Ghana CTAP - Health Sector Transparency and Accountability

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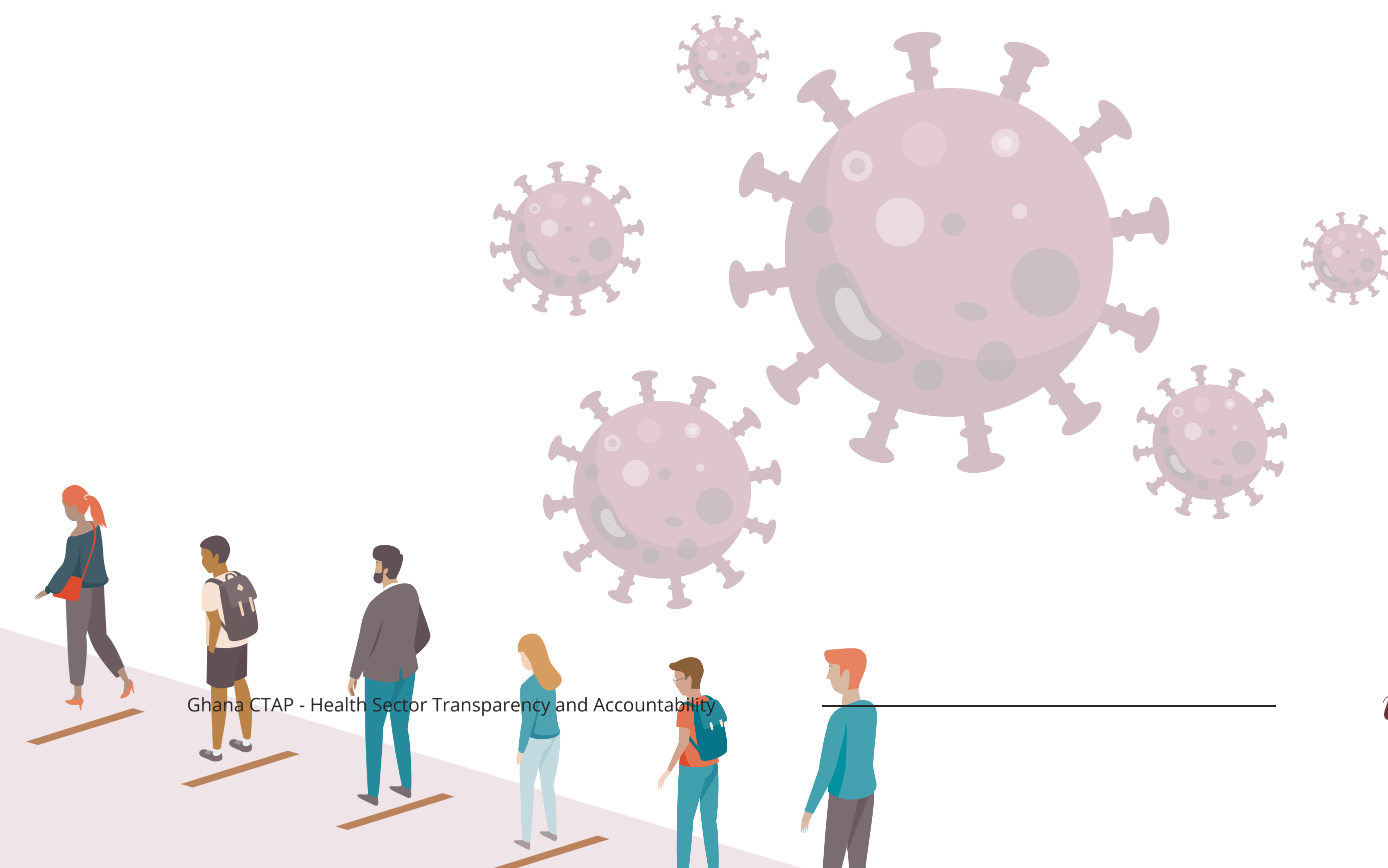


1.0 Executive Summary

Social Accountability (SA) within the context of the healthcare sector, allows for participatory citizen engagement where citizens are recognized as service users who are ultimately impacted by health care decisions and can affect change in health policies, health services, and/or health provider behaviour through their collective influence and action. SA plays an important role in addressing corruption, and increasing trust in public servants and government, which is key to accelerating efforts to achieve the Sustainable Development Goals (SDGs) and increasing the power and influence of citizens on agenda-setting.

To assess Ghana's health sector's resilience, transparency, and accountability across the thematic areas of health sector governance, civic environment, government, and governance space of the health sector accountability of the country, corruption, and resistance to reforms, the study used a systematic review of documents, using the READ Approach, to elicit the context in which the Ghanaian healthcare system has evolved over the past decade(s), generate questions, and assess the resilience, transparency, and accountability of the health sector.

The following are the conclusions from the study, organized according to the four thematic areas:

i. Health Sector Governance: **Ghana has a moderately decentralised and devolved health sector with clearly delineated governance and administrative structures spanning the community level through to the national level.** The moderately optimal system has propelled investments in the health workforce undergirded by enhanced professional regulation to increase geographical access, improve key health workforce indices, and enhance the efficiency of governance and management of the health system, moving the health system's overall holistic assessment score.

   However, notwithstanding the enhanced governance structure, the health system faces significant

governance challenges such as inadequate financing for health and health care services; inequitable access to health care services, including financial protection; referrals and reverse referrals for primary and specialized care; and keeping the health workforce duly motivated and up to speed on evolving trends.

(ii) **The healthcare sector, since the independence era, has retained a symbiotic relationship with its political economy, showing a positive relationship.** Investments and improvements in the sector depend on political stability and its attendant economic growth and development. However, this somewhat civil marriage between the Ghanaian health sector and its overarching political economy has not been without flaws, as a review of the roles and functions of the health care delivery process vis-à-vis the potential abuses revealed inherent corruption risks, which are intricately linked to the inelastic demand for healthcare services, among other factors.

(iii) **The legal framework of the health sector in Ghana has significantly improved the policy and regulatory environment, which has ensured the comprehensive and timely description of health sector information on the health and health system status of the country.** These legal frameworks, however, lend themselves to possible abuse given the vested interest and authority of the President of the Republic in appointing heads of the respective health sector agencies. Although Ghana's healthcare financing system is generally progressive due to the overall progressivity of taxes, which account for almost 50% of healthcare funding, the system has consistently failed to expend at least 15% of its GDP on health and healthcare-related activities as required by the Abuja Declaration.

(iv) **That the respective legal frameworks governing the health sector make room for community or civil society representation on governing boards/councils, the highest decision-making bodies, of healthcare delivery agencies at national, regional, and community levels.**

These findings corroborate how robust Ghana's health system, undergirded by massive investments in health infrastructure and health workforce, has been touted to be and how its growth trajectory has improved key health indices in the country over the past decade. These notwithstanding, inherent challenges persist and present the country with opportunities for growth and improvement, which require the collaborative action of relevant stakeholders such as the government, the private sector, and civil society groups too, among other things:

(a) take steps to ensure equitable access to healthcare.

(b) examine the roles and functions of the health care delivery process vis-a-vis the possible abuses to paint a corruption risk matrix and mitigating mechanisms.

(c) clamour for the amendment of the relevant legal frameworks that allow for the President of the Republic to appoint heads of the respective healthcare agencies in the country.

(d) aspire towards attaining the Abuja Declaration of spending at least 15% of Annual National Budget dedicated to health to close health financing gaps.

(e) deepen the implementation of relevant legal provisions that allow for citizen participation in health policy design and implementation.

6. Candace Eastman and Franklin Dolo (2016). Liberia Health Sector Scan
7. Wright, J., Health Finance & Governance Project. July 2015. Essential Package of Health Services Country Snapshot: Liberia. Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.
8. Liberia Medical and Dental Council, 2016

2.0 Introduction

2.1 Background

Social accountability can be defined as "an approach towards building accountability that relies on civic engagement; thus, an approach where ordinary citizens and/or civil society organizations participate directly or indirectly in exacting accountability.[1] In the context of health, social accountability is a form of participatory citizen engagement in which citizens are recognized as service users who are ultimately impacted by health care decisions and thereby can affect change in health policies, health services, and/or health provider behaviour through their collective influence and action.[2]

Experts note three elements of accountability:

1. answerability, or the obligation to justify one's actions;
2. enforcement, the consequences imposed if the action and justification are not satisfactory; and
3. responsiveness, the willingness of those held accountable to respond to demands made.[3] Social accountability can include grievance procedures and social audits to collect qualitative and quantitative data on citizens' opinions about their lived experiences with services.

Social accountability plays an important role in addressing corruption, and increasing trust in public servants and government, which is key to accelerating efforts to achieve the Sustainable Development Goals (SDGs) and increasing the power and influence of citizens on agenda-setting.[4,5,6,7] Corruption destabilizes the capacity of health systems to contribute to better health, economic growth, and development. Interventions and resources for corruption prevention and control are critical components of strengthening health systems for Universal Health Coverage.[8] Officials are also responsible for acting according to standards and commitments made public in the form of laws, regulations, guidelines, procedures, and policies.

