HARMONIZATION CHALLENGES OF RECENT HEALTH REFORMS FOR THE CHRISTIAN HEALTH ASSOCIATION OF GHANA(CHAG)

Peter Kwame Yeboah
Ghana

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Harmonization Challenges Of Recent Health Reforms For The Christian Health Association of Ghana (CHAG).

A thesis submitted in partial fulfillment of the requirement for the degree of

Master of Public Health

by

Peter Kwame Yeboah

Ghana

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ABSTRACT

The global search for appropriate health systems capable of improving population health outcomes has engaged governments all over the world. Accordingly, the Ministry of Health-Ghana (MOH) recently introduced two health reforms viz. Sector Wide Approach (SWAP) and National Health Insurance Scheme (NHIS). The Christian Health Association of Ghana (CHAG) is a major service provider with 40% share of total public health service delivery. Therefore, it operates within the policy environment of the MOH, and has subsequently been affected by both SWAP and NHIS. Anecdotal evidence had suggested that the performance of CHAG health services provision has been affected by these reforms: SWAP and NHIS.

Consequently, this study sought to review CHAG Member Institutions' (CMIs) performance/role, experiences and challenges in the context of these recent reforms, and to suggest appropriate recommendations for the CHAG National Coordinating Body (CNS). With the aid of a conceptual framework based on health systems and management functions, a documentary review, interviews and field experiences of the author were used for this thesis.

Findings from the study suggest that CHAG has not fully harmonized its management systems with the MOH/GHS. As a result, duplication, high transaction cost, inequitable resource allocations, reciprocal tensions and mistrust have ensued. Nevertheless, the reforms offer an opportunity for CMIs to integrate into mainstream MOH/GHS system. Furthermore, a framework (MoU-2003) for CHAG-MOH/GHS relationship, prospects for CMIs pro-poor mission and financial sustainability have been accentuated by these reforms. Consequently, conditions for CHAG's alignment with the MOH/GHS appear ideal, but this is hardly possible. However, owing to fundamental differences in beliefs, norms and values, CHAG and MOH/GHS collaboration, not integration, is more feasible. Accordingly, the study recommends measures including operationalization of the MoU-2003 at CMIs' levels, CHAG institutional reforms, recruitment of experts at CNS, etc., for CHAG-MOH/GHS mutual engagements.

Key words: Ghana, Sector-wide Approach (SWAP), Health Reforms, Health Insurance, Harmonization, Alignment, Non-Governmental Organizations (NGOs), Faith-Based Organizations (FBO).

PREFACE

I have been an upper-level Health Service Manager with CHAG over the past 12 years. My responsibilities include health planning/policy formulation and supervision of four health facilities located in 3 rural districts in Ghana. During my supervisory visits, common difficulties observed were general resource constraints, increasing workload and delays in unpaid bills. Upon further assessment, it was established that these problems have been accentuated by the implementation of recent health reforms: SWAP and NHIS.

SWAP emphasizes an integrated and programme based approach to managing the entire health sector. It further envisages equitable resource allocation through common planning and global budgeting. Therefore, it tends more towards harmonization of health sector management systems and common resource basket for health service providers. Of the total health services delivery in Ghana, CHAG's share amounts to 40%, thus making it the single largest service provider second only to government. Consequently, it had to adapt its institutional/organizational system in conformity with the tenets of SWAP. In addition to complying with the reform, CHAG continue to use its own management systems concurrently. Nonetheless, resource allocations through the MOH controlled basket are inequitably skewed in favour of the Ghana Health Service (GHS).

Healthcare affordability has been a major determinant for appropriate health seeking behavior in Ghana. Hence, the NHIS was introduced as an alternative means of mobilizing resources, and to redress healthcare access inequalities, which were attributable to the direct out of pocket payment. The reform introduced new accreditation, payment and performance monitoring systems for service providers including CHAG. Consequently, service provision and financial administration of CMIs have undergone fundamental changes. A standard infrastructure, minimum benefit package, billing system based on a statutory tariff structure and submissions of claims for re-imbursement have been instituted. Consequently, CMIs are inundated with increasing workload, revenue hold-ups and capacity development concerns due to accreditation and re-certification obligations.

