

The health care system in Ghana is confronted with the formidable task of improving and guaranteeing the health and well-being of the Ghanaian people. The health system has the responsibility of combating illnesses associated with poverty and lack of education; at the same time, it has to deal with a growing population, inadequate funding and resources, and an increasing burden on the health care system due to the HIV/AIDS epidemic.

This chapter provides a brief overview of the health care system in Ghana as it relates to infrastructure and outpatient services. The chapter provides a context in which to view the findings of the Ghana Service Provision Assessment (GSPA) survey.

Information is presented with respect to the following:

- Relevant history, including health sector reforms and reforms in drug policy
- General organization of the health care system
- Health facilities
- Health manpower
- Public health programmes
- Health insurance.

## **2.1 History**

### **2.1.1 Overview of the Health Situation**

The health of Ghanaians has been improving since Ghana's independence in 1960. Infant mortality rate (IMR) among Ghanaian children has fallen from 133 deaths per 1,000 live births in 1957 to 57 deaths per 1,000 live births in 1988, and the under-five mortality rate (U5MR) has decreased from 154 deaths per 1,000 live births in 1957 to 110 deaths per 1,000 live births in 1988 (Ghana Statistical Service and Macro International, 1999). Although improvement has been seen, the Ministry of Health (MoH) is of the view that rates of change have been slow, with current rates still far from desirable. The national level rates obscure the substantial differences that exist between groups and sectors of the country, and this is of great concern to the MoH. For example, IMRs vary from less than 57 deaths per 1,000 live births in the southern part of the country to over 100 deaths per 1,000 live births in the northern part.

Table 2.1 shows the major endemic health problems of various age groups in Ghana according to the Ministry of Health. The primary causes of preventable deaths in children under five years are malaria, malnutrition, diarrhoea, and acute respiratory infections (ARI).

With the current gross domestic product (GDP) estimated as US\$390 per capita, Ghana faces economic challenges, which are reflected in Ghana's poor state of health. These economic conditions make the choices of how to use Ghana's scarce resources to positively affect health care all the more important.

### **2.1.2 Health Sector Reforms**

The health sector has seen many changes during the past decades. Initially, the MoH assumed the role of the sole provider of services with collaboration from the missions and the paragonment institutions such as the military, the police, and the mines. Its services were oriented more toward curative care than preventive care and involved programmes that were to a large extent donor driven.

Age group	Disease (percent)	Disease (percent)	Disease (percent)	Disease (percent)	Disease (percent)	Disease (percent)
<1 year	Malaria (55.8)	Acute respiratory infections (11.2)	Diarrhoeal diseases (8.3)	Skin diseases and ulcers (4.4)	Anaemia (3.6 percent)	Pneumonia (2.1)
1-4 years	Malaria (57.3)	Acute respiratory infections (9.5)	Diarrhoeal diseases (6.4)	Skin diseases and ulcers (4.7)	Anaemia (3.4 percent)	Intestinal worms (1.8)
5-14 years	Malaria (49.7)	Acute respiratory infections (7.8)	Skin diseases and ulcers (3.4)	Diarrhoeal diseases (5.4)	Home and occupational accidents (3.3)	Intestinal Worms (2.7)
15-44 years	Malaria (38.5)	Pregnancy and related complications (6.3)	Other acute respiratory infections (6.0)	Skin disease and ulcers (4.1)	Home and occupational accidents (3.3)	Gynaecological conditions (3.1)
45-59 years	Malaria (35.8)	Hypertension (9.1)	Other acute respiratory infections (6.4)	Rheumatism and joint pains (4.5)	Skin disease and ulcers (3.9)	Acute eye infections (3.1)
≥60 years	Malaria (35.3)	Hypertension (12.3)	Other acute respiratory infections (7.0)	Rheumatism and joint pains (4.9)	Skin disease and ulcers (3.6)	Acute eye infections (3.3)

In 1996, Ghana developed Vision 2020, a long-term vision for growth and development that would move it from a low-income to a middle-income country by 2020. The Vision 2020 document defines the nation's areas for priority attention in the medium to long term as follows:

- Maximizing the healthy and productive lives of Ghanaians
- Fair distribution of the benefits of development
- Attainment of a national economic growth rate of 8 percent
- Reduction of the population growth rate from 3 percent to 2.75 percent
- The promotion of science and improved technology as tools for growth and development.