1. Danhoundo, G., Nasiri, K., & Wiktorowicz, M. E. (2018). Improving social accountability processes in the health sector in sub-Saharan Africa: A systematic review. BMC Public Health, 18(1), 1–8. https://doi.org/10.1186/s12889-018-5407-8
2. Fox, J. A. (2015). Social accountability: what does the evidence really say? World Development, 72, 346-361.
3. Lambert-Mogiliansky, A. (2015). Social accountability to contain corruption. Journal of Development Economics, 116, 158-168.
4. Bratton, M., & Gyimah-Boadi, E. (2016). Do Trustworthy Institutions Matter for Development? Corruption, Trust, and Government Performance in Africa. Afrobarometer Dispatch, 112, 1–17.
5. Mbachu, C., Onwujekwe, O., Ezumah, N., Ajayi, O., Sanwo, O., & Uzochukwu, B. (2016). Political economy of decentralising HIV and AIDS treatment services to primary healthcare facilities in three Nigerian states. African Journal of AIDS Research, 15(3), 293–300. https://doi.org/10.2989/16085906.2016.1205112
6. McDougall, L. (2016). Power and politics in the global health landscape: Beliefs, competition and negotiation among global advocacy coalitions in the policy-making process. International Journal of Health Policy and Management, 5(5), 309–320. https://doi.org/10.15171/IJHPM.2016.03
7. Schatz, F. (2013). Fighting corruption with social accountability: A comparative analysis of social accountability mechanisms' potential to reduce corruption in public administration. Public Administration and Development, 33(3), 161–174. https://doi.org/10.1002/pad.1648
8. Vian, T. (2020). Anti-corruption, transparency and accountability in health: Concepts, frameworks, and approaches. In Global Health Action (Vol. 13, Issue sup1). https://doi.org/10.1080/16549716.2019.1694744

2.0 Introduction

Identifying the conditions for implementing successful social accountability initiatives can help community leaders, civil society organizations (CSOs), or non-governmental organizations (NGOs) to increase their leverage.[9] Empirical studies have demonstrated the effectiveness of health communication, community group engagement, and provider incentives to bring about changes in behaviour.[10] Some of the key components of social accountability efforts with a combination of activities include civic and health education; priority setting and joint problem solving; empowering and educating clients to demand quality services; and supporting health service actors to recognize and act on citizens' demands. Social accountability could, in turn, help to raise the quality, accessibility, and availability of services.

A systematic review conducted by Danhoundo et al. (2018) showed that successful social accountability interventions involved engaging different sectors and stakeholders, namely community members and health facility staff; ensuring social accountability tools were locally and contextually based; integrating data and information collection and tools; fostering trust between citizens and leaders; having clear roles, standards, and responsibilities of those involved in the accountability process; having financial and technical support from experienced groups, and involving citizens and the community meaningfully in the process.

On the other hand, impediments to social accountability's implementation included citizens' lack of interest, fear of retaliation for speaking out, a lack of funding and strategic knowledge, and the length of time required to develop, plan, implement, and evaluate social accountability projects, and a lack of government involvement.

2.2 Objectives

This study assessed health sector transparency and accountability in Ghana, such as health sector governance, civic environment, government, and governance space of the health sector accountability in the country, corruption, and the resistance to reforms.

2.3 Approach

The study employed the READ approach to document analysis.[11] The READ approach to document analysis entails the systematic review of documents to provide the context in which they were developed, generate questions, and measure changes in different transformational epochs. The use of this approach in the study ensured the careful gathering of key information from the literature around transparency and accountability in the health sector.

The approach consisted of four steps:

- (a) readying the transparency and accountability documents, including reports;
- (b) extracting data from the reports;
- (c) analysing the extracted data from the reports; and
- (d) distilling findings from the analysed data.

Narrative Synthesis was then used to adopt a textual approach of 'telling the story of the findings.[12] Since the study sought to assess transparency and accountability in the health sector, the synthesis addressed the following: health sector governance in Ghana; the political economy of the healthcare sector; laws and legislative oversight on healthcare; healthcare policy, funding, and gaps; and citizen data and voices on healthcare access and accountability. All relevant documents included in the analysis were guided by the study objectives. A validity assessment of the reports was thereafter done to mitigate the impact of the methodological quality of the reports on the study report.

9. *Paschke, A., Dimancesco, D., Vian, T., Kohler, J. C., & Forte, G. (2018). Increasing transparency and accountability in national pharmaceutical systems. Bulletin of the World Health Organization, 96(11), 782–791. https://doi.org/10.2471/BLT.17.206516*
10. *Curry, D. W., Rattan, J., Nzau, J. J., & Giri, K. (n.d.) 2016. Delivering High-Quality Family Planning Services in Crisis-Affected Settings I: Program Implementation.*
11. *Dalglish, S. L., Khalid, H., & McMahon, S. A. (2020). Document analysis in health policy research: the READ approach. Health policy and planning.*
12. *Dixon-Woods, M., Agarwal, S., Young, B., Jones, D., & Sutton, A. (2004). Integrative approaches to qualitative and quantitative evidence. London: Health Development Agency, 181.*

3.0 Findings

The findings of this study are categorized into four categories:
1) health sector governance

2) political economy of the healthcare sector;

3) laws and legislative oversight on healthcare;

4) healthcare policy, funding, and gaps; and

5) citizen data and voices on healthcare access and accountability.

3.1 Health Sector Governance

Governance is thought to be a key determinant of economic growth, social advancement, and overall development, as well as achievement of the SDGs in low- and middle-income countries.[13] Governance comprises delegating some decision-making authority from individuals to a governing entity, with implementation overseen by one or more institutions and accountability systems in place to monitor and ensure progress on decisions made.[14] For health services, the implementation process requires consideration of a minimum of three sets of key actors: policymakers; service providers; and citizens/clients. Health system governance concerns the actions and means adopted by society to organize itself in the promotion and protection of the health of its population.[15]

In Ghana, at the top of the health sector governance structure in Ghana is the Ministry of Health (MOH) which oversees the entire health sector. The MOH is responsible for, among other things, health policy formulation, resource mobilization, monitoring, and regulation of the delivery of 4health care by different agencies . Another key function of the MOH is to formulate appropriate policies that will ensure adequate production of appropriate numbers and mix of human resource personnel; equitable distribution of health personnel; adoption of appropriate retention strategies; and performance-related reward systems that will enable the MOH to meet its vision of improving the wellbeing of Ghanaians. The Human Resource for Health

13. Siddiqi, S., Masud, T. I., Nishtar, S., Peters, D. H., Sabri, B., Bile, K. M., & Jama, M. A. (2009). Framework for assessing governance of the health system in developing countries: Gateway to good governance. Health Policy, 90(1), 13–25. https://doi.org/10.1016/j.healthpol.2008.08.005
14. Ciccone, D. K., Vian, T., Maurer, L., & Bradley, E. H. (2014). Linking governance mechanisms to health outcomes: A review of the literature in low- and middle-income countries. Social Science and Medicine, 117, 86–95. https://doi.org/10.1016/j.socscimed.2014.07.010
15. Dodgson, R., Lee, K., & Drager, N. (2002). Global Health Governance, A Conceptual Review. Centre on Global Change & Health London School of Hygiene & Tropical Medicine Department of Health & Development World Health Organization, February, 1–27. https://doi.org/10.4324/9781315254227-33

Directorate (HRHD) at the MOH has a mission to involve all agencies of the MOH, other stakeholders such as academia, the private sector, health partners, other ministries, departments, and agencies (both within and outside the country) in the formulation, implementation, monitoring, and evaluation of effective human resource for health policies that guide production, management, and training of the health workforce.[16]

Despite the efforts of the HRHD, the distribution of health workers in the country is highly skewed in favour of more affluent regions, mostly in the south. Highly skilled professionals such as medical doctors and specialized personnel (nurses, pharmacists, allied health professionals, etc.) are concentrated in the national capital (Greater Accra region). Two of the teaching hospitals (Korle Bu and Komfo Anokye) employ more than 45 per cent of the country's doctors, while less than 15 per cent are in the district hospitals. Health workers are concentrated in the southern sector, where social amenities are concentrated, limiting opportunities to improve service delivery in rural areas, where more than 65 per cent of the population lives. Additionally, the majority of the highly skilled health staff are in the public sector. The private self-financing sector, however, employs 10 per cent of Ghana's health workforce, mostly in the urban areas. The private sector has a large number of health facilities, yet they appear to have a proportionately smaller number of staff than the public sector.[16]

The MOH, working in partnership with its agencies and stakeholders, aims at improving human capital, thus “creating wealth through health” through the development and implementation of proactive policies that will ensure improved health and vitality. The structure of the health sector includes various agencies that can be clustered into policy, regulatory, and service delivery groups (see Figure 1). The health care system in Ghana is tasked with improving and guaranteeing the health and wellbeing of the Ghanaian people.[17] The sector has evolved intending to improve population health outcomes, provide financial security, and ensure that Ghana's health system is more responsive, efficient, egalitarian, and sustainable to achieve universal health care (UHC).

