



HEALTH BUDGET BRIEF

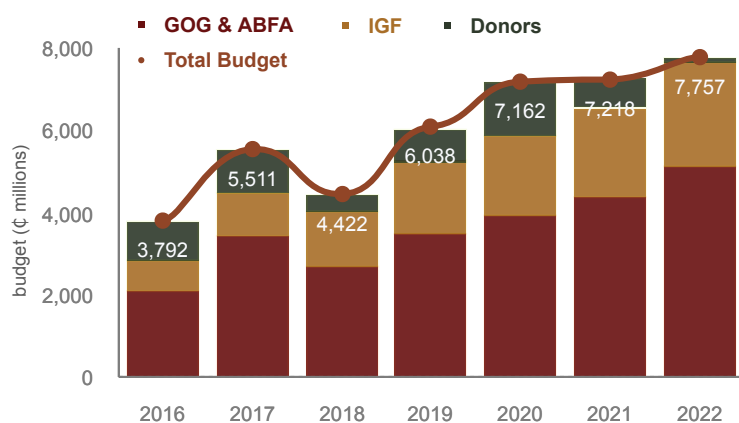


Health services in Ghana are funded from three main sources: the Government of Ghana (GoG) budget, internally generated funds (IGF) and funding from donors. A small amount of funding also comes from the Annual Budget Funding Amount (ABFA). Figure 1 shows how these sources' shares of total health funding is changing: in 2017, donor funding was 19%, but is set to decline to 1% by 2022. The donor funding is being replaced primarily by a 14% increase in IGF's share and, to a lesser extent, by GoG funding (4%). Whether this is a sustainable approach to replacing donor funding or not largely depends on the financial health of the National Health Insurance Scheme (NHIS), which is the biggest "purchaser" of health services and, therefore, the main contributor to IGF.

Between 2016 and 2019, the GoG funding of health grew at an average annual rate of 18%, keeping pace with the growth in the total GoG budget. Over the same period, IGF grew at 35% per year and donor funding declined by an average of 6% per year. Between 2019 and 2021, total health funding is set to grow at an average annual rate of 9%. GoG funding is set to increase by 13% per year, which is significantly lower than the expected 28% annual growth in the total GoG budget. This indicates that Government is not giving the same level of priority to funding health services as it is to other areas.

The envisaged decline in donor funding is very steep. This places an enormous obligation on Government to give effect to the vision set out in the Ghana Beyond Aid strategy document and to fund those services that donors were previously funding.

Health expenditure and budgets by funding source, 2016-2022



Source: MoH PBB, 2019

1

Allocate at least GH¢ 39 million for goods and services for Community-Based Health Planning and Services (CHPS) to improve the quality of these services. In the 2019 Budget for the Ghana Health Services, goods and services amounted to 0.23% of the total budget. This low allocation severely constrains the ability to deliver key services under the CHPS mandate.

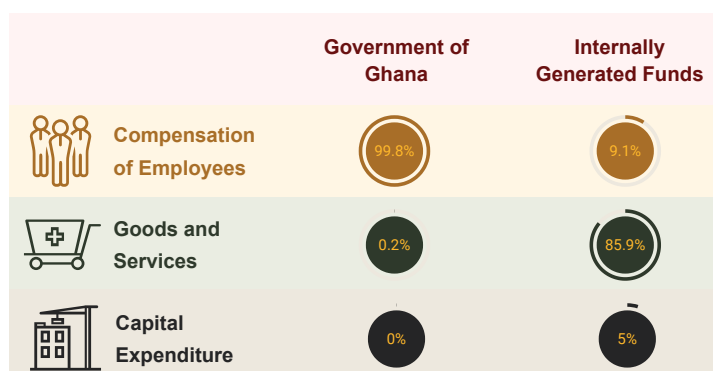


Improved coverage of primary and promotive healthcare is critical to achieving sustainable and affordable universal health care (UHC). The Community-Based Health Planning and Services (CHPS), along with the NHIS (clinical services), is the main vehicle for achieving this. Despite a large budget, allocations in the healthcare sector are not well balanced towards achieving this goal.

In 2019, the Government of Ghana budget to the Ghana Health Services is comprised of 99.8% for compensation of employees and only 0.2% for goods and services. The primary source of funds for goods and services is IGF, where goods and services comprised 86.0% of the budget, against 9.0% for compensation of employees and 5.0% for capex. However, IGF are supposed to be used on clinical services only. So IGF do not fund goods and services at the promotive or primary level, nor for CHPS. This means there are little to no funds allocated to pay for basic equipment, medicines and infrastructure at the primary level of the health system.