The MoH had developed and published its Medium-Term Health Strategy (MTHS) document and a five-year programme of work that is to guide health development in Ghana from 1997 to 2001. The objectives of the programme of work were to achieve the following:

- Increased geographical and financial access to basic services
- Better quality of care in all facilities and during outreaches
- Improved efficiency in the health sector
- Closer collaboration and partnership between the health sector and communities, other sectors, and private providers both allopathic and traditional
- Increased overall resources in the health sector, equitably and efficiently distributed.

Its mission statement, which summarizes the overall direction of the health sector, is as follows:

As one of the critical sectors in the growth and development of the Ghanaian economy, the mission of the health Ministries, Departments and Agencies is to improve the health status of all people living in Ghana through the development and promotion of proactive policies for good health and longevity; the provision of universal access to basic health

service, and provision of quality health services which are affordable and accessible. These services will be delivered in a humane, efficient, and effective manner by well trained friendly, highly motivated, and client oriented personnel.

In 1997, the common perception was that government, religious missions, and other donor-financed nongovernment organizations (NGOs) dominated health service provision. The government had, for some years, identified primary and preventive care and the major instrument for reducing morbidity and lengthening life. Although there had been substantial progress in developing a district-based package of primary services during the 1990s, this was still being delivered unevenly and was substantially dependent on vertical programmes. Moreover, there were important differences in the approach to health service priorities being adopted by religious missions, providers, and other private providers.

Until recently, the MoH developed its own policies, implemented and regulated them, evaluated its own performance, and developed the human resources needed to run the health service. This was deemed inefficient, and as part of the overall institutional reforms, there was a decision to decentralize roles and responsibilities to different agencies.

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 sector service delivery component, separating the service delivery, policy, and regulatory components of the MoH. 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.

The Ghana Health Service was officially launched in February 2003. Although the GHS is under the administrative supervision of the MoH, GHS staff are no longer civil servants; this allows more flexible management options. In establishing the GHS, the MoH recognizes the pluralistic nature of the provision of health service in the country. The Ministry's policies aim at improving public sector services and at strengthening the Private Medical and Dental Practitioners' significant contribution to service delivery. The health sector expanded to include the government health services; private, traditional, and nongovernment providers; civil society; and community groups.

### **2.1.3 Reforms in Drug Policy**

The revolving drug fund (RDF) was started in 1992, using capital that had accumulated in facilities through the retention of fees during the previous year. These funds were used in two ways. A portion was withdrawn from facilities and used to form the seed capital of the regional medical stores, and the remainder was left at the health facility as the seed capital for the revolving drug fund. Guidance on the operational aspect of the fund was provided in the Cash and Carry manual written in 1989 and used for the initial training of staff. Other manuals relating to the operation of the RDF, such as procurement procedures, were developed.

The status of the various manuals or their application or applicability is not clear. Guidance on charges that can be made against the drug fund is also not clear. The pricing of drugs varies between facilities, with little standardization concerning the pricing policy. This variation is important as it means that the system fails to meet the government's strategy of equity and affordability in respect to health care

provision. In addition, the expected cash flow from drug sales falls short of the government’s target as a result of credit sales that are becoming the norm (Ministry of Health and Ghana Health Service, 2000).