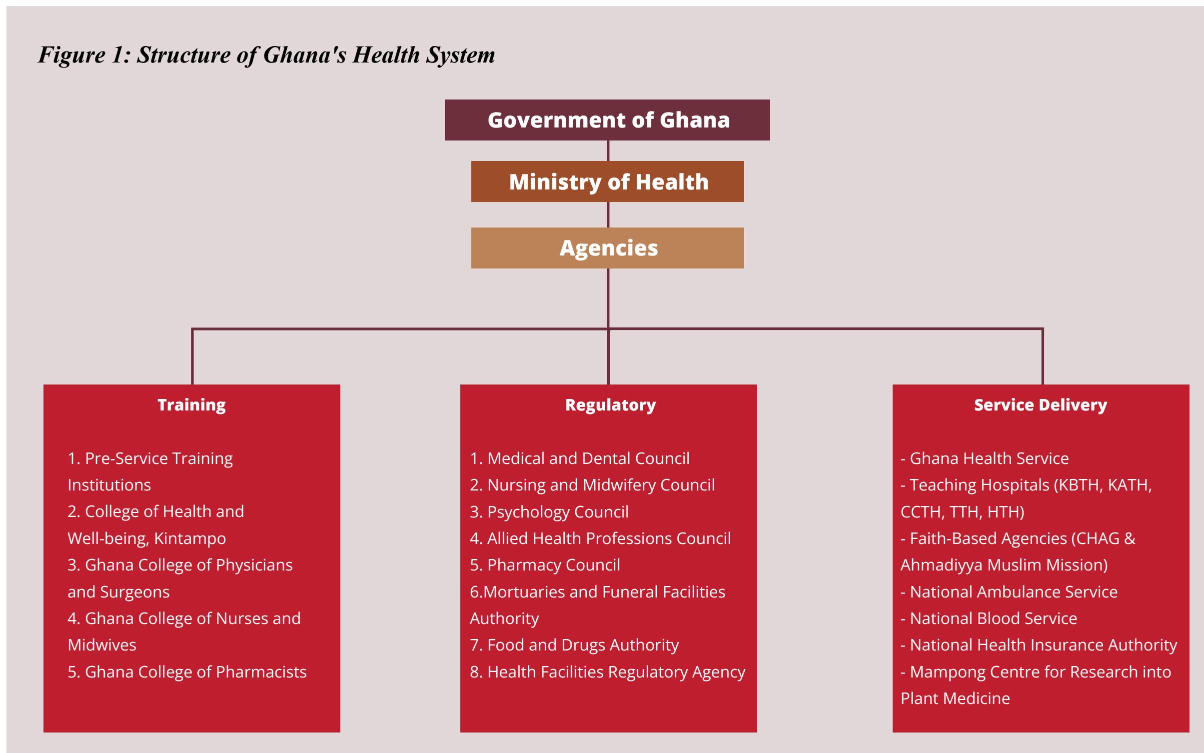
Major stakeholders in the health sector are the Ministry of Health, Ghana Health Service, National Health Insurance Authority, Health Facility Regulatory Authority, Private Healthcare Organizations, Faith-based Healthcare and umbrella organizations, Health Professional Associations and Societies, and development partners. The GHS, as an agency under the MOH, primarily administers the health services provided by the government and implements government policies on healthcare. Furthermore, the GHS is in charge of the delivery of public health services by hospitals and quasi-government health facilities at the regional, district, and community levels. Regional and district hospitals provide secondary level health care, whilst health centres and Community-based Health Planning and Services (CHPS) provide basic preventative and curative health care at the community level. Tertiary level health facilities, which are agencies under the MOH, provide specialized health care services. However, private and faith-based hospitals are not necessary under the GHS.

In 2003, the National Health Insurance Scheme (NHIS) was created to provide financial access to quality basic health care for residents in Ghana, adopting free maternal care in 2004 and free mental health care services in 2012. The NHIS operates Ghana’s public healthcare system and allows three different kinds of insurance plans (District Mutual Health Insurance Schemes, or DMHIS); private mutual insurance schemes; and private commercial insurance schemes). The most popular plan is the DMHIS, which operates in every district in Ghana.[18]

16. Ministry of Health. (2011). Ghana Human Resources for Health Country Profile. Ministry of Health, Ghana.
17. Ghana Statistical Service, & Ministry of Health Ghana. (2003). Overview of the Health System in Ghana. Ghana Service Provision Assessment Survey 2002, 13–24
18. Gajate-Garrido, G., & Owusua, R. (2014). The National Health Insurance Scheme in Ghana: Implementation Challenges and Proposed Solutions. SSRN Electronic Journal, December. https://doi.org/10.2139/ssrn.2373242

3.0 Findings

Figure 1: Structure of Ghana's Health System



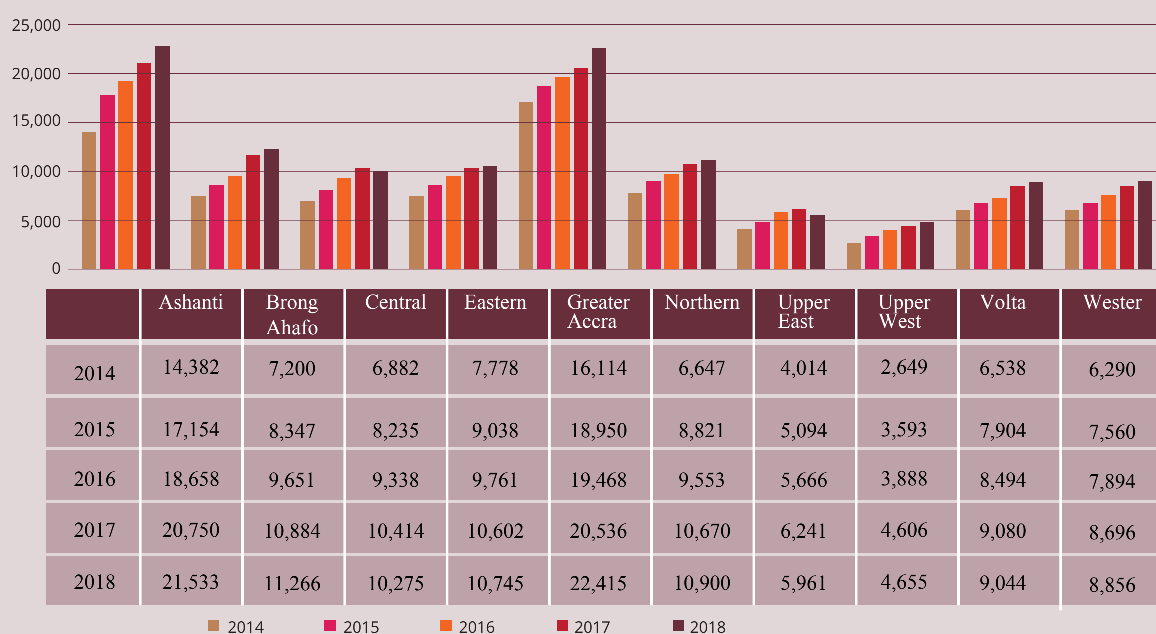
Improvements in the sector have been seen in access to healthcare over the past decades.[19] There has been an increase in coverage by health facilities and community-based health planning and services (CHPS) have been promoted to support community-based primary health care.[20] The number of doctors, nurses, and other health workers per population has also increased. The total number of doctors has increased by 40% from 2,615 in 2013 to 3,669 in 2017[21] and nurses by 52% from 24,533 in 2013 to 37,190 in 2017. Key successes in the health of the population include a significant reduction in under-five mortality from 111 in 2003 to 80 per 1000 live births in 2014; a reduction in infant mortality rate from 64 in 2003 to 41 per 1000 live births in 2014; increased financial access due to NHIS; free maternal care; an increase in skilled birth attendants during delivery from 59% in 2008 to 74% in 2014.[22] a reduction in HIV prevalence from 3.6% in 2007 to 1.3% in 2013 ; and the introduction of the Mental Health Act.[23]

19. Escribano-Ferrer, B., Cluzeau, F., Cutler, D., Akufo, C., & Chalkidou, K. (2016). Quality of Health Care in Ghana: Mapping of Interventions and the Way Forward. Ghana Medical Journal, 50(4), 238–247. https://doi.org/10.4314/gmj.v50i4.7
20. Nyonator, F. K., Awoonor-Williams, J. K., Phillips, J. F., Jones, T. C., & Miller, R. A. (2005). The Ghana Community-based Health Planning and Services Initiative for scaling up service delivery innovation. Health Policy and Planning, 20(1), 25–34. https://doi.org/10.1093/heapol/czi003
21. Ministry of Health-Ghana. (2018). Holistic Assessment of 2017 Health Sector Programme of Work. Ministry of Health, Ghana, 1–110.
22. GDHS, 2015