The 2019 GOG budget shows zero allocations for goods and services to CHPS, and in the years when there have been allocations, they are often not released. Even when some funds were released, they were dedicated to supporting co-financing arrangements with donors, leaving none for discretionary spending by the Ghana Health Services. Whilst some donor funding is available for actual health service provision at the promotive/primary/CHPS level, this is insufficient. Additionally, donors will not fund health provision-related services (e.g. water, utilities, transport, etc.) that are critical to the functioning of CHPS. These, therefore, go unfunded. Research is required to cost promotive/primary/CHPS services to lay the foundation for sound budgets for these services. However, as a starting point it can be safely assumed that at least 10% of the cost of delivering these services is required for goods and services. This means that at least GH¢ 39 million should be budgeted for goods and services in 2020.

Breakdown of expenditure allocations to the Ghana Health Service, 2019



Source: MoH PBB, 2019

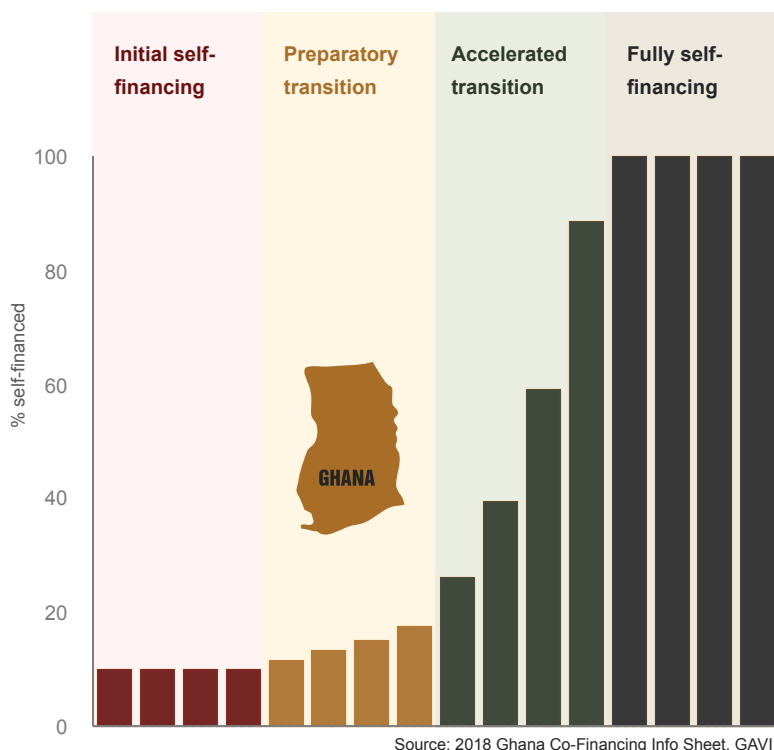


2

To cover both its backlog and 2020 co-financing obligations, the Government needs to budget for at least US\$6.9 million (GH¢ 37.8 million) for GAVI co-financing of routine immunisations.



Co-financing phases under GAVI



GAVI, the Global Vaccine Alliance, brings together public and private sectors with the shared goal of creating equal access to new and underused vaccines for children living in the world's poorest countries. A centrepiece of GAVI's strategy is its co-financing policy, which provides that, as countries progress on a trajectory of increasing Gross National Income (GNI) per capita, there is a phasing out of GAVI support and the countries take on higher levels of co-financing.

The co-financing policy encourages governments in GAVI-supported countries to invest in new vaccines, enhancing country ownership of vaccine financing. It helps them plan for financially-sustainable immunisation programmes in preparation for phasing out GAVI support for these vaccines. These objectives are fully aligned with the Government's own stated objectives as set out in the Ghana Beyond Aid strategy document.

Ghana is currently in the GAVI "Preparatory transition phase", meaning that the government's contribution increases by 15% per year. In this phase, the co-financing requirement is a percentage of the price of the vaccines. When a country enters the "Accelerated transition phase", the government's share of vaccine costs increases from the level it had reached during the previous phase to 100% of the cost over a period of five years.

