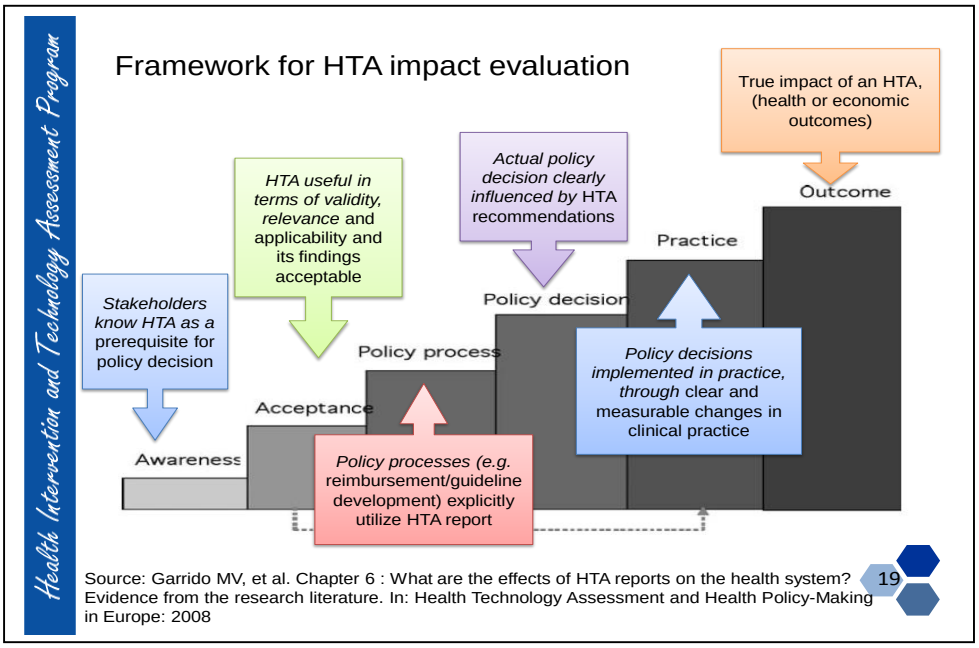
There are clear benefits of HTA to Ghana as it can use HTA to improve outcomes and efficiency of healthcare interventions. HTA can help in expanding coverage, improving quality of care, patient safety, and financial sustainability; as it takes taking the efficiency and efficacy of care delivery into consideration. HTA can help and guide policy makers e.g. how to define the cost of services.

HTA is useful where a health sector employs systems thinking in its approach to interventions. In designing a benefit package, HTA can help determine what should be included and what

should be excluded. Data from established private health insurance companies could also a useful input for designing the NHIS benefit package. The decision as to whether to use Disability-Adjusted Life Years (DALY) or Quality-Adjusted Life Years (QALY) as a benchmark is not as important and having capacity to implement the option selected. It is however noted that QALY can capture all aspects of health outcomes more comprehensively than DALY).

Students in academic institutions can be guided in selection of their thesis and research work to focus on issues relevant to HTA so that their data and work can be used as sources of information to guide decision-making. Though HTA programmes at their inception generally use the traditional approach of clinical trials etc., there is the need to move beyond this to strengthen economic analysis. HTA is useful for reviewing alternative approaches and demonstrating comparative advantage.

It must be noted that when a decision is made to design a benefit package for a population, there will be implications for other components of the health system - HR, infrastructure etc which must be dealt with holistically. It is therefore important that all stakeholders work together in a transparent manner to design a benefit package. Institutionalization of HTA is one way to achieve this by integrating structures and processes. For example, Ghana's benefit package is too generous and has some contradictions such as provision of free maternal health care but condoms at a cost. There is the need to apply some level of scientific analysis to both medicines and non-drug consumables before anything is added to the benefit package. For Ghana, HTA can also help in pricing and price negotiations. Considering that HTA is about making informed choices based on evidence, it should provide a good basis for pausing, reflecting and deciding on the way forward.



B4: Reducing Fraud and Abuse in Health Insurance

Highlights of Presentation

Healthcare fraud diverts resources from the provision of quality patient care. It has a direct and negative impact on human life in terms of diverting resources needed for effective healthcare. The WHO has identified fraud as one of the top ten causes of inefficiency in healthcare spending. There are four main types of healthcare fraud. These are fraud by managers and staff, healthcare professionals, citizens and patients, and contractors and suppliers. Fraudulent activities include misdirection of resources, false diagnoses, procedures and claims, as well as supply of counterfeit drugs and sub-standard equipment etc.

There is a need to invest in dealing with fraud by facilitating stronger national and international fraud control networks as well as encouraging professional training and accreditation for work on fraud. Approaches to dealing with fraud also need to move away from a 'pay and chase' focus to a proactive and comprehensive approach that identifies and applies the right solutions focused on outcomes, such as reduction in losses. There is a need for statistically sound legal methods of measuring fraud and quantifying the effect of reduction in losses due to fraud and tracking their tangible financial benefits. It is generally more preferable to pre-empt fraud rather than just react to it.

A report on the financial cost of healthcare fraud provides staggering data on the extent of the menace, averaging from 7% to as high as 15% of healthcare expenditure. Some reports even provide examples of reductions in cost of up to 40% within 12 months. An organisation, which is resilient to fraud is one that has in place mechanisms to identify the problem; formulates a strategies to address it; provides authority and resources to the institution or structure dealing with fraud; and ensures integrated and professional action. The fraud resilience is a tool for providing a 'helicopter view' of how well an organisation is protected against fraud so that weaknesses can be identified and removed. The link between fraud losses and fraud resilience is clear and can be calibrated.