Similarly, the average life expectancy at birth of Ghanaians increased from 61.03 years in 2010 to 63.78 years in 2018, while about 9 out of every 10 households had access to an improved source of drinking water. Additionally, antenatal care (ANC) by skilled providers increased marginally by some 2 percentage points from 96% in 2007 to 98% in 2017, while those making at least 4 ANC visits increased significantly from 77% to 89% over the same reference period. Significant shifts in birthplace trends were also observed, with a nearly double increase in the percentage of most recent live births or stillbirths delivered in a health facility in the last five years (up from 54 per cent in 2007 to 79 per cent in 2017) and an equally more than a proportionate shift away from home delivery (45 per cent in 2007 vs. 20 per cent in 2017). These improved health indices have been attributed to huge investments in the country's human resources for health over the past decades. **Ghana increased its Health Workforce (HWF) density by about 2.5 times, from 10.7 doctors, nurses, and midwives per 10,000 people in 2005 to 26.5 at the end of 2018.[24] Given current and comprehensive HLMA datasets, however, the density of doctors, nurses, and midwives per 10,000 population improved markedly in 2021 to some 45.37 doctors, nurses, and midwives per 10,000 population, surpassing the WHO global benchmark of 44.5 doctors, nurses, and midwives per 10,000 population required for the attainment of the tracer indicators of SDG goal 3.[23]**

The absolute number of general doctors, specialist doctors, nurses, midwives, dentists, pharmacists, laboratory technicians, community health workers, other health workers, and health managers and support staff amounted to some 122,183, representing about 3.5% of the total number of selected cadres in the African Region as at 2018. By the close of 2018,[25] the country boasted of a total of 115,650 staff on the public health sector payroll, representing a 2.7% increase over 2017's total of 112,479. The corresponding monthly net salary of the health workforce amounted to some US $28,708,399.5, registering about a 5.5% increase over 2017, which recorded 23.3% over 2016.

Figure 2: Regional Distribution in health sector



	Ashanti	Brong Ahafo	Central	Eastern	Greater Accra	Northern	Upper East	Upper West	Volta	Wester
2014	14,382	7,200	6,882	7,778	16,114	6,647	4,014	2,649	6,538	6,290
2015	17,154	8,347	8,235	9,038	18,950	8,821	5,094	3,593	7,904	7,560
2016	18,658	9,651	9,338	9,761	19,468	9,553	5,666	3,888	8,494	7,894
2017	20,750	10,884	10,414	10,602	20,536	10,670	6,241	4,606	9,080	8,696
2018	21,533	11,266	10,275	10,745	22,415	10,900	5,961	4,655	9,044	8,856

23. WHO. (2015). Health workforce 2030: towards a global strategy on human resources for health.
24. James Avoka Asamani et
25. WHO. (2021). The State of the Health Workforce in the WHO Africa Region (Survey Report). Retrieved from https://apps.who.int/iris/bitstream/handle/10665/348855/9789290234555-eng.pdf?sequence=1&isAllowed=y. Retrieved 2021 https://apps.who.int/iris/bitstream/handle/10665/348855/9789290234555-eng.pdf?sequence=1&isAllowed=y

3.0 Findings

To boast the country's COVID-19 preparedness and response strategy, the government by November 2020 recruited an additional 45,107 health workers, registering a 35% boost in the public sector health workforce capacity and an increase in the recurrent public health sector compensation bill by about US $213.58 million per annum.[26] The recruitment of health workers, especially the critical ones, remained strategic over the years, as shown in Table 1:

Table 1:Distribution of Selected Health Workforce Categories 2017 - 2021

Category	Year 2017	Year 2018	Year 2019	Year 2020	Year 2021
Enrolled Nurse	16625	16078	18201	18799	24490
Professional Nurse	12088	11826	14724	16154	24097
Community Health Nurse	14218	13270	14201	13981	16134
Professional Midwife	6857	7780	9062	9368	13300
Medical/Physician Assistant	963	1116	1214	1461	1556
Certified Registered Anaesthetist	284	304	339	367	421
Medical Officer - House Officer	406	365	313	201	472
Medical Officer - General	758	833	931	1131	1331
Medical Officer - Specialist	338	371	373	381	357
Medical Officer - Consultant	4	5	13	16	13
Pharmacist	425	408	421	324	448
Grand Total	**52966**	**52356**	**59792**	**62183**	**82619**

Source: Ghana Health Service 2021 Annual Report

Nationally, the doctor-to-population ratio (a measure of how many people a doctor could potentially attend to) has been on a steady decline, falling from 1:10,430 in 2014 to 1:7,192 in 2018 and ultimately to 1:6,355 in 2020 [27,28]

Concurrently, the midwife to WIFA and nurse to population ratios improved from 1:943 to 1:560 (2016-2020) and 1:727 to 1:701 (2019-2020), respectively.

26. Asamani, J. A., Ismaila, H., Okoroafor, S. C., Frimpong, K. A., Oduro-Mensah, E., Chebere, M., . . . Kuma-Aboagye, P. (2022). Cost analysis of health workforce investments for COVID-19 response in Ghana. BMJ Glob Health, 7(Suppl 1). doi:10.1136/bmjgh-2022-008941
27. GHS. (2020). 2020 GHS Annual Report. GHS
28. Tarlue, M. (2021). Ghana Records Improvement In Doctor-to-population ratio. Retrieved from https://dailyguidenetwork.com/ghana-records-improvement-in-doctor-to-population-ratio/

These investments in the health workforce, backed up by improved professional regulation and the expanded coverage and benefits package of the national health insurance scheme, improved both geographical and financial access to healthcare for the average citizen. The hitherto three deprived regions in Northern Ghana that lacked critical human resources like doctors and nurses to provide needed healthcare services could by the end of 2021 boast 155 doctors.[29] Furthermore, the influx of recruits into the system resulted in significant improvements in the health system's governance and management efficiency, moving the health system's overall holistic assessment score closer to the health sector objective three – improve efficiency in governance and management of the health system-from 3.7 in 2020 to 3.97 in 2021.[30]

Similarly, increased health workforce densities bolstered sub-national health governance structures and leadership, as previously vacant management roles at these levels were filled as they became available.[30] Again, the placement of community health workers in local communities to provide preventive and basic curative health services strengthened the required co-production, involvement, and cooperation of the citizens/patients in the provision of healthcare, thereby strengthening transparency and accountability.[31]

These notwithstanding, Ghana's health system continues to face significant governance challenges, such as inadequate financing for health and health care services; inequitable access to health care services, including financial protection; referrals and reverse referrals for primary and specialized care; and keeping the health workforce duly motivated and up to speed on evolving trends.

Current health expenditure (CHE) as a share of GDP has been in a nosedive for the past five years (2015–2019), falling from 4.6% in 2015 to about 3.4% in 2019[32,33]. Healthcare service availability and readiness have remained variable across the respective service delivery points, varying from as high as 92.8% in regional/district hospitals through 70.8% in health centres to about 64.3% at the CHPS compound level.[34]

Additionally, the government's definition of UHC as "all people in Ghana having timely access to high-quality health services irrespective of ability to pay at the point of use" appears to be faltering, as its strategic purchaser for healthcare services, i.e., the national health insurance scheme, claims reimbursement schedule often lags by an average of 6 months.[35,36]

As a consequence, service provision has been hindered[37] and out-of-pocket (OOPS) as a share of CHE increased from 35.8% in 2015 to some 36.2% in 2019,[33] thereby removing the inherent financial risk protection for the vulnerable in Ghanaian society.

Due to these governance challenges, the overall universal health coverage index plateaued at 47% in 2017 and the human capital index at 0.44 in 2018.[38] The trend of TB case notification per 100,000 continues to fall, from 60.0 in 2013 to 48.8 in 2019, as does the goal of attaining the global average of 8-10% for notification of childhood TB. Similarly, malaria continues to be the leading cause of morbidity and mortality with approximately 12 million suspected cases, representing 42.8% of OPD cases, reported and accounting for 22.2% and 1.1% of total admissions and total deaths in the country in 2019 respectively. Noncommunicable diseases like hypertension, heart disease, and

29. GHS. (2021). 2021 Ghana Health Service Human Resource Annual Report. Accra
30. GHS. (2022). 2021 Ghana Health Service Holistic Assessment Report. Retrieved from Accra:
31. Kickbusch, I., & Gleicher, D. E. (2012). Governance for health in the 21st century. Retrieved from
32. WHO. (2010). The Abuja declaration: ten years on.
33. WHO. (2022). Global Health Expenditure Database. Retrieved from https://apps.who.int/nha/database/ViewData/Indicators/en. Retrieved 16/06/2022, from WHO https://apps.who.int/nha/database/ViewData/Indicators/en
34. Ayanore, M., Asampong, R., Akazili, J., Awoonor-Williams, J. K., & Akweongo, P. (2022). Sub-national variations in general service readiness of primary health care facilities in Ghana: Health policy and equity implications towards the attainment of Universal Health Coverage. PloS one, 17(6), e0269546.
35. MOH. (2020). Ghana's Roadmap for Attaining Universal Health Coverage 2020 - 2030. Accra: MOH
36. NHIA. (2022). 2021 Annual Performance Report. Accra
37. Citinewsroom. (2021). Delayed payment of NHIS claims hindering smooth healthcare services. Retrieved from https://www.modernghana.com/news/1071359/delayed-payment-of-nhis-claims-hindering-smooth.html
38. WB. (2020). UHC Service Coverage Index - Ghana. Retrieved from https://data.worldbank.org/indicator/SH.UHC.SRVS.CV.XD

cerebrovascular disease accounted for 17.6% of institutional deaths during the same period.[39]

The maldistribution of the health workforce remains a serious headache for health workforce policymakers, as has the verticalization of in-service training programs. As regards the regional distribution of the HWF, the existing trend where the southern regions had the highest HWF densities continued, albeit with marginal gains in the deprived regions. The Greater Accra Region restored its lead as the region with the highest share of the health sector workforce (22,415 – 19.4%), overtaking the Ashanti Region (21,533 – 18.6%). The Upper West Region, meanwhile, continued to have the lowest number of HWF, followed by the Upper East Region.