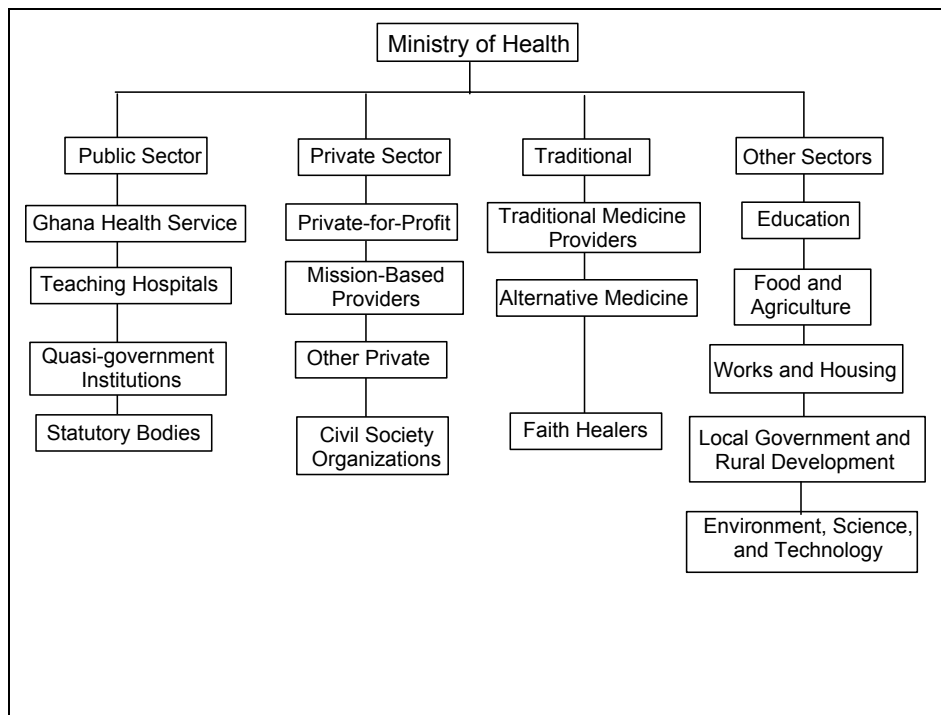
## 2.2 Overview of the Health System

### 2.2.1 Public Sector

#### Organization of the Ministry of Health

Figure 2.1 provides an outline of the various sectors and organizations for which the MoH has some responsibility.

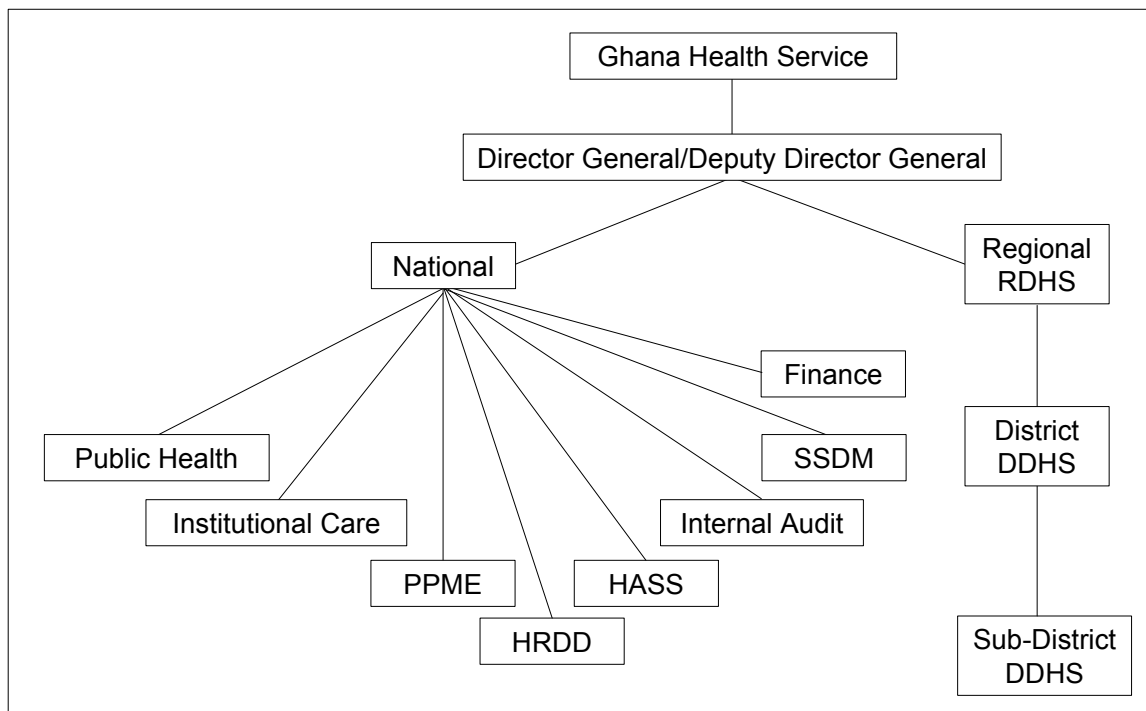
**Figure 2.1 Relationship of the Ministry of Health to the various sectors and organizations in Ghana**