Tackling healthcare fraud is central to having an effective health system and ultimately improving health outcomes. There is the need to be specific about the definition of fraud to get the right processes to deal with it. A range of sanctions can be applied to address fraud. These include prosecution, regulatory sanctions, recovering funds etc. There is the need for providing the right technical skills and ethical standards to tackle fraud. The honest majority must be mobilised to fight against corruption. There are good reasons to build coalitions that work together in the fight against fraud. They are able to foster learning about problems together, agreement on common high standards and supporting each other.

Highlights of presentation – Ghana's experience

Health insurance fraud is an intentional act of deceiving, concealing, or misrepresenting information that results in undeserved health care benefits being paid to an individual or group. Both a member and a provider can commit fraud. Types of fraud by providers include billing for services not rendered, up-coding of services, double billing/duplicate claims, misrepresentation of diagnosis, un-bundling of services, unnecessary services, inappropriate referrals for financial gain and insertion/substitution of medicines. Types of fraud by members

include impersonation – a non-member using a member's identity; ganging – members of a family using one member's card; provider shopping, illegal cash exchange for prescriptions and frivolous use of services.

Mechanisms that help to prevent/mitigate fraud include use of appropriate payment mechanisms, effective claims processing, effective data analysis, clinical audits and claims verification. The NHIA created a Claims and Clinical Audit Division in 2009 and commenced full scale clinical audits in January 2010. A clinical audit manual and tools have been developed in collaboration with stakeholders, particularly providers. The clinical audit process works with multi-disciplinary teams from both the public and private sector. Provider stakeholder groups such as GHS and CHAG helped develop the methodology for the clinical audits and facilitated implementation of the audits. This made the buy-in more acceptable-relying on peer review to make judgements.

Highlights of Discussion

a. The motive of clinical audit teams is to see whether providers have adhered to quality of care and treatment protocols. The process measures regularity of acts of omission or commission e.g. regular supply of an expensive drug.
b. Finance and capacity constraints affect scope and coverage of clinical audits.
c. Adverse policies can encourage corruption, abuse and wastage in the system. Cash flow management and timely reimbursements will help to address the issue of fraud.
d. A robust IT system will help to identify fraud e.g. online interface between NHIA and providers to help minimise fraud.
e. There is a need to promote a close working relationship between NHIA and the honest majority of healthcare providers.
f. Implement strong arrangements for detection so people see that the chances of getting away with fraud are slim.
g. Ensure certainty and proportionality of sanctions – different sanctions for lower value and higher value fraud.
h. Facilities should engage in dialogue with NHIA to strengthen their internal controls.
i. Provide incentives to report fraud; incentivise providers to identify and report fraud.
j. Different payment mechanisms have different liabilities to fraud e.g. fee for service – leads to inflation of inputs; DRGs – leads to upcoding; capitation – leads to reduction or denial of services and unnecessary referrals.
k. Capitation requires robust monitoring to succeed.

Conclusions and Recommendations

Recommendations to address the challenge of fraud include encouraging, protecting and rewarding whistleblowers. Also to be considered are early reimbursement for providers with clean claims, tariff incentives for adherence to treatment protocols, training of health insurance staff in fraud detection, and increased advocacy and sensitization on the impact of fraud. Other strategies are to pass specific health insurance fraud laws to require financial penalties in addition to refund of fraudulent payments and suspension or revocation of professional licenses of providers engaged in fraud.

B5: Presentation of Study Results

B5.1 Towards a Client-Oriented Health Insurance System in Ghana

Highlights of Presentation

A study on perspectives of key NHIS stakeholders from the three main groups (clients, providers and insurers) were presented from 64 health facilities in 8 districts in the Western and Greater Accra Regions. The focus was on waiting periods for NHIS ID card issuance, quality of services received and decisions for enrolling into the Scheme. The study showed that social trust/capital and enrolment behavior are determined by the accessibility of services, especially in the Western Region, where facilities are concentrated in the district capitals and are poorly inaccessible to people from the periphery. This state of affairs undermines the policy emphasis on primary health care service delivery. In order to overcome barriers and promote the facilitating factors, the study noted that it is important to bring all stakeholders together at frequent intervals to deliberate on pertinent issues. It is important to build trust in the formal (vertical social capital) and informal (horizontal social capital) set-ups. Availability of drugs at accredited facilities tends to be of high priority for clients.

Highlights of Discussion

Barriers and facilitating factors from the three main groups were discussed in depth. While providers look at quality from a technical angle, clients tend to focus on relationships. Cost recovery, appropriateness of tariffs and constant review of tariffs, as well as promptness of reimbursement were of paramount importance to providers. As regards NHIS accredited facilities, lack of availability of drugs was a major issue in clients' decision to enroll. There is the need for health facility development in rural areas with improved water, sanitation and hygiene (WASH) interventions. There is also need to work in multi-disciplinary teams which have clear performance contracts that push for efficiency within the system, while advocating for cost sharing at higher levels of care. Clients have to be well informed by leveraging grassroots advocacy involving the traditional power structures.