3.2 Political Economy of the Healthcare Sector

The political economy of health is concerned with the interaction of political and economic domains in shaping individual and population health outcomes. It is premised on the idea that politics and the economy cannot be separated. Politics both creates and shapes the economy.[40] The political economy of health is necessary for explaining and addressing persistent health inequalities and emerging public health crises under global capitalism, a political-economic system that shapes nearly all aspects of our lives, though it attracts relatively little attention in the field of public health.[41]

Ghana's healthcare system has maintained a symbiotic relationship with its political economy since independence, demonstrating a favourable association. The political economy of self-rule with the nationalist commitment of a 7-year development plan boosted infrastructure and industrialisation, with a key emphasis on free access to basic services such as health and education. During this era, the health system, underpinned by a comprehensive policy on advancing public healthcare, saw the government building health infrastructure and creating the Ministry of Health to promote health and vitality through access to quality health care for people living in Ghana.[42,36] These interventions significantly improved social services, and access to healthcare became easily accessible.

However, the succeeding era, between 1966 and 1981, known as the era of political instability, heralded rampant coup d'états characterised by general insecurity, poor economic performance, and the introduction of austerity measures to mitigate the impact of the 1976 global economic recession. This era marked no/abysmal improvements in the health sector, propelled the massive brain-drain of skilled health workforce and catalysed the introduction of user fees,[43,44] curtailing the availability of the required health workforce and widening financial access to healthcare services.

The ensuing politically stable era, meanwhile, saw marked improvements in the marriage between the political and economic domains and their impact on individual and population health outcomes. Attempts were made at decentralisation and devolution, as well as at introducing strategic purchaser systems, i.e., Community-Based Health Insurance Schemes (CBHIS) and subsequently the national health insurance scheme to remove all financial barriers to healthcare services. The sector devolved to the community level in tandem with its managerial supervisory responsibilities, embraced global health targets such as UHC and SDGs, and designed disease-specific

39. GHS. (2018). 2018 Annual GHS Report. GHS
40. Novignon, J., Lanko, C., & Arthur, E. (2021). Political economy and the pursuit of universal health coverage in Ghana: a case study of the National Health Insurance Scheme. Health policy and planning, 36(Supplement_1), i14-i21.
41. Harvey, M. (2021). The political economy of health: Revisiting its Marxian origins to address 21st-century health inequalities. American Journal of Public Health, 111(2), 293-300.
42. Brinkerhoff, D. W. (2004). Accountability and health systems: toward conceptual clarity and policy relevance. Health policy and planning, 19(6), 371-379.
43. Dadson, I., & Kato, R. R. (2015). Remittances and the Brain Drain in Ghana: A Computable General Equilibrium Approach. Retrieved from
44. Dovlo, D. (2004). The brain drain in Africa: An emerging challenge to health professionals' education. Journal of Higher Education in Africa/Revue de l'enseignement supérieur en Afrique, 1-18.

programmes, such as the National Malaria Control Programme (NMCP), National AIDS/STI Control Programme (NACP), and National Tuberculosis Control Programme (NTP) to reduce morbidities and mortalities associated with malaria, HIV/AIDs, and tuberculosis respectively.

Ghana's attainment of a low-middle-income status propelled growth in its real economy, significantly reducing the share of its population's poverty headcount ratio at US $1.90 per day to some 12.7% and GDP per capita to US $2,260.9 in 2019. These improvements commensurately led to improvements in health indices. There has been a massive infrastructure drive to improve geographical access to healthcare and the deepening of the implementation of the national health insurance scheme to bridge the financial access to healthcare. **As at end of December 2021, the NHIS, with a total active membership of almost 18million subscribers, had expanded its benefit package to include childhood cancers and family planning services.**

Regardless of these measures, it has been demonstrated that the Ghanaian health sector's marriage to its encompassing political economy has not been without flaws. For example, Transparency International's Global Corruption Report in 2006 characterized Ghana's health industry as corrupt, with evidence of bribery and fraud across the spectrum of medical services. A review of the roles and functions of the health care delivery process vis-a-vis avenues for possible abuses revealed that the risks of corruption in the Ghanaian health sector were intricately linked to the inelastic demand for healthcare services, the connected nexus of regulators, payers, providers, consumers, and suppliers interacting in service provision, and information asymmetry amongst these varied actors, making it difficult to identify and control for diverging interests[45,46,47].

Corruption in the health sector can make the difference between life and death,[48] as it has severe consequences for access, quality, equity, efficiency, and efficacy of health services and is an obstacle to the long-term goal of achieving universal health coverage.[49] People who engage in corruption in the health sector may demand bribes for medication which should be free or they may let clients who bribe them queue-jump.[46] Corruption also costs lives when fake or adulterated medications are sold to health services. Ghana's public healthcare system has been faced with some of these issues.

3.3 Laws and Legislative Oversight on Healthcare

Ghana's legal framework for the health sector strives to improve the policy and legal environment so that reported health sector information describes the country's health and health system status as completely and accurately as possible. The Health Sector Acts are as follows:

1) Ghana Health Service and Teaching Hospitals Act;

2) GHS ACT 525;

3) HPRBA ACT 857;

4) Mental Health Act 846 (2012);

5) National Health Insurance Act 2012 (852); and

6) Public Health Act 851.

The passage of Act 525 in 1996 established the Ghana Health Service (GHS) as the implementing body for public sector health services. This marked a clear statement of intent for the public

45. Agbenorku, P. (2012). Corruption in the Ghanaian healthcare system: the consequences. Journal of Medicine and Medical Sciences, 3(10), 622-630.
46. Hirschfeld, M. J. (2006). Book Review: Global corruption report 2006: Corruption and health. Nursing Ethics, 13(6), 665-666.
47. Savedoff, W. D., & Hussmann, K. (2006). The causes of corruption in the health sector: a focus on health care systems. Transparency International. Global Corruption Report.
48. Onwujekwe, O., Agwu, P., Orjiakor, C., McKee, M., Hutchinson, E., Mbachu, C., . . . Ichoku, H. (2019). Corruption in Anglophone West Africa health systems: a systematic review of its different variants and the factors that sustain them. Health policy and planning, 34(7), 529-543.
49. Vian, T. (2008). Review of corruption in the health sector: theory, methods and interventions. Health policy and planning, 23(2), 83-94.

sector service delivery component, separating the service delivery, policy, and regulatory components of the MOH.[17] The act also paved the way for the strengthening of the regulatory bodies, especially the Food and Drugs Board, the Nurses and Midwives' Council, the Medical and Dental Council, the Traditional Medicine Board, the Funeral Homes Board, and the Private and Maternity Homes Board. Under Act 525, the MoH has been streamlined to be the backbone for the provision of general government policy direction, resource mobilization, monitoring and evaluation, and providing administrative support for the Minister.[17]

To make healthcare financially accessible to the average Ghanaian, the National Health Insurance Act 852 (2012) established a national health insurance scheme to pay for the cost of healthcare services to members of the scheme, establish private health insurance schemes, and provide for related matters. The Public Health Act 851 was passed to revise and consolidate the law relating to public health to prevent disease, promote, safeguard, maintain and protect the health of humans and animals and provide for related matters.

These legal frameworks have complementarily worked to provide the policy undertones to guide healthcare delivery (at all operational levels – community, subdistrict, district, regional, and quaternary), set standards to regulate service delivery, as well as regulate the training and practice of the health workforce. Specifically, the coming into being of the Ghana Health Service and Teaching Hospitals, reference ACT 525 of 1996, widened geographical access to healthcare services with almost 5,300 health facilities dotted across the country, resulting in about 81.4%, 61.4%, and 14.3% of the population having access to primary healthcare, secondary healthcare, and tertiary healthcare, respectively, as at 2019.[50]

Table 2: Distribution of Health Facility Types - 2021

Type of Health Facility	Number	Percentage (%)
CHPS	3,951	74.6%
Health Centre	1,132	21.4%
Polyclinic	51	0.9%
District (Primary) Hospital	148	2.8%
Regional Hospital	10	0.2%
Teaching Hospital	5	0.1%
Grand Total	**5,297**	**100%**

Source: Ghana Health Service Human Resource Information and Monitoring System (HRIMS)

50. Kirchner, S. (2021). 4 Facts about Healthcare in Ghana. Retrieved from https://borgenproject.org/facts-about-healthcare-in-ghana/

Similarly, financial barriers inhibiting access to healthcare largely withered over time given the national health insurance scheme. At the end of 2021, almost 18 million people, representing 99% of the 2021 target population, were active members of the NHIS.[36] The health training institutions for the training of preservice health workforce and postgraduate health colleges such as the Ghana College of Physicians and Surgeons, Ghana College of Nurses and Midwives, and Ghana College of Pharmacists have also increased their production capacities, churning out significant numbers of health workforce. On the other hand, the regulatory agencies have ensured the maintenance of professional standards and the sanctioning of errant practitioners.