## Ghana Health Service

The GHS, the public sector service provider, has eight directorates, as shown in Figure 2.2:

**Figure 2.2 Directorates of the Ghana Health Service**



The public health directorate is responsible for the Reproductive and Child Health Programme, the Malaria Control Programme, the National AIDS/STI Control Programme, the Occupational Health Programme, the Parasitic Diseases Control Programme, and others, with Maternal, Child Health, and Family Planning services included under the Reproductive and Child Health Unit.

### Regional and District Administration

As a result of decentralization and health sector reform, services are integrated as one goes down the hierarchy of health structure from the national to the subdistrict. This has affected the supervision system, whereby one technical person down the line may supervise several technical areas of service delivery.

### Structure of Delivery of Services

At the regional level, curative services are delivered at the regional hospitals and public health services are delivered by the District Health Management Team (DHMT), as well as the public health division of the regional hospital. The Regional Health Administration (RHA) provides supervision and management support to the districts and subdistricts within each region.

At the district level, curative services are provided by district hospitals, many of which are mission based. Public health services are delivered by the DHMT and the public health unit of the district hospitals. The District Health Administration (DHA) provides supervision and management support to the subdistricts.

At the subdistrict level, both preventive and curative services are provided by the health centres, as well as outreach services to the communities within their catchment areas. Basic preventive and curative services for minor ailments are being addressed at the community and household level with the introduction of the Community-based Health Planning and Services (CHPS). The role played by the traditional birth attendants (TBAs) and the traditional healers is also receiving national recognition.

### **2.2.2 Nongovernment and Private Sectors**

Although there are several health-oriented NGOs operating throughout the country, the population covered by the health services of these NGOs cannot be determined. The GHS supports the health services of NGOs and the private sector in several ways. In December 2002, the GHS initiated the process of awarding contracts to NGOs to undertake specific health services based on their comparative advantage. Government funds from the decentralized budget process were used to pay for the contracted NGO's service. The GHS also provides support to Mission health facilities by seconding staff and providing some essential equipment.

Currently, the private sector contributes 35 percent of health services in the country. Government support is targeted to raise this to 65 percent in the next 10 years. The private sector, however, provides basic curative health services and very few preventive services.

Modalities for supervision and monitoring of services of NGOs and the private sector are under development.

The NGOs and the private sector are to work with communities in collaboration with the DHMT and provide a quarterly progress report. Reports to the Policy Planning, Monitoring and Evaluation unit of GHS are presented biannually. Staff are trained by GHS but are not funded by the government. Their activities are guided by the GHS standards and protocols.

## **2.3 Health Facilities**

A distribution of health facilities by type of facility and region is shown in Table A-2.1.

### **2.3.1 Health Centres**

The health centre has traditionally been the first point of contact between the formal health delivery system and the client. It is headed by a medical assistant and is staffed with programme heads in the areas of midwifery, laboratory services, public health, environment, and nutrition. Each health centre serves a population of approximately 20,000. They provide basic curative and preventive services for adults and children, as well as reproductive health services. They provide minor surgical services such as incision and drainage. They augment their service coverage with outreach services, and refer severe and complicated conditions to appropriate levels. The polyclinic is the urban version of the rural health centre. Polyclinics are usually larger, offer a more comprehensive array of services, are manned by physicians, and can offer complicated surgical services. They are mainly in metropolitan areas.

### **2.3.2 District Hospitals**

District hospitals are the facilities for clinical care at the district level. District hospitals serve an average population of 100,000 to 200,000 people in a clearly defined geographical area. The number of beds in a district hospital is usually between 50 and 60. It is the first referral hospital and forms an integral part of the district health system.