35%

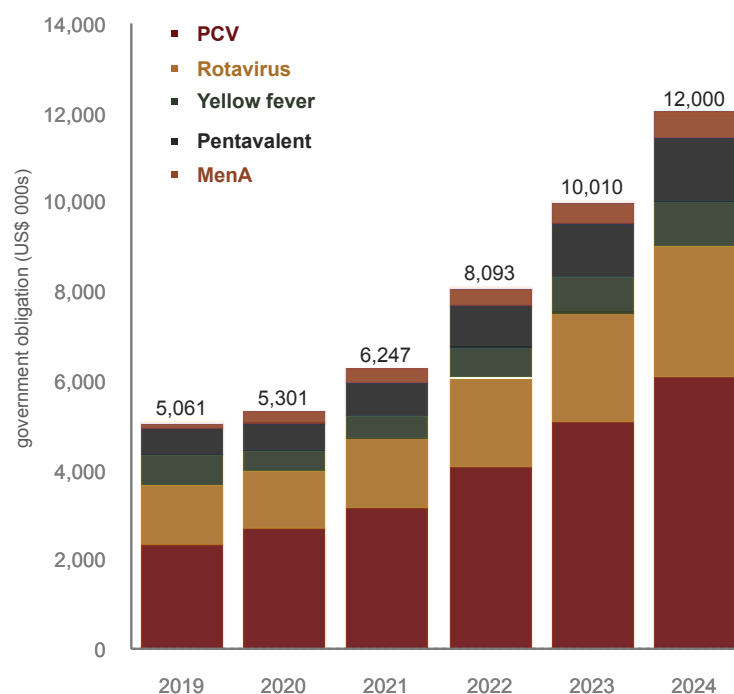
In 2017, the Government funded only 35% of the total expenditure on routine immunisation; the other 65% was funded by donors.

In 2017, GAVI provided US\$37.7 million to Government towards routine immunisation and vaccines purchase. Government contribution to routine immunisation was US\$13.2 million, or 35% of the total cost. Given this level of co-financing, and applying the 15% increase applicable within the preparatory transition phase, Ghana is projected to enter the accelerated transition phase in 2021-22. From this point, Ghana will have 5 years to increase its financing commitments to meet the full price of the applicable vaccines.

Under GAVI, Ghana's co-financing obligations for 2019 amount to US\$5.1 million – covering the PCV, pentavalent, yellow fever, rotavirus and meningitis A vaccines, - which amount the Government has already paid. This is projected to grow to US\$12.0 million by 2024 as Ghana enters the accelerated transition phase in the move towards full self-financing of these vaccines.

However, in 2016 and 2018 the Government defaulted on its payments. The Government is required to settle its US\$1.2 million of 2016 co-financing arrears in 2019, and is expected to settle the arrears from 2018 in five US\$800 000 tranches – one in 2019, two in 2020 and two in 2021. This means that, in 2020, the Government needs to budget for a total of US\$6.9 million to cover its GAVI US\$5.3 million 2020 co-financing obligation, and US\$1.6 million of its 2018 arrears obligation.

Projected government obligations under GAVI, 2019-2024



Source: 2018 Ghana Co-Financing Info Sheet, GAVI

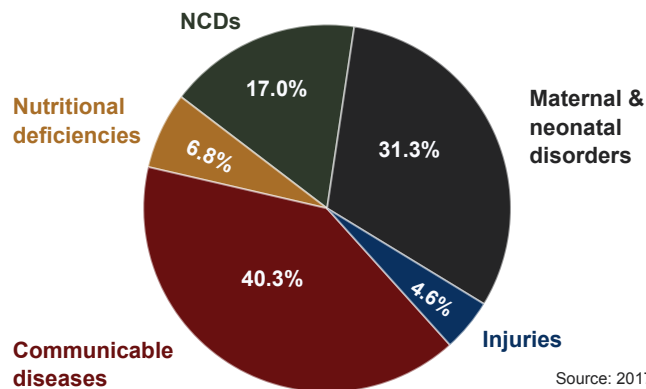


3

Provide adequate budgets for the prevention and control of communicable diseases, particularly PMTCT and paediatric HIV. Communicable diseases among children resulted in productivity losses of GHS 10 billion in 2017, equivalent to 6.9% of GDP. Currently interventions in these areas are funded primarily by the Global Fund and PEPFAR, therefore in line with the Ghana Beyond Aid Strategy it would be appropriate for the Government to move towards providing adequate funding particularly for PMTCT and the treatment of neonatal respiratory and enteric infections.



Causes of child mortality and morbidity in Ghana, 2017



Source: 2017 GBDS, IHME

The current structure of budget/expenditure information does not show what the Government is spending on the prevention and control of communicable diseases, and yet communicable diseases contribute more to productivity losses than any other health risk category. The continued high costs associated with communicable diseases is a strong indication that funding for the prevention and control of these diseases is inadequate.