UHC is a journey that requires progressive population coverage for healthcare services. With active NHIS card holders at 30% and cumulative membership at 60% (at the time of the study) innovative ways of encouraging people to renew their cards should be top priority. To make this possible, two pillars of UHC (expenditure management and revenue generation) should be debated between the three key stakeholders of the Scheme namely clients, providers and insurers.

B5.2: Expenditure Analysis of the Free Maternal Care Programme of the Ghana National Health Insurance Scheme

Highlights of Presentation

The Free Maternal Programme as implemented by the NHIS is based on a human approach. It is not equity-focused, therefore both the rich and the poor have free care during pregnancy, delivery and after delivery. At inception, government decided to apply a DFID grant to fund the

programme. However, there was no indication as regards the long-term funding arrangements for the programme.

The study observed that most beneficiaries of the programme do not renew their cards until the next pregnancy. This is when the eligibility criteria for free maternal care is once again available to be taken advantage of. The analysis of service data from one of Ghana's sub-metropolitan areas was used to assess the sustainability of recurrent expenditure on public social welfare programmes – with specific focus on the free maternal care programme. The programme is one of Ghana's social protection programmes launched in 2008 (others are the capitation grant, school feeding programme and LEAP). The universal approach, which is the human rights approach was used instead of the targeted approach which tends to be equity-focused. The findings on total claim expenditure showed that antenatal care (ANC) was the component with the highest claim expenditure at the out-patient level and Spontaneous Vaginal Delivery (SVD) the component with the highest claim expenditure at the Regional Specialist Hospital (RSH) level.

The NHIA expenditure on the programme during the study period (January to December 2009) exceeded income, resulting in a huge deficit. 62% of all free maternal claims were for ANC of which 60% were from the RSH. The average ANC claim expenditure of the RSH was higher than the overall average. Average ANC claim expenditure was lower at the RSH than at the Government Polyclinic. The average SVD claim expenditure was higher at the Government Maternity Home than at the Polyclinic and RSH.

It is virtually impossible to create a health system devoid of tensions relating to financial sustainability. Financial sustainability of social protection programmes such as the Free Maternal Care programme beyond grant periods is fraught with challenges. In the case of the programme, this was due to failure from the onset to look at long term sustainability, commitment by international development partners to deliver on promised support, inadequate attention to containing claims expenditure and lack of adequate attention to provider payment mechanisms. The gatekeeper system was also not strictly adhered to. Medicines were a major cost driver with a concomitant effect on cost escalation.

Highlights of Discussion

Equity is important in UHC, yet the free maternal care programme falls short of equitable principles, hence the need to identify the poor for exemption. Sustainability of social protection programmes such as the Free Maternal Programme beyond grant periods tend to be problematic, hence the need to improve sustainable ways of targeting of the poor and ensuring equity. Measures intended to benefit the poor if not properly targeted are likely to result in an increased use of services by more resourceful people who previously (before the introduction of the social protection programme) utilized private health facilities. The effect is that such programmes benefit the urban rich more than the poor who live in rural communities and suffer various forms of deprivation (including the absence of health facilities).

Summary and Conclusions

It is important to avoid dependency on donor support for social protection programmes such as the Free Maternal Programme which have long-term fiscal implications. In designing such programmes, critical attention should be paid to strategic purchasing of services to ensure sustainability. There are incentives and disincentives inherent in different provider

mechanisms, thus careful attention should be paid during programme design to how services will be compensated. Targeting within a universal programme is a feasible option, but the criteria for identifying the poor should be well spelt out. It should rule out inadvertent exclusions and excluding those in hard-to-reach areas due to physical inaccessibility.

Targeting within a universal programme requires a coordinating mechanism to identify, register and provide services. There will continue to be tensions between the universal approach (a human rights perspective) and the targeting approach which is equity-focused and more sustainable. Technology should be used to improve the efficiency of the targeting process so that social protection programmes become equity-focused.

PARALLEL SESSION C

C1: Market Place: Innovative Approaches to Coverage

Highlights of Presentation

There are global, regional and national interventions to identify and reach the poor. While some use poverty maps based on surveys such as the Ghana Living Standards Survey, others use per capita income and salary levels. The general consensus is that identifying the poor is a very difficult task fraught with numerous challenges. This is most evident in a environment with an uncontrolled informal sector and a subsistence economy. In areas where about 80% of the population is poor, the entire population is usually considered poor. Is it not however possible to identify the 20% non-poor population for non-exemption?

Conclusion and recommendations

Ghana's NHIS is a predominantly a tax-based financing scheme considering that premiums constitute only 5% of total revenue. The question that arises is whether it will be better to eliminate premiums and introduce more progressive taxes such as SIN tax (on alcohol, tobacco and drugs) taxes on oil, and increases in VAT and import duties.

School enrolment would be a viable way of increasing coverage. This can be done by requiring all persons attending school from kindergarten to university to possess active NHIS cards. If well managed, such an approach could also help generate additional revenue as the risk pool will be expanded.

Within Ghana's NHIS, there should be no out of pocket payment at the point of service delivery for accredited facilities and this should be given effect to in legislation.

A key challenges that undermines Ghana's UHC approach is the lack of sustainable funding. The political nature of the NHIS requires bringing on board representatives from the major political parties for an aggressive policy advocacy, especially within the legislature for a sustainable health financing regime. Such an approach will help improve coverage of Ghana's NHIS and improvement in access to services.