In that perspective, this study is intended to review CHAG's experiences, challenges and concerns with regards to these major reforms: SWAP and NHIS. Findings from the study would hopefully input into CHAG's realignment, and influence MOH-CHAG relationship

ABBREVIATIONS

BMC……Budget and Management Centre

BPEMS**……**Budget and Public Expenditure Management Systems

CAGD……Controller and Accountant General Department

CHAG……..Christian Health Association of Ghana

CHCU……Church Health Coordinating Units

CMI……CHAG Member Institutions

CNS……..CHAG National Secretariat

DPF……Donor Pooled Funds

DHD……..District Health Directorates

GAG……..Government Auditor General

GOG……Government of Ghana subventions

GHS……..Ghana Health Service

IGF……..Internally Generated Funds

MOH……..Ministry of Health

MTEF……..Medium Term Expenditure Framework

NHIS……National Health Insurance Scheme

POW……Programme of Work

SWAP……Sector Wide Approach

SRH&R……..Sexual Reproductive Health & Rights

CHAPTER 1. Background information – Ghana

1.1 Geography and History

Ghana is a sub-Saharan African country that is centrally located in West Africa with a total land area of 238, 537 square kilometers. It has a southern coastline (Gulf of Guinea) and 3 neighbouring francophone countries; comprising Togo on eastern border, with Cote d'Ivoire and Burkina Faso on the west and northern borders respectively. With tropical climatic conditions, Ghana's average annual temperature is about 26 0C (79 0F) with wet and dry seasons.

Historically, Ghana gained independence on 6th March 1957 from British colonial rule, followed by a republican sovereign status on 1st July, 1960. Politically, Ghana is a constitutional multi-party democratic state with a presidential system of government. It is organized into 10 administrative regions, which is further divided into 138 districts for ease of local governance (GDHS, 2003)

1.2 Demographic Profile

As at 2000, the population was 18.9 million with projected growth rate of 2.7 per annum. According to the GDHS (2003), life expectancy at birth amongst males and females is 55 and 60 years respectively, whilst the sex ratio is 97.9 males per 100 females. Of the total population, 41.3% are 0-14 years, whilst 5.3% are above 65 years and the majority 53.4% are between 15 -64 years (GDHS, 2003). The high proportion of children and youth indicates high dependency ratio in Ghana's social structure.

1.3 Socio-Economic Context

1.3.1 Economy

Ghana's economy is largely agro-based, and employs about 50% of the population (GDHS, 2003). Other important areas of economic activity are mining, logging and retail trade. Hence, the leading exports and foreign exchange earners are cocoa, gold and timber, as well as tourism, which is fast gaining prominence. The country's major import is crude oil, rendering

it vulnerable to the destabilizing impact of volatile movements in international commodity pricing. As at 2004, Gross Domestic Product (GDP) growth rate was 5.8 %(IMF, 2005).

1.3.2 Patterns and Trends in Poverty

Ghana is ranked 135th out of 177 on the Human Development Index (HDI) table classified by the UNDP. Selected indicators for human poverty in Ghana comprise the probability of not surviving past age 40, inaccessibility to potable water and children under weight for age, which are 23.8%, 25% and 22% respectively (UNDP, 2007). Poverty in Ghana is inequitably spread between the rural and urban areas. This is shown in the socio-economic differentials in childhood mortality, which shows rural areas in worse conditions. The GDHS (2003) identifies these socio-economic variables/differentials as residence, region, mother's status/education, and wealth quintile. Post-neonatal mortalities are reportedly higher in rural areas than in urban areas. With 56.2% rural-based population, diseases of poverty are, therefore, prevalent in rural Ghana (GSS, 2000).

1.3.3 Education

Even though education is a major determinant of maternal and child health in Ghana, 28.2% of women have never been to school, whilst barely 2.6% has post secondary education (GDHS, 2003). The UNDP(2007) records general adult illiteracy rate in Ghana as 42.1%

1.4 Health Status

Ghana's Infant mortality ratio is 64 deaths per 1000 live births (GDHS, 2003), whilst maternal mortality ratio stands at 540 per 100,000 live births (WHO, 2006). The Ghana Poverty Reduction Strategy (GPRS II, 2005) earmarks Malaria and HIV/AIDS as diseases of developmental and public health importance requiring strategic partnerships. They are also the two main causes of death in Ghana (WHO, 2006). Malaria in Ghana accounts for 44.5% of Outpatient Attendance (OPD), 10% of lost Disability Adjusted Life Years (DALY), and cost 3% of GDP annually in economic burden. At the prevalence rate of 3.4%, the HIV/AIDS pandemic threatens a devastating impact on productivity. Furthermore,

there are marked variations in health status across the different geographical regions and socio-economic groupings in Ghana (GPRS II).