Legal oversight over the operations of the health sector rests with the Parliament of Ghana, which reviews, monitors, and supervises the executive arm's implementation of relevant health sector policies.[51] The Parliament of Ghana employs several tools, broadly categorised into three – the committee arena, the plenary arena,[52] and other arenas, in its legislative oversight over the health sector. The Parliament of Ghana employs several tools, broadly categorised into three – the committee arena, the plenary arena,[52] and other arenas, in its legislative oversight over the health sector.Employing the Committee Arena mechanism, the Parliament of Ghana through its Select Committees on Health and Finance scrutinises and recommends for approval and/or sanctions the activities and funding arrangements of the health sector, following which the plenary arena, which entails the whole legislature in the main chamber of the house, approves or disapproves recommendations from the Committee Arena. The last oversight tool available to the Parliament of the Republic is the other arenas where it employs tools outside the chamber/committee levels, such as statutory audits, parliamentary visits, and other forms of investigations to exert its legislative oversight over the health sector.

Notwithstanding these in-built checks and balances in the legislative environment, the architecture lends itself to possible political abuse or interference. By the spirit and letter of this relevant health sector legislation, the authority to appoint administrative heads of all public health agencies is vested in the President of the Republic, lending itself to possible abuse and exercise in the appointment of "political puppets".

Further, the country's hybrid of the Westminster parliamentary model and the American Presidential model of democratic governance lends it to some inherent internal and external challenges.[53,54,22] For example, Parliament's inability to have its own budget independent of the executive arm of government, the compulsion of the President to draw not less than half of his/her ministers from parliament, the constitutional provision that causes a member of parliament to lose his/her seat when evicted from his/her political party, and the quality of members of parliament to appreciate their oversight duties are some of the challenges that chip away at parliament's oversight and autonomy over the executive.[54]

Ultimate legal oversight over the health sector, in view of these inherent challenges bedevilling the Parliament of Ghana, therefore extends to include citizen/civil society advocacy and demand for transparency, as well as interpretation of transparency demands and subsequent sanctions for breach of same by the judiciary. Legal oversight thus becomes a function for all.

51. Drolc, C. A., & Keiser, L. R. (2021). The importance of oversight and agency capacity in enhancing performance in public service delivery. Journal of Public Administration Research and Theory, 31(4), 773-789.
52. Stapenhurst, R., & Pelizzo, R. (2012). Improving democracy and accountability in Ghana: The importance of parliamentary oversight tools. Governance, 25(2), 335-346.
53. Ofori-Mensah, M., & Rutherford, L. (2011). Effective parliamentary oversight: mission impossible?
54. Srem-Sai, J. (2014). Parliamentary oversight in Ghana-a brief review.

3.4 Healthcare Policy, Funding and Gaps

The health sector recognizes its role in increasing access to health services, better healthcare and greater equity for the poor and vulnerable through partnerships.[55] The healthcare policy in Ghana aims to improve access to quality, efficient and seamless health services that is gender, youth-friendly and responsive to the needs of people of all ages in all parts of the country (Ministry of Health, 2014).

The healthcare policy objectives are:
1) to bridge the equity gaps in geographical access to health services;

2) to ensure sustainable financing for healthcare delivery and financial protection for the poor;

3) to improve efficiency in governance and management of the health system;

4) to improve quality of health service delivery, including mental health services;

5) to enhance national capacity for the attainment of the health-related MDGs and sustain the gains; and

6) intensify prevention and control of non-communicable and other communicable diseases.[56]

Health financing affects the entire health system's performance, including the accessibility, quality, and efficiency of primary health care. In May 2005, a strategy (WHA 58.33) was adopted by the fifty-eighth World Health Assembly (WHA) on sustainable health financing, universal coverage, and social health insurance. It urged countries, including Ghana, to ensure that health financing systems include a method for prepayment of financial contributions for health care. The aim was to spread the risk among the population to avoid terrible health care expenditure and hardship for care-seeking individuals.[56] Healthcare financing is one of the most critical components of the health system because, without expenditure, staff remuneration, medical equipment, and many health facilities will not be in place. It provides the inputs and economic system for the health system to function and serves as a causal element of health system performance in terms of health, equity, and efficiency.[57] Health financing has three main functions, namely revenue-raising through taxes, pooling and purchasing of health services. Purchasing refers to the apportionment of resources from a purchasing agent to a healthcare provider in exchange for providing health services.[58]

Some studies have shown that health care expenditure positively influences health outcomes.[59,60,61,62,63] These outcomes were measured by using infant mortality, child mortality, and life expectancy.

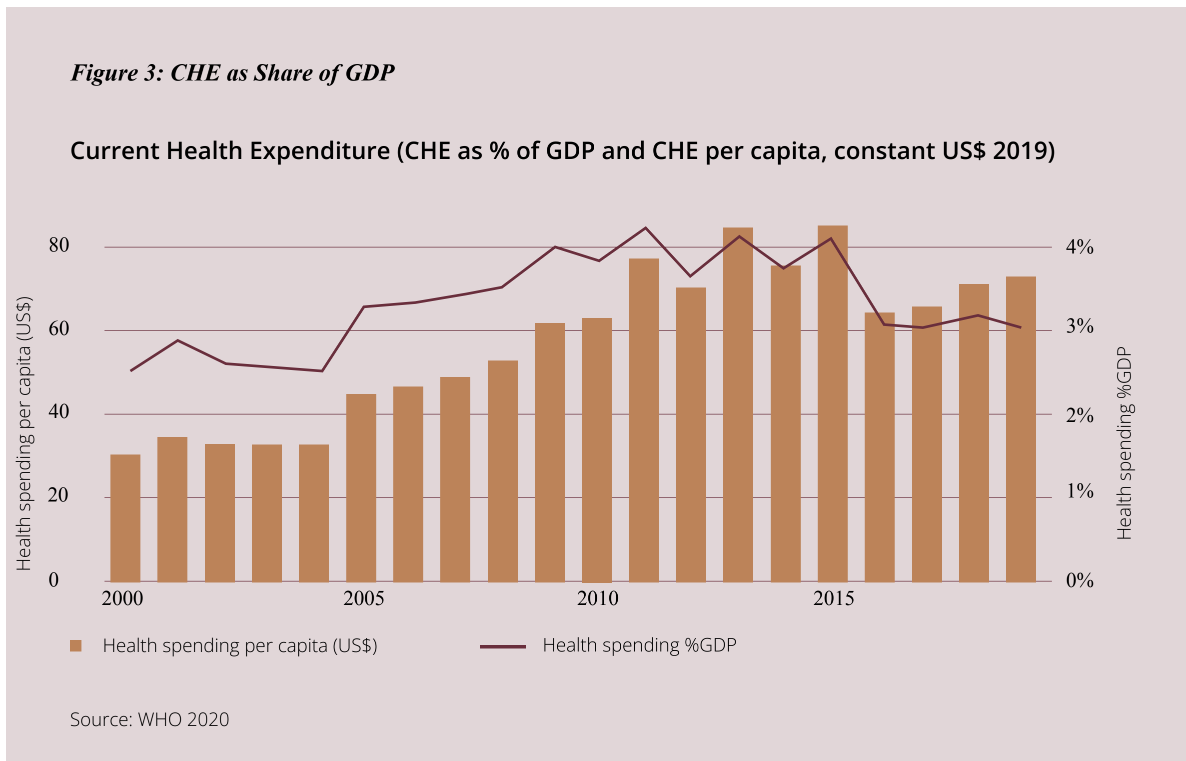
With regards to Ghana's health care financing system, Akazili et al. (2011) found that the health care financing system is generally progressive. The overall progressivity of taxes, which accounted for nearly half of health care funding, was largely responsible for the progressivity of health care financing.