A district hospital should provide the following:

- Curative care, preventive care, and promotion of health of the people in the district
- Quality clinical care by a more skilled and competent staff than those of the health centres and polyclinics
- Treatment techniques, such as surgery, not available at health centres
- Laboratory and other diagnostic techniques appropriate to the medical, surgical, and outpatient activities of the district hospital
- Inpatient care until the patient can go home or back to the health centre
- Training and technical supervision to health centres, as well as a resource centre for health centres at each district hospital
- Twenty-four-hour hospital services
- The following clinical services:
  - Obstetrics and gynaecology
  - Child health
  - Medicine
  - Surgery, including anaesthesia
- Accident and emergency services
- Nonclinical support services
- Referral services
- Contribution to the district-wide information generation, collection, planning, implementation, and evaluation of health service programmes.

### **2.3.3 Regional Hospitals**

Regional hospitals form a secondary level of health care for their locations. They provide services to a geographically well defined area of a population of about 1.2 million. Regional hospitals are an integral part of the regional health system, functioning to support it. They provide specialized care, involving skills and competence not available at district hospitals, which makes them the next level of referral from district hospitals. Their personnel should include medical professionals, such as general surgeons, general medical physicians, pediatricians, general and specialized nurses, and midwives.

Regional hospitals should have 150 to 200 beds.

Regional hospitals should provide general clinical services in the following disciplines:

- Medicine
- General surgery and anaesthesia
- Paediatrics
- Obstetrics and gynaecology
- Dental services
- Psychiatry
- Accident and emergency services
- Ear, nose, and throat
- Ophthalmology
- Dermatology.

They should also provide the following services:

- Laboratory and diagnostic techniques for referrals from the lower levels of the health care system
- Teaching and training for health care personnel such as nurses and medical students
- Supervision and monitoring of district hospital activities
- Technical support to district hospitals, such as special outreach services.

#### **2.3.4 Teaching Hospitals**

Teaching hospitals are centres of excellence and complex health care. Governance of teaching hospitals is unusual because it involves many players, such as the MoH, the Ministry of Education, and university and political influences in the community; teaching hospitals have a high social and political profile. The care at these facilities requires more complex technology and highly skilled personnel. They have a high concentration of resources and are relatively expensive to run. They also support the training of health workers both preservice and in-service.

Teaching hospitals have the following functions:

- Health care
  - They provide complex curative tertiary care. They also provide preventive care and participate in public health programmes for the local community and the total primary health care system. Referrals from districts as well as the regions are ultimately received and managed at the teaching hospitals. The teaching hospitals have a special role in providing information on various health problems and diseases. They provide extramural treatment alternatives to hospitalization, such as day surgery, home care, home hospitalization, and outreach services.
- Quality of care
  - Teaching hospitals should provide a leading role in setting high-quality clinical standards and treatment protocols. The best quality of care in the country should be found at teaching hospitals.
- Access to care
  - Patients might only have access to teaching hospitals through a well-developed referral system.
- Research
  - With the concentration of resources and personnel, teaching hospitals contribute in providing solutions to local and national health problems through research.
- Teaching and training
  - Teaching functions are one of the primary functions of the teaching hospital. They provide both basic and post-graduate training for health professionals.



### 2.3.5 Private Maternity Homes

Private maternity homes fall under the governance of the Ghana Registered Midwives Association. They represent 17 percent of the health facilities providing reproductive health services in Ghana and have facilities in every region, with the highest number in the Ashanti region, followed by Greater Accra, and the least in the Upper East and West regions. Working in close collaboration with the Reproductive and Child Health Unit of the GHS, they offer reproductive and family planning services. In addition, some child welfare activities are carried out on their premises by health staff of public health facilities.

## 2.4 Health Manpower

Table 2.2 presents the number of health providers in comparison to population. Statistics for laboratory staff is not available.