C2: Market Place - Crafting a Sustainability Roadmap

Highlights of presentation

Sustainability is about meeting the needs of today without compromising those of tomorrow. Determinants of sustainability in health financing begin with having a full understanding of the healthcare market, incomes and fiscal space, how to align demand for healthcare services with supply for the present, and how to forecast the evolution of the market to ensure the future is not compromised by decisions taken for the present.

There are many factors that come into play when sustainability is being pursued. These factors go beyond supply and demand of health care and include external factors such as population demographics, rising burden of NCDs and the overall fiscal climate. Additional factors include management capacity in the areas of leadership and technical skills, which brings about efficiency and effectiveness. A committed leadership with a competent workforce is able to define services to be provided against the outcomes to be achieved. The ability to make rational economic choices is critical for achieving resource allocation and technical efficiencies. This is underpinned by ability to set credible, clear, evidence-based benchmarks, with assumptions that are transparent and detailed to allow monitoring and evaluation at all times.

The NHIS is said to have 8.9 million active members as of 2012 which represented to 34% of the population. The population in the highest economic quintile is reported to have coverage of 38% as against 17% for the population in the lowest economic quintile. The desire to increase coverage in Ghana should not be divorced from critical considerations about financial sustainability of the NHIS. Policy makers should be guided by the choices they make for the present and their financial implications for the future and choose to reach a compromise in terms of population coverage and benefit coverage.

Highlights of Discussion

The cost containment measures the NHIA has started to put in place are laudable. Ghana should continue to vigorously pursue sustainability measures by intensifying clinical audits and applying rewards and sanctions to ensure compliance with billing and treatment protocols. Instant ID biometric card issuance should be scaled-up and computerization of work processes expanded through initiatives such as e-Claims. There is a strong need to introduce close-ended payment systems that impose caps for high volume services and medicines. The NHIA should work closely with health providers to cost health services and determine the volume of services to be put in the capitation basket for primary healthcare. This should be coupled with a strong gatekeeper system. This is urgent if the Scheme is to be sustainable.

As regards ways in which the implementation of the NHIS can be improved, there is need for additional measures to improve evidence generation capacity at all levels to for effective management of resources and decision making. There is the need to put in place a robust monitoring and evaluation system that can be used to continuously re-orient the Scheme. It is pertinent to note that the serious deficits in human resources for health in Ghana requires to be frontally addressed as part of the strategy to sustain the NHIS and to gradually move Ghana towards UHC. Ghana suffers a wide deficit in the doctor/nurse to patient ratio and a mal-distribution of human resources across the country. In the area of health insurance

management, there is a general lack of staff with the necessary skills for the management of health insurance issues at both the provider and payer level.

Conclusions and Recommendations

Strategies for dealing with the sustainability of the NHIS in particular, and UHC programmes in general have to be divided into short, medium and long term timeframes. Such considerations should not be limited to financial sustainability alone but should include a balance between hospital care and primary care that is linked with the health workforce. Education and training of the health workforce should promote the right attitudes and skills, and a willingness to be deployed when necessary.

Sustainability should bring about wellbeing for all and not for some. Sustainability should be directed to delivery of services that target attainment of the MDGs, reduction in the burden of NCDs, health promotion and disease prevention and ensure participation of communities.

The NHIA needs to advocate for increased allocation of revenues, but it should at the same time demonstrate evidence of prudent expenditure management that leads to efficiency gains through strong and strict enforcement of cost containment measures.

C3: Developing Measurement Matrices

Highlights of Presentation

UHC aims to expand healthcare access, improve healthcare outcomes and ensure financial risk protection for a given population. Equity in all these three dimensions is a critical measure as regards success of a UHC programme. Despite this fact, various stakeholders have different perspectives on what are the indicators of equity. Program managers generally expect indicators that are practical, quick and inexpensive to measure, and easy to interpret. Administrative staff at the headquarters expect simple indicators that can be applied across the country in a standard manner and are easy to explain to policy makers. Development partners want indicators that have a global appeal for ease of comparison across countries. Clients want equity indicators that are transparent, trustworthy, recognize networks and their membership, and whose findings they can interrogate.

The Social Franchise Metrics Working Group conducted a pilot study to find a good routine equity monitoring indicator. The options considered were the Multi-Dimensional Poverty Index (MPI), which the Group dismissed as not feasible to collect. The Group then proceeded to work with the Progress out of Poverty Index (PPI) and the Wealth Index (WI), which had been piloted in 5 countries in 2012 as part of franchise client exit interviews. The results were compared against defined selection criteria which showed that both PPI and WI were easy to collect. PPI was easier to analyze than WWI. With PPI, the poverty threshold was easy to interpret whereas with WI quintiles used were widely and easily understood.

Regarding cost, the PPI application cost between $200,000 to $250,000 per country, in addition to maintenance costs. WI was found to be inexpensive and based on publicly available DHS data. When compared within the national context, both PPI and WI showed similar accurate and validated findings with national poverty rates. With PPI, it was difficult or impossible to do sub-group analysis whereas with the WI it was easy to carry out subgroup analysis. On cross-country comparisons PPI was able to identify the proportion of the population living on less than USD1.25/day across countries. However WI could only do that within each country.

The Wealth Index can be used routinely by randomly selecting NHIS facilities or enrollment centers and conducting exit surveys among clients. Surveys include about 20 questions on household characteristics that add approximately 10 minutes to each interview. Surveys can be conducted on a quarterly or semi-annual basis. The process requires centralized data analysis. Capacity can be developed using a tool kit and standard syntax files.