Despite the country's progressive health finance trajectory, the government has continually failed to spend at least 15% of its GDP on health and healthcare-related activities. CHE as a share of GDP recorded its lowest ebb of 2.77% in 2004 and rose to some 4.71% of GDP in 2011, only to plummet downwards by almost 1.3 percentage

58. World Health Organization. (2010). The World Health Report: Health Systems Financing The path to Universal Coverage
59. Baldacci, E., Teresa Guin-Siu, M., & De Mello, L. (2003). MORE ON THE EFFECTIVENESS OF PUBLIC SPENDING ON HEALTH CARE AND EDUCATION: A COVARIANCE STRUCTURE MODEL. Journal of International Development J. Int. Dev, 15, 709–725. https://doi.org/10.1002/jid.1025
60. Cochrane, A. L., St Leger, A. S., & Moore, F. (1997). Health service "input" and mortality "output" in developed countries. Journal of Epidemiology and Community Health, 51(4), 344–349. https://doi.org/10.1136/jech.51.4.344
61. Farag, M., Nandakumar, A. K., Wallack, S., Hodgkin, D., Gaumer, G., & Erbil, C. (2013). Health expenditures, health outcomes and the role of good governance. International Journal of Health Care Finance and Economics, 13(1), 33–52. https://doi.org/10.1007/s10754-012-9120-3
62. Jaba, E., Balan, C. B., & Robu, I.-B. (2014). The Relationship between Life Expectancy at Birth and Health Expenditures Estimated by a Cross-country and Time-series Analysis. Procedia Economics and Finance, 15(14), 108–114. https://doi.org/10.1016/s2212-5671(14)00454-7
63. Xavier, C., Benoit, A., & Brown, H. K. (2018). Teenage pregnancy and mental health beyond the postpartum period: A systematic review. Journal of Epidemiology and Community Health, 72(6), 451–457. https://doi.org/10.1136/-jech-2017-209923

points to close the 2019 fiscal year at 3.42%. Similarly, health spending per capita mimicked the pattern of CHE as a share of GDP, rising from an all-time low of US $31.45 in 2000 to a high of US $87.82 in 2015, as shown in figure 3.

Figure 3: CHE as Share of GDP



Source: WHO 2020

These funding gaps occasioned funding support from sources such as out of pocket payments/spendings, social health insurance contributions through voluntary health insurance contributions, and external aid, which varied by share contribution. In 2000 for example, the Government of Ghana's share of total health spending amounted to a paltry 27.8%, with OOPPs commanding a whopping 52.6% of the counterpart funding. External aid amounted to almost half of GoG's share of total health spending (12%), while voluntary health insurance contributions and other sources accounted for 4% and 3.58%, respectively (WHO, 2022).[33]

GoG's share further decreased to some 24.14% in 2002, contrasting sharply with an all-time high OOPP share of 54.18%. Meanwhile, external aid, averaging about 13.42% over the past two decades, recorded its lowest and highest shares of 8.42% and 24.93% in 2012 and 2015, respectively.[33]

6. Candace Eastman and Franklin Dolo (2016). Liberia Health Sector Scan
7. Wright, J., Health Finance & Governance Project. July 2015. Essential Package of Health Services Country Snapshot: Liberia. Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.
8. Liberia Medical and Dental Council, 2016

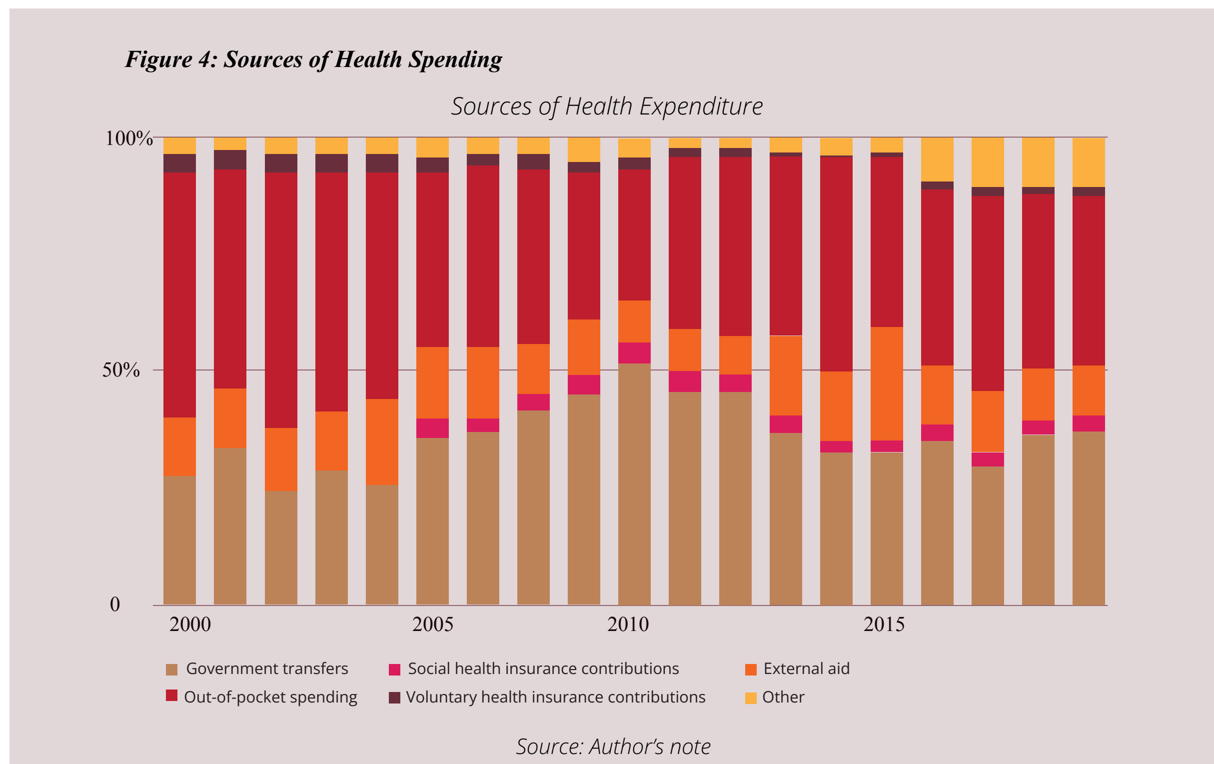


Figure 4: Sources of Health Spending

Source: Author's note

Meanwhile, when disaggregated by disease condition, external aid sources of funding on infectious diseases (HIV/AIDS, TB, and malaria) as a percentage share of health spending averaged 91% between 2014 and 2018, peaking at some 94% in 2014[33].

Table 3: Disaggregation of External Aid by Per Capita and Share of EXT

Country	Indicators		2014	2015	2016	2017	2018
Ghana	External sources of funding on Infectious and Parasitic Diseases as % of External Health Expenditure (EXT)		94	91	91	91	91
	External sources of funding by Diseases and Conditions	in current US$ per capita	13	20	9	9	8

Source: Adapted from GHED-WHO 2022

6. Candace Eastman and Franklin Dolo (2016). Liberia Health Sector Scan
7. Wright, J., Health Finance & Governance Project. July 2015. Essential Package of Health Services Country Snapshot: Liberia. Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.
8. Liberia Medical and Dental Council, 2016

There are, however, some in-built mechanisms to safeguard the misuse of funds in the health sector in particular and the public sector in general. These methods include everything from financial responsibility to performance accountability to political accountability.

To strengthen its financial accountability systems, Ghana enacted and/or amended several of its laws, such as the Financial Administration Act; Financial Administration Regulations; Procurement Act; Internal Audit Agency Act; and the Audit Service Act, and upgraded a chunk of its public finance management systems. The Medium-Term Expenditure Framework (MTEF) became the government's budget preparation system, which categorised budget expenditures into administrative and economic functions. In the expenditure control arm, internal audit arrangements have been strengthened with the establishment of an independent Internal Audit Agency, and the core government accounting system has been replaced with the computerised Budget and Expenditure Management System, and the payroll system by the Integrated Personnel and Payroll Data System.

Subvented funds by the Government of Ghana to the health sector pass through these systems, as do the retirement of healthcare expenditures. Periodically, internal and external audits are conducted to provide reasonable confidence that healthcare resources are used judiciously, with due consideration for economy and efficiency, and that the results of health sector programs are consistent with the goals and objectives of the Health Sector. Infractions are recorded as audit observations, and respective managers are required to respond to the observations, detailing why such occurrences occurred, what mechanisms will be put in place to prevent recurrence, and what punitive actions, if any, have been meted out to the perpetrators. If the audit observations are not resolved within the time frame specified, they are forwarded to the Public Accounts Committee of the Ghanaian Parliament, whose responsibility it is to "examine the audited accounts showing the appropriation of the sums granted by Parliament to meet the public expenditure of the government as presented to the House by the Auditor-General of Ghana".[64]

Donor funds going through the government treasury system abide by these accountability measures, whilst other donor funding arrangements—where disbursements (fund releases) are tied strictly to the achievement of an agreed set of results and not inputs (expenditures). Results indicators and disbursement linked indicators (DLIs), which represent industry priorities, are crucial to achieving program goals under various finance mechanisms.

In all cases, however, funding arrangements between the government and/or a donor require the approval of the Republic's Parliament, which serves as the legal framework for oversight of the implementing arm of government.