Region	Population 2000	Number of doctors	Number of nurses	Population-to-doctor ratio	Population-to-nurse ratio
Western	1,924,577	122	1,361	15,775	1,414
Central	1,593,823	104	1,427	15,325	1,117
Greater Accra	2,905,726	1,016	5,694	2,860	510
Volta	1,635,421	103	1,895	15,878	863
Eastern	2,106,696	132	2,429	15,960	867
Ashanti	3,612,950	509	2,250	7,098	1,606
Brong Ahafo	1,815,408	113	1,493	16,066	1,216
Northern	1,820,806	42	1,104	43,352	1,649
Upper East	920,089	43	874	2,137	1,053
Upper West	576,583	27	524	21,355	1,100
Total	18,912,079	2,211	19,051	8,554	993

For the year 2000, the doctor-to-population ratio is 20,357 in the private sector and 14,752 in the public sector. The nurse-to-population ratio is 3,675 in the private sector and 1,295 in the public sector. As many as 915 nurses requested verification of their professional certificates in 2001, which indicates the number of nurses intending to leave the country in search of better opportunities (Nurses and Midwife's Council Register, 2002). Ghanaians constituted 9 percent of 5,334 sub-Saharan medical graduates in the United States (Hagopian et al., 2003).

## 2.5 Public Health Programmes

The MoH is focusing on a number of health priorities in Ghana, and specific health programmes have been developed to address these health priorities. The programmes are discussed below.

### 2.5.1 Reproductive and Child Health

The GHS has sanctioned the existence and free unfettered operation of the Reproductive and Child Health Unit. This unit has active branches at all levels throughout the country. For the past 13 years, the unit has provided an annual report based on data from regional, district, subdistrict, and other partners.

The components of the reproductive health programme are as follows:

- Safe motherhood, including antenatal, safe delivery, and postnatal care, especially breast-feeding, infant health, and women's health
- Family planning
- Prevention and treatment of unsafe abortions and postabortion care
- Prevention and treatment of reproductive tract infections, including sexually transmitted diseases and HIV/AIDS
- Prevention and treatment of infertility
- Management of cancer, including prevention and management of cervical cancers
- Responding to concerns about menopause
- Discouragement of harmful traditional practices that affect the reproductive health of men and women, such as female genital mutilation
- Information and counselling on human sexuality, responsible sexual behaviour, responsible parenthood, preconception care, and sexual health.

Family planning services are designed to assist couples and individuals in their reproductive ages to space or limit the number of births, prevent unwanted pregnancies, manage infertility, and improve reproductive health. Services provided at delivery points include the provision of short-term methods (condoms, spermicides, oral contraceptives, and natural family planning methods), reversible long-term methods (IUDs, injectables, and implants), and permanent long-term methods (minilap tubal ligation, and vasectomy). Other activities include training of tutors, in-service training of staff, and counselling.

Currently, the reproductive health care system, which was designed for adults, is being modified to meet the needs of adolescents as well.

The child health programme constitutes all child health activities aimed at promoting and maintaining the optimal growth and development of children age 0-18 years. For programmatic purposes, it has been subdivided into three groups:

- Children under 5 years (0-4 years)
- School-age children (5-15 years)
- Adolescents (10-18 years).

The components of the child health programme include the following:

- Neonatal health care
  - Antenatal care services
  - Postnatal care services
- Child welfare services
  - Promotion of exclusive breastfeeding for the first six months and timely introduction of complementary feeding
  - Immunization
  - Growth promotion and nutrition rehabilitation
  - Curative care for minor ailments and injuries

- School health services
  - Screening and examination of school children and food vendors
  - Immunization
  - Health education on current public health issues
  - Management of minor ailments and injuries
  - Maintenance of a hygienic school environment
  - Referrals
- Adolescent health
  - Identification and management of common health problems affecting adolescents
  - Provision of services focused on adolescents, including counselling; information, education, and communication (IEC); and reproductive health issues in general
  - Referrals.