Highlights of Discussion

Participants considered whether the equity measurement process should be undertaken by the NHIS or by an independent body. It was posited that it would be useful to use a tripartite arrangement of government, industry or practice and academia. Measurement of equity should employ simple but effective means of monitoring e.g. trends in OOP expenditure disaggregated by who is paying, service coverage, and quality of services. It was suggested that a range of indicators already exists on quality, equity and coverage and that these will have to be focused and aligned with UHC. The process should ensure quality procedures,

timeliness, capacity to address issues promptly as well as sharing and dissemination of reports to influence policy.

Recommendations

a. Policy decisions towards UHC should be evidence based.
b. Policymakers, implementers and stakeholders should jointly agree to a core minimum set of indicators that can be easily collected, analyzed and reported on in a timely manner.
c. Champions should be identified to lead the process and clear leadership responsibility for measurement should also be identified.
d. Governing bodies need to be committed to investing in UHC measurement.

C4: Leveraging Information Technology for Efficiency

Highlights of Presentation

Information Technology (IT) has become an important part of all production and service delivery activities in the world today. Healthcare service delivery is no exception. IT is a tool that can be used to deliver quality healthcare to the ever-increasing number of people who need it. It is also critical for the successful implementation of healthcare related projects, which are becoming more and more complex. Using IT in health requires involvement of a wide range of stakeholders including healthcare and IT professionals. Challenges with using IT in health care include cost, issues with data security and confidentiality, and the difficulty of getting health professionals to adapt to using IT.

IT can be especially useful for the scale up national health insurance schemes. Currently, a number of processes within the Ghana's NHIS are IT driven. Examples are issuance of ID cards, a pilot electronic claims system as well as enterprise resource planning systems. Areas in Ghana's health system that will benefit from IT use are fraud control, quality assurance, drug management, and patient records management. There is also a potential for telemedicine. To ensure scale-up of the use of IT in healthcare, Ghana has to improve capacity in the areas of electronic data security and privacy. One method used in the US to deal with the issue of confidentiality is the use of medical students as transcribers to enter doctor's notes and visit details in electronic record systems.

Effective change management and communication are also essential for the successful implementation of IT projects. There are three groups of persons in the health sector who are critical for an effective transition to using IT. They are IT professionals, IT literate health care workers and IT literate consumers. Involving physicians in IT projects will help foster physician ownership of projects. Training programs for health care professionals should also include IT training. Incentive programs can also be used to encourage older professionals to learn IT. Infrastructure also needs to be developed to support the implementation of IT projects. Other essential elements of successful IT projects in the health care sector are standardization, user-friendly interfaces, effective communication and stakeholder involvement.

Conclusion and recommendation

Information Technology is an essential requirement for building effective and efficient health systems. National level health insurance schemes such as Ghana's by implication require IT systems to be effective and efficient. Challenges to IT scale-up in Ghana's health sector include the cost, poor infrastructure for supporting IT systems and lack of IT literacy among health care professionals. For successful IT implementation, there should be capacity building for IT use among health care workers. Additionally, there should be standards in place for IT programs to be successful.

C5: Accelerating the Private Sector Response

It is in the interest of Government to promote private sector participation in the health insurance and healthcare delivery generally. Examples of the power of the private sector to help achieve the objectives for which the NHIS was set-up abound. A case in point is a healthcare professional who saw the opportunity presented by the NHIS at the establishment of the Scheme, left the public sector and set up a private healthcare facility which now has 120-bed capacity. For the private healthcare sector, consistency in timing of resource flows is critical for planning and cash management. The NHIA should therefore regularly reimburse providers, to ensure certainty in operations. Tariffs need to be reviewed regularly to reflect market rates as unrealistic tariffs create a disincentive to supply. The private sector should be actively engaged in provider payment reform.

The private sector needs clients to enable it cover costs. Within the private sector, competition has intensified as a number of facilities strive to provide comprehensive services. However, quality may be compromised when a facility without requisite staff tries to provide all services. The best practice of separation of services backed by law should be implemented in Ghana. Standards and effective regulation should be used to support the private sector to become an active player in the provision of healthcare – using the same standards for both public and private sector. Regulation should be responsive and not overburden a private sector that is already resource-constrained. The private sector should be integrated into the gatekeeper system to ensure uniform implementation.

In view of the fact that healthcare staff are mal-distributed, there is a skewed distribution of health professionals in favour of urban areas and higher levels of care. This situation should be rectified to ensure adequate human resources at primary facilities. Private sector involvement in training of health workers should be promoted and consideration given to providing primary healthcare on a private sector platform. This could provide an incentive for the private sector to relocate rural areas. The NHIS should be empowered to use its purchasing power to redirect resources accordingly.

There is a need to build trust between the public, NHIA and providers. There has been a reluctance to invest in Ghana's healthcare system because of lack of trust and unpredictability. Steps should therefore be taken to build such trust. In tandem, efforts should be made to assure clients about the capacity of the private sector to provide quality services. The success of such an approach will be determined by provider payment systems adopted which should generally ensure that patients get the quality of services for which they enrolled in the Scheme. In this regard, provider payment reform should be accompanied with strategies that help to increase buy-in.

