TOWARDS ELECTION 2020: 
RESHAPING GHANA’S HEALTH SECTOR DEBATE

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INTRODUCTION

Ghana’s Fourth Republic has been running for the past 26 years with elections being organized on a four-year cycle. In every election year, health has featured quite prominently as a campaign issue and every government the nation has had have made claims of making significant investments in this area. Yet, the benchmark indicators that categorize the collective wellbeing of the nation do not seem to reflect these touted investments. With the December 2020 elections approaching, political parties seeking the mandate to govern must be able to show a clear correlation between the promises they make and the impact these would have on our wellness indicators. It is also important that they indicate how these would be funded with detailed estimates of cost.

Health systems like any other public service have identifiable Key Performance Indicators (KPIs). According to Loeb 2004 and McIntyre et al. 2001, evidence of tracking health performance can be traced back at least 250 years. From its inception, these efforts have been frustrated by professional, practical and political barriers. In Ghana, evidence of centralised tracking of health performance indicates that this was initially done by the Ministry of Health using the Health Service Facts and Figures Document. Subsequently, it was taken over by the Ghana Health Service (GHS) in 2014 with the Health Ministry coming out with a new document called the Holistic Assessment of Health Sector Program of Work.

Though both documents – Health Service Facts and Figures, and Holistic Assessment of Health Sector Program of Work – are now published yearly, they give little indication on how the performance markers fit into the framework of the health-related Sustainable Development Goals (SGDs). Also, there seems to be little or no scrutiny from the public, journalists and civil society to track the year-on-year progress in health service delivery and outcomes. With these lapses, politicians can make health promises without any clear execution plan to either achieve the singular goal of gaining a political advantage or retaining power. This often results in disjointed health planning, abandoned physical infrastructural projects, procurement without technocratic input and huge financial losses to the state. In the end, the voter is short-changed and the quality of healthcare they receive remains abysmal. However, by constructively engaging politicians around the health promises they make to ensure they are achievable, many of these losses can be avoided and ultimately, the quality of life of the Ghanaian will be improved.
HEALTH KEY INDICATORS

Health system performance can be measured using several indicators including the overall population’s health (Average Life Expectancy and Healthy Life Expectancy), equity (Healthcare Access and Quality Index and Health Insurance Coverage) and productivity (Out-patient per capita and health personnel efficiency rating). These indicators can be tracked historically and can also be projected into the future. Politicians seeking public office must be able to explain and correlate their manifesto commitments and pledges to these indicators and demonstrate clearly what traction they are going to achieve, how they are going to self-monitor and how the voter can independently access progress. Civil society could in the case of the two major political parties in Ghana, the New Patriotic Party (NPP) and the National Democratic Congress (NDC), take a historic look at their health spend and ascertain whether the improvements in health achieved over their respective tenure afforded the Ghanaian value for money.

❖ Life Expectancy (LE): This is the average period that a person may expect to live. It can be said to be the single measure of all parameters that go into the health of a society. In Ghana, as a result of gains made in the fight against infant mortality, predicted life expectancy at birth is currently 69 years (women 71.5 years, men 66.5 years). However, the actual life expectancy is 64.5 years (women 67.4 years, men 61.6 years). Meaning, on average we are living 4.5 years below our potential and 7.5 years below the average world life expectancy of 72 years.

❖ Healthy Life Expectancy (HALE): This is the equivalent number of years of good health that citizens can expect to live. The closer this indicator is to actual life expectancy, the better the quality of care the society receives. Ghana’s HALE is 56.4 years, while the global HALE is 63.1 years. This implies that on average, each citizen will spend 8.1 years of their lives in poor health.

❖ Healthcare Access and Quality (HAQ) Index: This provides a summary measure of healthcare access and quality for a given location. The higher your index score the better your trajectory in achieving universal health coverage. Ghana’s HAQ is 39.3, indicating that 61.7% of the country is without adequate healthcare access. Between 1990 and 2000 the average annual increase in HAQ was 1.4%. This had increased to 1.8% annually by 2016. However, if this average is maintained, it will take Ghana over three decades to achieve universal health coverage.

❖ National Health Insurance Coverage: The current NHIS coverage is 35.3% according to both the HOLISTIC ASSESSMENT OF HEALTH SECTOR PROGRAM OF WORK document released in July 2018 and The Ghana Beyond Aid Charter and Strategic Document. The highest coverage ever achieved was 40% in 2015. Thus over 60% of Ghanaians are without adequate health security.