Specific health risks within communicable diseases include malaria (12.8% of total productivity losses), diarrheal diseases (7.3%), lower respiratory infections (6.9%) and HIV/AIDS (4.5%).

¢9.9 billion

In 2017, deaths and disability resulting from communicable diseases among infants and children costed Ghana ¢9.9 billion in productivity losses. This is equivalent to 6.9% of Ghana's GDP.

Malaria is the second-largest single contributor to child mortality and morbidity in Ghana, and accounts for GH¢ 3.2 billion in productivity losses. In 2017, the prevalence rate of malaria in children aged 6–59 months is 36%, with only 49% of children under 5 sleeping under an insecticide-treated net at night. Of all pregnant women, only 52% receive the recommended minimum three doses of IPTp-SP for the treatment of malaria in pregnancy, while 18% of pregnant women receive no treatment at all. Increased coverage of both mosquito net usage and IPTp is necessary to reduce these rates of incidence and prevalence.

Diarrheal diseases are the third-largest single contributor to child mortality and morbidity, causing GH¢ 1.8 billion in productivity losses. Only 21% of people in Ghana have access to basic sanitation services, while 22% practice open defecation. Similarly, only 48% have access to basic hygiene services, while 28% don't have access to any handwashing facilities whatsoever. Improved practices in handwashing and disposal of liquid waste is critical to reducing the incidence of diarrheal diseases and other enteric infections.

Lower respiratory tract infections and TB are the fourth-largest contributors to child mortality and morbidity in Ghana, and account for GH¢ 1.7 billion in productivity losses. The 2017 Ghana Demographic and Health Survey (GDHS) shows that 4% of children under age 5 had symptoms of acute respiratory infection in the two weeks before the survey alone. Despite such high incidence rates of lower respiratory infections and TB, according to the latest data, advice or treatment was sought in only 56% of the cases. This proportion is even lower amongst rural households (51%) and households in the lowest income quintile (47%). Worryingly, data from the GDHS suggests that there is a stigma attached to TB infection, with 33% of women (who are more likely to seek treatment for a child) saying that they would want to keep a family member's TB status a secret. An increase in treatment-seeking behaviour, and availability of treatment, is important to providing timely treatment for TB and other respiratory infections.

HIV/AIDS among neonates specifically accounts for GH¢ 832 million in productivity losses. Data shows that 70% of HIV-positive pregnant women receive ARV prophylaxis to prevent mother-to-child transmission, and only 33% of pregnant women were tested for HIV during their pregnancy and received their results and counselling. Increased coverage in HIV screening of pregnant and lactating women and of PMTCT can address these problems.

NEGLECTED TROPICAL DISEASES

Neglected tropical diseases were the cause of **13.6%** of child mortality and morbidity in 2017. Production losses from these cases amounted to **¢3,370 million**.



ENTERIC INFECTIONS

Enteric infections were the cause of **9.5%** of child mortality and morbidity in 2017. Production losses from these cases amounted to **¢2,353 million**.



RESPIRATORY INFECTIONS & TB

Respiratory infections and TB were the cause of **7.7%** of child mortality and morbidity in 2017. Production losses from these cases amounted to **¢1,919 million**.



NEONATAL HIV/AIDS

Neonatal HIV/AIDS was the cause of **4.5%** of child mortality and morbidity in 2017. Production losses from these cases amounted to **¢1,119 million**.



HEALTH SECTOR BUDGET BRIEF



4

Increase budgets for improving coverage for nutrition interventions, and specifically provide GH¢ 6.4 million for RUTF in 2020. Nutritional deficiencies among children resulted in productivity losses of GH¢ 1.7 billion in 2017, equivalent to 1.2% of GDP. These losses could be averted through improved targeting and coverage of existing nutrition interventions in the most vulnerable regions. There is an urgent need for Ready-to-Use Therapeutic Foods (RUTF) to treat children with acute malnutrition.