There should be increased consolidation of the private sector to enable it deliver quality healthcare services based on scale. Health sector stakeholders and partners should be committed to public-private partnerships and be willing to share PPPs experiences. Improved private sector governance, formation of partnerships and networks should be encouraged.

The private sector has played a key role in the evolution of health insurance from the days of the launch of the pilot community health insurance Scheme in Nkoranza. The Scheme, which was for people in the catchment area of the town had the support of the traditional council and community. A key driver for the success of the initiative was community ownership. Though

the initiative faced severe resource constraints, the high level of commitment from management, staff and the community helped to sustain it. Lessons from the district Schemes should guide the NHIA's operations.

On the whole, the response of the private sector should be both in the areas of financing and the service provision. The involvement of the private sector in advisory services and support systems for healthcare provision should also be highlighted.

CLOSING SESSION

The Closing Session was presided over by the Hon. Minister of Gender, Children & Social Protection. During the session, the Chief Executive expressed the NHIA's appreciation to all those who had contributed to making the conference a success, and singled out all sponsors for acknowledgement, especially, the Rockefeller Foundation and the World Bank- Japan Partnership for UHC.

The Closing Session summarised the opportunity the conference had provided for a reflection on the successes and challenges of the NHIS, sharing of best practices and restating the critical place of UHC in development.

The conference ended with the issuance of the following Communiqué:

"Statement by the National Health Insurance Authority at the Universal Health Coverage Conference held in Accra, Ghana from 4-5, November 2013 under the theme "Towards Universal Health Coverage – Increasing Enrolment Whilst Ensuring Sustainability

At the Universal Health Coverage Conference held under the theme "Towards Universal Health Coverage – Increasing Enrolment whilst Ensuring Sustainability" held in Accra, Ghana, from 4-5 November, 2013, there was an overwhelming consensus among participants that the NHIS will require the following in order to achieve its objective of providing financial access to healthcare for the population of Ghana:

1. Continued political support
2. Transparency and effective consultation
3. Efficient use of resources
4. Commitment to quality at all levels of service
5. Equity in population coverage, access to services and financial risk protection
6. Generation, management and effective use of knowledge for decision making

The NHIA finds participants' feedback on these issues highly relevant and is committed to putting these forward as critical issues to be considered in the making of policies for improving access to healthcare in Ghana.

Recognizing that these issues are as true for Ghana as they are for other low and middle-income countries, the NHIA wishes to encourage participants at this conference to take account of these observations in policy reforms aimed at improving access to healthcare for their populations."

Issued on behalf of the National Health Insurance Authority

Annex A - Conference Program

Plenary Sessions	
10:00 -11:30 Monday 4th November	Plenary Session 1: **Ghana's Journey to Universal Health Coverage so far: Successes & Challenges**
	Moderator Hon. Sherry Ayittey, Minister of Health, Ghana **Presenters** Irene Agyepong, School of Public Health, University of Ghana **Panelists** Nii Ayite Coleman, Health Insurance Focal Person, Ministry of Health, Ghana Hon. Moses Adibo, Former Deputy Minister of Health, Ghana Hon. Matthew Poku-Prempeh, Member, Health Committee, Parliament of Ghana Hon. Mohammed Mubrarak-Muntaka, Member, Health Committee & Majority Chief Whip, Parliament of Ghana
12:00 -13:30 Monday 4th November	Plenary Session 2:**Towards Innovative Healthcare Financing: Experiences from the World**
	Moderator Nii Moi Thompson, Senior Economist, UNDP **Presenter** Sheila O'Dougherty, Vice President of International Health Policy & Systems, Abt Associates Inc, Washington DC, USA **Panelists:** Gina Lagomarsino, Managing Director, R4D, Washington DC, USA Jin Ma, Executive Dean of School of Public Health Shanghai Jiaotong University, China Mark Basset, Director, Bassett Consulting Services Ltd. & World Bank Consultant, UK Caroline Jehu-Appiah, Senior Health Economist, African Development Bank, Tunisia
16:15-16:45 Monday 4th November	Plenary Session 3: **Shaping UHC Policy for Post 2015: Opportunities & Risks**
	Presenter Jeanette Vega, Managing Director, Rockefeller Foundation, USA
08:30-10:00 Tuesday 5th November	Plenary Session 4: **Improving Health Outcomes: New Trends in Patient Safety**
	Moderator Ebenezer Appiah-Denkyira, Director General, Ghana Health Service **Presenter** Shams Syed, African Partnerships for Patient Safety, WHO, Geneva **Panelists:** Kedar Mate, South African Programme Director, Institute for Health Improvement Ekow Acquah, HCA Garden Park Medical Centre, Mississippi, USA Cynthia Bannerman, Deputy Director, Quality Assurance, Ghana Health Service, Ghana John Yabani, Tema Municipal Health Directorate, Ghana Health Service(TBC)
10:30-12:00 Tuesday 5th November	Plenary Session 5. **Effective Resource Management: The Optimal Provider Payment Mix**:
	Moderator Hon. Matthew Poku-Prempeh, Member of Health Committee, Parliament of Ghana **Presenter** Cheryl Cashin, Senior Fellow, R4D, Washington DC, USA **Panellists**