### 2.5.2 Expanded Programme on Immunization

In Ghana, the Expanded Programme on Immunization (EPI) was introduced in 1978 as a strategy to improve child health. Since 1985, the programme has been operational in all 10 regions and 110 districts. The programme's focus was on childhood immunizations against tuberculosis (TB), diphtheria, neonatal tetanus, pertussis, acute poliomyelitis, measles, and yellow fever. Immunizations against *Haemophilus influenzae* type b (Hib) and hepatitis B (HepB) vaccine were introduced in 2002. Despite several attempts to improve the programme, the national immunization coverage has remained low (MoH, 1992). In response to these low percentages, Ghana has implemented strategies and set a minimum target of 75 percent for DPT3/OPV3 coverage to be attained by the year 2001 as part of the health sector reform documented in the MTHS (MoH, 1995). The EPI goals articulated in this strategy include the following:

- Eradication of poliomyelitis by the year 2000
- Elimination of measles by the year 2004
- Control of hepatitis by the year 2004
- Control of yellow fever by the year 2004.

As part of attempts to improve the EPI services in the country, the policy environment was strengthened. In 1991, daily immunization services (DIS) were introduced for all delivery points, including hospitals (Policies and Priorities for the Health Sector 1994-1995, MoH). The DIS policy stated that health workers should use every contact with a child under five years of age to inquire about their immunization status and should proceed to vaccinate them or refer them as needed. There is evidence, however, that this policy is not being adhered to.

Another strategy encouraged by EPI includes static, outreach, and satellite clinics. Static clinics are facility based and operate daily from 8 a.m. to 3 p.m. All logistics and other items needed for immunization are expected to be available at these sites. Referrals from other types of clinics are received and attended to. Outreach clinics have staff who move from their station (static) to render the same kind of services they would have carried out at the static clinic in the communities. Specialized care is usually not provided. Logistics and vaccines are carried by the team. Outreach services are held either weekly, fortnightly, or monthly, depending on staff strength and distance of operation. Satellite clinics are performed close to the static clinics. Their purpose is to decongest static clinics. The main difference between outreach and satellite clinics is the distance from the static clinics. In a recent review, EPI was

criticized for its overdependence on outreach immunization activities, and the review suggested that more static sites be created.

The safety of injections policy was also introduced. It states that to ensure the safety of injections, the needles and syringes for routine immunizations should be disposable and autodestructive. Health staff are to use one sterile needle and syringe for each injection and should not reuse disposable syringes and needles. These needles are to be placed in a puncture-proof container after use and disposed of by burning (destructive incineration) or burying at least 0.5 m below the surface.

## **2.6 Health Insurance**

### **2.6.1 Health Insurance**

For several years, the percentage for recurrent allocation to the health sector had been stagnant around 6 percent. In 2003, the percentage increased to 12 percent, and it is hoped that this will continue until the Abuja declaration target of 15 percent is reached by the year 2006. The allocation of resources has now been built into a “deprivation index,” such that about 50 percent of recurrent expenditures goes to the district level, where most people live. Releases from the Poverty Reduction Fund have been targeted toward the deprived areas.

So that health care is affordable, the health insurance scheme is being vigorously pursued. The bill and legislative instruments (LIs) were presented to Parliament in 2003 for cabinet approval. Parliament has also approved the bill, which is awaiting the President’s assent for it to be passed into law. Currently, several small-scale pilot projects are ongoing within various districts in the country.

### **2.6.2 Other Health Funding Activities**

An exemption policy to address the needs of the most financially vulnerable (paupers) was first designed to cover the services for contagious illnesses, such as TB and leprosy (LI 1313 Hospital Fees Regulations, 1985). The exemptions list has since been revised and expanded. A presidential fiat authorized exemptions for other vulnerable groups that were grossly underutilizing services (pregnant women, children under five years of age, and the aged). The present system has mixed objectives. Some elements promote the use of services that might otherwise be underused and to improve efficiency, while other elements are intended to minimize the cost of health care for the poor (Health Research Unit summary report on exemptions study, Ministry of Health, 2000).

There have been problems with the design and implementation of the exemption scheme. Although exemption guidelines have been distributed widely, provider knowledge about how exemptions should be applied varies and is low. As a result, exemptions are applied variably at the different health levels within and between regions. Services for all other diseases are to be paid for out of pocket, unless the system declares the person a pauper.