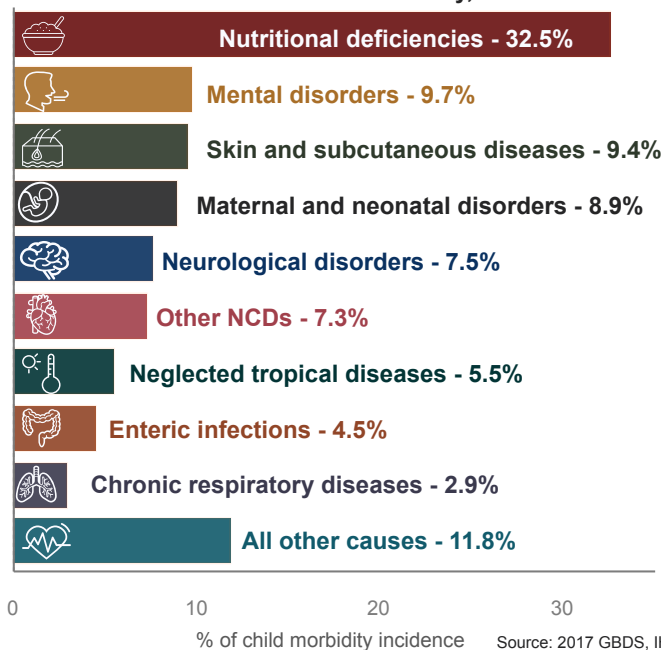


In Ghana, 18% of children are stunted and 7% of children are wasted. While the incidence of stunting is fairly strongly related to income – rates of stunting are 25% among the poorest quintile and only 9% among the richest quintile – rates of wasting are fairly consistent across the income cohorts (7% among the poorest and 6% among the richest quintile).

Nutritional deficiencies are a significant contributor of child mortality and morbidity, and result in productivity losses amounting to GH¢ 1.7 billion, or 1.16% of GDP. In almost half of the deaths due to communicable diseases, malnutrition is implied, and the deaths could have been prevented with good nutrition. The primary deficiencies are protein-energy malnutrition, dietary iron deficiency and Vitamin A deficiency. This highlights the need for improved interventions in these specific areas – improvements in the treatment and prevention of severe acute malnutrition, and increased coverage of Vitamin A and iron supplementation amongst children and pregnant and lactating women. Increased budgetary allocations towards these areas should be prioritised. Specifically, the Government needs to budget for the provision of Ready-to-Use Therapeutic Foods (RUTF) to treat children with acute malnutrition. An RUTF treatment costs around GH¢ 108 per child. It is estimated that, to meet demand, the Government needs to budget at least GH¢ 6.4 million for RUTF in 2020, and the equivalent in following years.

Among children aged 5–14 years specifically, nutritional deficiencies are the single largest contributor to mortality and morbidity, and negatively affect education outcomes. The MoH and MoGCSP need to set adequate nutritional standards for the School Feeding Programme to ensure that the meals provided by caterers meet the nutrition needs of children. Girls are particularly vulnerable because of menstruation. Iron and folic acid supplementation for girls improves their wellbeing and education outcomes.

Causes of child morbidity, 2017



5

Ensure adequate budgets for services aimed at reducing neonatal deaths. The neonatal mortality rate in Ghana is 24.1 per 1 000 live births, double the SDG target of 12 per 1 000 live births. Investment to prevent neonatal deaths results in a triple return by reducing newborn deaths, stillbirths, and maternal mortality and morbidity.



There has been steady improvement in reducing neonatal mortality rates since 1990, but at the current rate of improvement, it is forecast that, at best, Ghana will only reach the SDG goal of 12 neonatal deaths per 1,000 live births by 2036.

Maternal and neonatal disorders are the single largest cause of child mortality and morbidity in Ghana, with associated productivity losses amounting to GH¢ 7.8 billion, or 5.34% of GDP. Ghana has made significant progress in realising key antenatal and neonatal healthcare provision targets. The Ghana Health Services has set a target of:

- 85% of pregnant women receiving a minimum of four antenatal visits. The MICS 2017 shows that the national average has reached this target, but four regions were still below it, with Volta at 75%.
- 65% of deliveries be attended by a trained health worker. The MICS 2017 shows that 79% of births were attended by a skilled attendant. However, again there are regional disparities, with the Northern Region still below the national target at 60%.

Improving budgets for allocations to antenatal and neonatal health care service provision will help to ensure that these targets are met. As a start, the MoH, working with the Japan International Cooperation Agency (JICA), has produced a maternal child health handbook to give to all mothers of newborn children. In 2018, there were just over 973 000 live births. The booklet costs about US\$1 (GH¢ 5.4) to produce, which means that GH¢ 5.3 million needs to be budgeted for their production and distribution each year. This is the type of expenditure that should fall under the goods and services budget for CHPS.

Actual and projected neonatal mortality rate, 1990-2037