	Osei Acheampong, Director, R&D, National Health Insurance Authority, Ghana Rozita Hussein, Deputy Director, Health Financing Unit, Ministry of Health, Malaysia Gilbert Buckle, Executive Director, Christian Health Association of Ghana
14:15-15.45 Tuesday 5th November	Plenary Session 6: Improving Targeting of the Poor and Ensuring Equity: Emerging Systems and Approaches
	Moderator Hon. Nana OyeLithur, Minister, Ministry of Gender, Children & Social Protection, Ghana **Presenter** Nishant Jain, Deputy Programme Director, GIZ, India **Panellists** SomilNagpal, Senior Health Specialist, World Bank, South Asia Region Marty Makinen, Programme Director, Results for Development, Washington DC, USA Mawutor Ablorh, Director of Social Protection, Ministry of Gender, Children & Social Protection, Ghana Dr. Stephen Ayidiya, Member of the Board, NHIA, Ghana

Parallel Sessions					
14:30 -15:45 Monday 4th November	Parallel Session A**: Strengthening Health Systems for UHC: What Counts?**				
	A1: **Improving Health Infrastructure** **Moderator** ***Akua Kwateng-Addo***, *Director of Health, Nutrition & Population, USAID-Ghana* **Presenter** ***Frank Poen***, *Project Director, Pharmaccess Foundation, Netherlands* **Panelists** • ***Monwabisi Gantsho,*** *Chief Executive, Council for Medical Schemes, South Africa* • ***Nicodemus Gebe*****,** *Head of Biomedical Engineering Unit, Ministry of Health, Ghana* • ***Ben Amponsah-Nkansah***, *Capital Investment Unit, Ministry of Health, Ghana*	A2: **Developing & Deploying HRH** **Moderator** ***David Ofori-Adjei***, *Rector, College of Surgeons& Physicians, Ghana* **Presenter** ***Patrick Kadama,*** *Director for Policy and Strategy, African Centre for Global Health and Social Transformation, Uganda* **Panelists** • ***Seth Acquah***, *Health Systems Consultant, Accra, Ghana* • ***Ken Sagoe,*** *Former Director, Tamale Teaching Hospital, Tamale, Ghana* • ***AfisahZakariah,*** *Director, PPME, Ministry of Health, Accra, Ghana*	A3: **Mainstreaming Monitoring & Evaluation** **Moderator** ***Kpesa Whyte***, *Senior Policy Advisor, Office of the President, Ghana* **Presenter** ***Mercy Bannerman,*** *Independent Consultant & Board Member, NHIA, Ghana* **Panelists** • ***Nathan Blanchet,*** *Senior Program Officer, R4D, Washington DC, USA* • ***Erasmus Agongo***, *Director, PPME, Ghana Health Service, Accra, Ghana* • ***Djabanor Narh***, *Partner, Ernst & Young, Accra, Ghana* • ***Perry Gollo***, *Monitoring and Evaluation Advisor*	A4: **Expanding Primary Healthcare** **Moderator** ***Mwihaki Kimura Muraguri***, *Associate Director, Rockefeller Foundation, Africa Regional Office, Nairobi, Kenya* **Presenter** ***Sam Adjei***, *Executive Director, Centre for Health & Social Services, Accra, Ghana* **Panelists** • ***Kamaliah Mohd Noh***, *Deputy Director (Primary Health Care) Family, MOH, Malaysia* • ***Ama de-Graft Aikins*** *Associate Professor, Bio Data, Regional Institute for Population Studies, University of Ghana* • **Marty Makinen, R4D**, *Programme Director, Washington DC, USA* • ***Guy Stallworthy,*** *Senior Programme Officer, Bill & Melinda Gates Foundation, USA*	A5**.1 Presentation of Study:** The Challenge of NCDs in Sub-Saharan Africa **Moderator** ***Samuel Akoriyea Kaba***, *Director, Institutional Care, Ghana Health Service, Accra, Ghana* **Presenter** ***Patricio Marquez***, *Lead Health Specialist, Human Development Sector Leader, The World Bank, Accra, Ghana* A5.2 **Presentation on Analysis of Survey Results** Performance of Health Facilities in NHIS Accreditation **Moderator** ***Samuel Akoriyea Kaba***, *Director, Institutional Care, Ghana Health Service, Accra, Ghana* **Presenter** ***Nicholas Tweneboa,*** *Independent Consultant, Accra, Ghana*