❖ Out-patient per capita (OPC): This is the number of outpatient visits to health facilities during one-year relative to the total population of the same geographical area. It is a good measure of primary healthcare utilization and can be a good indicator of early health intervention strategy. In most countries this averages at four visits per patient per year. Ghana’s OPC is currently 0.98 (on average each citizen attends an outpatient appointment less than once a year). This index has been dropping since 2014 in line with NHIS coverage decline.
ACCOUNTABILITY RELATIONSHIP

Health is a public service, therefore, its performance must be monitored by citizens who can aggregate, comparative performance measures on productivity and cost-effectiveness in a manner that ensures improved access and equity of care. To achieve this, those seeking public office must be able to demonstrate at the outset, a good understanding of these health outcome indicators and show how any inputs they make in this area can positively appreciate specific indicators. More importantly, it should show a correlation to improving the actual life expectancy of Ghanaians, while bridging the 8.1-year gap between LE and HALE. In demonstrating this correlation, there should be an understanding of the limits on the national health spend which is currently 6.9% of GDP. Emphasis should also be placed on how this figure will be brought closer to the Abuja Declaration on health expenditure figure of 15% GDP.

Cognisance should be taken of the low health professional to population ratio and the artificial nurse excess and how these can be improved. There should be awareness around Information Technology (IT) and how tools in this area could help improve the efficiency and reach of health professionals. Emerging threats like the midlife chronic disease creep and their impact on the nation’s quality of health must be understood and potential options must be explored to arrest the situation, together with potential funding streams.

COMPARATIVE ANALYSIS

To inform this discussion and set the stage, we must compare the NPP and NDC over the periods they have managed our health economy based on inputs and the impact these have had on our health outcome indicators. To achieve this, I have looked at the performance of these two political parties over two separate eight-year periods (2001-2008 for NPP and 2009-2016 for NDC). The charts below provide a pictorial view of the data.

1. Inputs

The data indicates that from 2001 to year-end 2008, the NPP government spent $9.3 Billion (an average of $1.16 Billion annually) on health with an average spend per citizen of $38.86 (peak Health expenditure per capita $68 in 2008). The NDC on the other hand from 2009 to year-end 2016 spent a total of $23.43 Billion (average spending of $2.93 Billion annually) on health with an average annual spend per citizen of $84.86 (peak Health expenditure per capita $111 in 2013). Indicating that the NDC spent 2.5 times more on health than the NPP.
However, while the NPP consistently increased and almost quadrupled the annual health spend from $0.55 Billion in 2001 to $2.07 Billion in 2008, the NDC at its peak less than doubled health expenditure from the 2008 figure to $3.86 Billion in 2013, but this dropped back over the next three years to $2.42 Billion in 2016. With regards to health expenditure as a percentage of GDP, the NDC committed more of the national purse (average 5.78%) compared with the NPP (4.74%). None of the parties was close to the Abuja Health Declaration figure of 15%.

1. Outputs

One of the main objectives of health investment by governments is to ensure adequate resourcing. This could be seen in parameters such as improvement in infrastructure and the training and recruitment of health human resources. These are termed output indicators. Health output indicators augment inputs to ensure that outcomes are in line with the aspirations of the health system. It is, therefore, possible to track human resource indices like the number of doctors and nurses to a population of 1000 as a means of estimating where health expenditure is providing the required results.

The diagram below shows how doctor to population (DPR) and nurse to population (NPR) ratios have trended against yearly total health expenditure.

It is clear using DPR and NPR as test indicators for health human resource that the ratios do not change much as our health expenditure increases. Any increased training and recruitment seem not to be matching up with our population growth rate, hence our ratios have flatlined or in some instances declined. The World Health Organization (WHO) indicates a desirable doctor–population ratio as 1:1,000. But since 2004, Ghana’s ratio has never gone above 0.2:1,000. As at 2016, the ratio was similar to that for Ghana in 1970. Similarly, the desirable nurse-population ratio is 4:1,000 but Ghana’s highest ratio was 1.6:1,000 in 2013 and has been dropping since.

A look at the average annual percentage growth rate of doctors and nurses from 2004 helps to explain this. With Ghana’s population increasing by an average of 2.43% annually, the average annual percentage growth rate for doctors was 8.19% and that of nurses 11.91%. Adjusting for population growth therefore, the
true annual growth rate for doctors and nurses were 5.76% and 9.48% respectively. Trajectories that made it difficult for these human resources to population deficits to be bridged.

Another output that significantly leverages outcomes is the number of hospital beds available to the population. Though data from private providers according to government figures are incomplete, in 2017 the total number of hospital beds available across the country was 23,829 (0.79 beds per 1000 population) with government health facilities accounting for 56.92% of the total. The diagram below shows a correlation between HEPC and the percentage annual change in the number of government institutions hospital beds.