3.5 Citizen Data and Voices on Healthcare Access and Accountability

A healthy population is a fundamental ingredient for nation-building; hence, citizens' access to quality healthcare is considered a matter of human right that everyone must enjoy without distinction.[65] The United Nation's Sustainable Development Goal on Health (SDG 3) recognizes this point and calls on all countries to achieve universal health coverage and access to quality

65. World Health Organization [WHO], & [UNICEF], T. U. N. C. F. (2018). A vision for Primary health care in the 21st Century. World Health Organization, 1–64.
66. WHO. (2017). Monitoring the Health-Related Sustainable Development Goals (SDGs). February, 3.

health care by 2030 as a means to achieving sustainable development.[66]
Campbell et al. (2000) define quality health care as the extent to which healthcare provision delivers the desired health outcome. The issue of quality encompasses all matters relating to the availability of qualified professionals, modern technology for health delivery, infrastructure, and access to safe, effective, and affordable medicine.[67] One paper argued that the quality of health care in sub-Saharan Africa remains poor. As a result, a vast majority of its citizens continue to suffer from preventable and curable diseases, while others die from such. Also, the growing poverty levels among the African population, coupled with the lack of proper government policy for its older population, has limited their access to health care and resulted in depleted welfare in general.[68]

Other studies also reported a myriad of challenges that hinder access to quality healthcare delivery in Africa. Some of these are the lack of basic health care facilities, especially in rural areas, the need for favors or bribes to get services because of limited access, and the government's inability to improve basic health care services.[68,69]

Ensuring quality healthcare provision requires greater cooperation between the government, service providers, and the community to better assess health needs and select the most cost-effective means of addressing them[65].

According to WHO and UNICEF (2018), "people-centeredness" is a vital strategy for enhancing the quality of healthcare delivery because it encourages people to take an active role in their own health and care, which lowers the likelihood of problems and improves overall wellbeing.

The people-centeredness approach also demands community participation in health care priority setting and policy development to ensure policies reflect the needs of the communities and to promote greater accountability. Accountability in this context means that all stakeholders involved in the delivery of health care services, including ministries, health facilities, and health care workers, are held responsible for meeting the needs of the people for whom they were set up.[70] Ghana is making efforts towards a "people-centeredness" approach as well as creating an enabling environment for accountability by including community members in the governing boards of health facilities and routinely organizing performance reviews of health facilities at the facility, sub-district, district, and regional levels that include community members.

In Ghana, the respective legal frameworks governing the health sector make room for community or civil society representation on Governing Boards/Councils, the highest decision-making bodies, of healthcare delivery agencies at national, regional and community levels. For example, while section 4 (1) (g) of the Ghana Health Service and Teaching Hospitals Act, Act 525 of 1996, provides for the appointment of a member of a trade union to the governing council, section 18 (e-g) of the act provides for the appointment of a representative for each of the Muslim and Christian faiths in the operational region, a member of the regional house of chiefs, and two other residents of the region, one of whom must be a woman.

Operationally, boards of respective healthcare delivery facilities have representation from the communities in which they work, although there are reported delays in the constitution of these boards/councils/committees.

67. Grundy, Q., Parker, L., Wong, A., Fusire, T., Dimancesco, D., Tisocki, K., Walkowiak, H., Vian, T., & Kohler, J. (2022). Disclosure, transparency, and accountability: A qualitative survey of public sector pharmaceutical committee conflict of interest policies in the World Health Organization South-East Asia Region. Globalization and Health, 18(1), 1–23. https://doi.org/10.1186/s12992-022-00822-8
68. Alao, B. (2013). SYSTEM IMPROVEMENT IN NIGERIA: EXAMINING SENIOR HEALTHCARE PROGRAMS FROM CITIZENS' PERSPECTIVES. July. https://doi.org/10.1190/segam2013-0137.1
69. Armah-Attoh, D., Selormey, E., & Houessou, R. (2016). Despite Gains, Barriers Keep Health Care High on Africa's Priority ist. Afrobarometer Policy Paper No., 6(31), 26.
70. Rauscher, M. (2018). Governance Evidence Compendium Medical Products, Vaccines, and Technologies.

Key Findings

Ghana
Capital: Accra

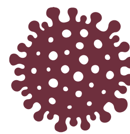
40%
increase in the number of doctors, from 2,615 in 2013 to 2017 and nurses by 52% from 24,533 in 2013 to 37,190 in 2017

111
reduction in under-five mortality in 2003 to 80 per 1000 live births in 2014

59%
increase in skilled birth attendants during delivery from in 2008 to 74% in 2014

GDP
Current health expenditure (CHE) as a share of GDP falling from 4.6% in 2015 to about 3.4% in 2021.

Average life expectancy at birth of Ghanaians increased from 61.03 years in 2010 to 63.78 years in 2018



COVID-19 preparedness and response strategy, the government by November 2020 recruited an additional 45,107 health workers, registering a 35% boost in the public sector health workforce capacity...

Accra region is said to be the region with the highest share of health sector workforce (22,415 - 19.4%) overtaking the Ashanti region (21,533 18.6%). The Upper west region have the lowest number of HWF followed by the upper East Region

A reduction in HIV prevalence from 3.6% in 2007 to 1.3% in 2013

9 out of every 10 households
had access to an improved source of drinking water

A reduction in infant mortality rate from 64 in 2003 to 41 per 1000 live births in 2014

4.0 Recommendations

4.1 Conclusion and Route to Reform

Social accountability can be defined as "an approach Within the sub-Saharan region, Ghana's health system has been touted as being robust, undergirded by massive investments in health infrastructure and health workforce. This has led to upward trends in the nation's health indices during the past decade. Ghanaians' average life expectancy at birth increased from 61.03 years (60.10 years for males and 61.97 years for females) in 2010 to 63.78 years in 2018 (62.72 years for males and 64.85 years for females); the infant mortality rate was reduced to 34 per 1,000 live births in 2019 (down from 47 per 1,000 live births in 2010), and the under-five mortality rate was reduced to 46 per 1,000 live births in 2019 (down from 69 per 1,000

In terms of increasing coverage of essential services, the 2017 Maternal Health Survey revealed that almost 9 out of every 10 households had access to an improved source of drinking water, with some slight variation, however, between urban (95%) and rural (81%) households. Additionally, antenatal care (ANC) by skilled providers increased marginally by some 2 percentage points from 96% in 2007 to 98% in 2017, while those making at least 4 ANC visits increased significantly from 77% to 89% over the same reference period. Significant shifts in birthplace trends were also observed, with a nearly double increase in the percentage of most recent live births or stillbirths in the last five years delivered in a health facility (up from 54 percent in 2007 to 79 percent in 2017) and an approximately equivalent move away from home delivery (from 45% in 2007 to 20% in 2017).

These notwithstanding, the inherent challenges in the system present Ghana with opportunities for growth and improvement, which require the collaborative action of relevant stakeholders such as the government, the private sector, and civil society groups.

4.2 Recommendations

Therefore, in line with the findings above, the following recommendations are proffered:

a. ***Under the Health Sector Governance theme,*** steps will be taken by GoG to ensure equitable access to healthcare. This could be accomplished in the short-to-medium term by ensuring the redeployment of existing health workforce from overstaffed regions, and in the long term by employing and then deploying health workforce to underserved geographical areas. Civil society organizations, on their part, could intensify advocacy against political interference in the employment and subsequent deployment of the health workforce, which often ends up in inequitable distribution. Again, GoG, Civil Society Organisations and Development Partners could put in both push and pull measures to attract and retain the needed health workforce in the underserved areas.

Similarly, the Government of Ghana must ensure the implementation of the well-known Agenda 111 (which seeks to design and build 111 health facilities across the country) to bridge geographical access to healthcare and strengthen the strategic purchaser system in order to make healthcare affordable to the average Ghanaian. The private sector and civil society, on their part, could partner with the government in building health facilities, thereby creating jobs as well as instituting affordable private health insurance schemes, amongst others. The latter could also intensify advocacy for the NHIA's timely reimbursements, thereby enhancing financial access to healthcare services and lowering OOPPs.

That, in view of the recent brain drain of skilled health professionals to the global south because of worker shortages occasioned by the COVID-19 pandemic, both hygiene and non-hygiene incentives be put in place to keep the health workforce motivated. However, since it is not possible to entirely curtail the brain drain, interim measures such as task-sharing and the building of the competencies of auxiliary health professionals to perform jobs otherwise not theirs could be explored.

b. ***Regarding the finding on corruption in the health care sector as a suppressor effect on the otherwise emollient political economy of the sector,*** it is recommended that GoG review the roles and functions of the health care delivery process vis-a-vis the possible abuses to paint a corruption risk matrix and mitigating mechanisms. GoG could invoke relevant anti-corruption regulations to deal with culprits, aside from collaborating with civil society to intensify their watchdog roles in advocating for transparency and accountability in the management of the health system by the relevant actors.

Civil society could, meanwhile, clamour for the amendment of the relevant legal frameworks that allow for the President of the Republic to appoint heads of the respective healthcare agencies in the country. When completed, this will reduce the possibility of assigning potential 'political puppets' to technical non-partisan posts, thereby separating policy from politics.

c. ***GoG's under-spending on health and healthcare has undoubtedly been established to be impacting negatively on health outcomes in the country.*** Consequently, it is proposed that GoG, as a matter of urgency, strive towards attaining its ratification of the Abuja Declaration by expending at least 15% of Annual Budget on health.

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