12:00-13:15 Tuesday 5th November	Parallel Session B: **Securing more Value from Available Resources**				
	B1: **Country Case South Korea: Contracting for Medicines.** **Moderator** ***Stephen Opuni***, *Chief Executive, Food & Drugs Board, Ghana* **Presenter** ***Eun Young Bae***, *Associate Prof.Gyeongsang National University, South Korea* **Panelists** • ***Patrick Stephenson***, *MPedigree, Ghana* • ***Samuel Boateng***, *Director of Procurement & Supplies, Ministry of Health, Ghana* • ***Andreas Seiter***, *Senior Specialist, World Bank, Washington DC, USA* • ***Kwesi Eghan***, *Senior Programme Associate, Management Sciences for Health,* • ***O.B Acheampong,*** *Director, R&D, NHIA, Ghana*	B2**:50 Years of UHC in Japan: a Lesson in Sustainability.** **Moderator** ***Patricio Marquez***, *World Bank, Accra* **Presenter** ***Tomoko Ono***, *Economist, OECD, Paris, France* **Panelists** • ***Rina Uchida,*** *Embassy of Japan* • ***Francis Asenso Boadi***, *Deputy Director, NHIA, Ghana* • ***Justice Novignon***, *Lecturer School of Public Health, University of Ghana*	B3: **Generating Evidence for Benefit Package Design: Role of Health Technology Assessment.** **Moderator** ***Isaac Adams***, *Director for Research & Statistics, Ministry of Health, Ghana* **Presenters** • ***Derek Cutler,*** *Programme Officer, NICE, UK* • ***SripenTantivess***, *HITAP, Ministry of Health, Thailand* **Panelists** • ***Martha Gyansah-Lutterodt***, *Director of Pharmaceutical Services, Ministry of Health, Ghana* • ***KhuongAhn Tuan***, *Ministry of Health, Vietnam* • ***Adukwei Hesse***, *Medical Consultant & CEO, Executive Health Care and Consult, Ghana*	B4: **Reducing Fraud & Abuse in Health Insurance.** **Moderator** ***Edward Amissah-Nunoo***, *Deputy Chief Executive, NHIA, Ghana* **Presenters** • ***Jim Gee***, *Director of Counter Fraud Services, BDO LLP, UK* • ***Lydia Dsane-Selby***, *Director, Claims, NHIA, Ghana* **Panelists** • ***Isaac Morrison***, *Vice President, Society of Private Medical & Dental Practitioners, Ghana* • ***Daniel Asare,*** *Medical Director, Central Regional Hospital, Cape Coast, Ghana* • ***Dubby Mahalanobis***, *General Manager, Med X Health System, Accra, Ghana*	B5.1 **Presentation of Study: Towards a Client-Oriented Health Insurance System in Ghana.** **Moderator** ***Steve Ahiawordor***, *Member of the Board, NHIA, Ghana* **Presenters** • ***Edward Nketiah***-*Amponsah, Senior Lecturer, Economics Dept, University of Ghana,* • ***Robert Kaba Alhassan***, *PHD Student, University of Groningen, Netherlands* • ***Stephen Duku***, *PHD Student, University of Groningen, Netherlands* • ***Christine Fenenga***, *PhD Student, University of Groningen, Netherlands* **Moderator** ***Steve Ahiawordor***, *Member of the Board, NHIA* **B5.2 Presentation of Study: Expenditure Analysis of the Free Maternal Care Programme of the Ghana National Health Insurance Scheme** **Presenter**Emmanuel Odame Ankrah, PHD Student, University of Cape Town, South Africa

16-45-17:15 Tuesday 5th November	Parallel Session C**: Accelerating Ghana's March to UHC: Issues to Consider**				
	C.1. Market Place: Innovative Approaches to Coverage of the Poor. **Facilitator** ***Bertha Garshong***, *Health Research Unit, Ghana Health Service, Accra, Ghana* **Presenters** • ***Sidua Hor***, *Campaign for Universal Access to Healthcare, Ghana* • ***Genevieve Aryeetey***, *School of Public Health, University of Ghana.* • ***Nathan Blanchet***, *Senior Programme Officer, R4D, Washington DC, USA* • ***James Akazili,*** *Researcher, Navrongo Research Centre, Ghana Health Service*	**C.2. Market Place: Crafting a Sustainability Roadmap.** **Facilitator** ***Felix Asante***, *ISSER, University of Ghana, Legon, Ghana* **Presenters** • **Kofi Ntim**, *Managing Partner, Stallion Financial Services, Accra, Ghana* • ***Elkana Ong'uti,*** *Health Economist, Ministry of Health, Kenya* • ***Edward Nketiah-Amponsah,*** *Economics Department, University of Ghana* • ***Susan Elden,*** *Health Advisor, DFID, Ghana*	**C.3 Moderated Session: Developing Measurement Matrices.** **Moderator** ***Patrick Apoya,*** *Executive Director of Community Partnerships for Health and Development, Ghana* **Presenter** ***Ben Bellows,*** *Associate, Population Council, Kenya* **Panelists** • ***Selassie D'Almeida Amah****, Health Economic Advisor, WHO, Accra, Ghana* • ***Anthony Ofosu***, *PPME Division, Ghana Health Service* • ***Francis Asenso Boadi***, *Deputy Director, NHIA, Ghana*	**C.4 Moderated Session: Leveraging Information Technology for Efficiency.** **Moderator** ***Dorothy Gordon***, *Kofi Annan ICT Centre of Excellence, Accra, Ghana* **Presenter** ***Egbe Osifo-Dawodu***, *Partner, Anadach, CA, USA* **Panelists** • ***Caren Althauser***, *Programme Officer, PATH* • ***Mr. Cees Hesp***, *Director, Pharmaccess, Netherlands* • ***Perry Nelson***, *Director, MIS, NHIA, Ghana* • ***Sam Quarshie***, *Head of ICT Department, Ghana Health Service, Ghana*	**C.5 Moderated Session: Accelerating response of the Private Sector.** **Moderator** ***Faustina Fynn-Nyame***, *Country Director, Marie Stopes International, Ghana* **Panelists** • ***Onno Schellekens***, *Medical Credit Fund, Netherlands* • ***Antonio Quarshie-Awusah***, *Head Social Franchise & Marketing, Marie Stopes International-Ghana* • ***Edward Tagoe***, *Family Care Hospital, Offinso, Ashanti Region, Ghana* • ***Chacha Marwa***, *Chief Executive Officer and Managing Director, Bliss GVS Healthcare Ltd, Kenya* • ***Collins Akuamoah***, *Deputy Director, National Health Insurance Authority, Ghana*