It is clear from the above that increases in health expenditure did not increase significantly the number of beds available to Ghanaians. Between 2003 and 2016 the total number of government hospital beds increased from 11,411 to 13,564 (an annual average increase of 1.45%). With an average growth rate of 2.43%, this implies that the contribution of government health institutions to hospital bed per capita declined.

Our health strategy must be clear on how these specific gaps would be bridged to ensure outputs are the fulcrum that ensures inputs manifest as health outcomes that show improvements in the quality of life of Ghanaians.

3. Outcomes and Impact
Health expenditure must be shown to directly improve the quality of healthcare the Ghanaian receives through the conversion of health inputs and outputs into outcomes. Nationally, though since 1960, our life expectancy has increased from 45.8 years to 63.5 years as at 2017. Our life expectancy ranking, among countries in the world has consistently dropped. While Ghana was ranked 117th country where the population lived longer in 1960, by 2018, our ranking had dropped to 157th. Meaning, 40 countries have improved the average longevity of their citizens and overtaken Ghana in the last six decades.

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Maternal mortality ratio is the number of women who die during pregnancy and childbirth, per 100,000 live births. It is a primary indicator of the quality of care pregnant mothers receive during pregnancy, in the period of labour and post labour. Decreased maternal mortality can be closely correlated with the extent of health investment a country makes or Health Expenditure Per Capita.

A comparison of some health outcomes during the governance of the NPP and NDC in the indicated years are shown below

a. Change in Maternal Mortality Ratio:

Maternal mortality ratio is the number of women who die during pregnancy and childbirth, per 100,000 live births. It is a primary indicator of the quality of care pregnant mothers receive during pregnancy, in the period of labour and post labour. Decreased maternal mortality can be closely correlated with the extent of health investment a country makes or Health Expenditure Per Capita. In 2000 Ghana was ranked 140th out of 184 countries. By 2016 the country’s ranking had dropped to 153rd, meaning thirteen countries in the world had made better improvements in decreasing maternal mortality than Ghana had. Between 2003 and 2006 where health investment had a slight impact on decreasing maternal mortality, increased investment had no bearing on improving this health indicator irrespective of the political party in government.
b. Outpatient Per Capita

A major indicator of improvements in access to healthcare is a country’s Outpatient per Capita (OPPC) defined as the average number of times a citizen attends a primary healthcare appointment annually. First reported in Ghana in 2003, available data indicates that irrespective of the extent of health spending, no government has been able to improve this indicator significantly. From an initial index of 0.5 in 2003, it improved gradually till it peaked in 2013 at 1.16 and has been dropping since then, falling to 0.97 in 2017. Though OPPC has a close correlation with HEPC through improvements in healthcare access and efficiency, our last two governments have failed to demonstrate any positive correlation for this indicator.

c. Annual Change in Life Expectancy

Between 2001 and 2016, Ghana’s life expectancy improved by 6.3 years. This figure is slightly higher compared with the global average life expectancy which increased by 5.5 years but lower than 14 lower-middle-income countries that surpassed Ghana in the world ranking.

The indication from the above is that irrespective of who spent more on each citizen or which party increased HEPC significantly, the benefits of these expenditures to improving health outcomes for the citizens is difficult to justify.
CONCLUSION
To put this in context, Ghana consistently had a Health Expenditure per Capita higher than Kenya and Rwanda between 2001 and 2016. Yet, achieved less by way of health outcomes compared with these countries. For example, in 2016, while Ghana with a HEPC of US$68 had an Infant Mortality Ratio of 34.9 deaths per every 1000 live births, Rwanda with a HEPC of US$48.08 recorded 17 deaths per 1000 and Kenya had a ratio of 30.6 deaths per 1000 live births with a HEPC of USD$66.21. Likewise, life expectancy for Ghana is 63.5 years, Kenya 65.91 years and Rwanda 68.34 years. An indication that our health inputs have not delivered value for money irrespective of who has been managing our health system and the reason why debating health on the basis of inputs may be misleading to the voter.

It is imperative therefore, that we explore reasons why expenditure of $32.73 billion over the last 16 years has failed to halt our slide down world rankings of various health indicators as a means of understanding the health accountability dynamics between citizens and political public officeholders.

Since 1993, the public and civil society have failed to seek this accountability from public office holders because there has not been an effort to have easy measurable indicators that politicians can be judged against. Using these observations on respective performance as a starting point, I hope this would change in the next election. The expectation is that with clear deliverables that ensure that money is spent effectively, efficiently and in line with projected outcomes this challenge can be overcome in the 2020 election campaign and beyond.

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