1.5 Health Services

The Ministry of Health (MOH) is the central body responsible for health policy and strategy development. Following the passage of Ghana Health Service (GHS) and Teachings Hospitals (TH) Act 525, the GHS and TH serve as the service delivery arm of the MOH with other agencies. The Christian Health Association of Ghana (CHAG) is the second largest health service provider following the GHS/TH (DFIEC, 1999).

The Ghanaian health system is constrained by accessibility, availability, affordability and acceptability barriers (GPRS II, 2005). Geographical access to healthcare is hindered by distant locations of health facilities, lack of communication facilities as well as poor road and transport system. Service delivery barriers include low capital investment, human resource, organizational and management constraints. There are also broad socio-cultural barriers to healthcare accessibility, notably gender (GPRS II, 2005).

1.6 Health Expenditure

Ghana's Total Expenditure on Health (THE) as a percentage of GDP is 4.5%, whilst general Government Health Expenditure (GHE), as a proportion of Total Government Expenditure (TGE) is 5 % (WHO, 2006). Under the GPRS I, the GHE was to increase to 7.5% in 2005 with a per capita health expenditure equivalent of $10, which is still far below the $30-40 recommended international threshold(WHO, 2002). The country relies heavily on private funding for health financing. In 2003, the private expenditure on health as a percentage of THE was a significant 68.2%, as against government's 31.8% contribution (WHO, 2006). The Private group is, therefore, a major Partner in the Ghanaian health system.

1.7 Health Sector Reforms in Ghana; Policy and Practice

Ghana adopted a Medium Term Health Strategy (MTHS) with a 5-Year (1997-2001) Programme of Work (POW), which had four sector-wide objectives comprising: access, efficiency, quality and intersectoral action. A second 5-Year POW (2002-2006) was launched in 2002, whereupon the MOH sought to review and expand the contractual relationships with the

private sector and Non-governmental Organizations (NGO). In response to this paradigm, a Private Sector Unit within the MOH was set up to co-ordinate and promote rational public-private collaboration. In the 2007 POW review, the MOH acknowledged the significant private sector's contribution, and anticipated progressive partnerships with the private sector and NGOs in ensuing years. Prior to 2004, the 'Cash and Carry System', which required on the spot out-of- pocket payment for health care, had been a financial barrier to prompt care seeking behaviour. Presently, the Ministry of Health (MOH) is implementing the National Health Insurance Act (2004), Act 650, and Legislative Instrument, LI 809, intended to improve accessibility to affordable quality health care (GPRS II, 2005). Also, the 2007-2011 POW is being implemented, with sector wide indicators to track progress in health sector financing, equity and collaboration within the health sector.

CHAPTER 2. Problem Statement, Objectives and Methodology

Introduction

The Christian Health Association of Ghana (CHAG) has existed as a Private-not-for profit non-governmental agency with its pro-poor mission, reliance on expatriate missionary staff, donor support, user fee charges and government subventions for its operations over the years. It has been autonomous with its own internal management systems and flexibility in the manner of health service delivery. Since the late 1990's, however, CHAG has had to readjust its system in response to the changing health policy context within which it operates notably; Sector Wide Approach (SWAP) and National Health Insurance Scheme (NHIS).

2.1 SWAP

Definition and rationale

SWAP is a health system philosophical construct that emphasizes systems thinking including integration of the public and private service providers that operate under the stewardship of the Ministry of Health (Green et al, 2002). In the understanding of Cassels (1997) "*Health SWAps should ultimately be concerned with the sector as a whole, and thus the entire network of public, private and voluntary institutions financed, managed or regulated by the ministry of health*".

SWAP emerged as a strategic response to the impact of many projects and vertical programs, which led to fragmentation and duplication in health systems. It aims to improve health outcomes/status by strengthening health systems (Cassels, 1997). In Ghana, SWAP was expected to increase overall resource inflow to health sector for equitable and efficient allocation to achieve sectoral objectives (Addai & Gaere, 2001). Furthermore, SWAP has a presumed advantage to grant appreciable autonomy and flexibility to facilitate planning and delivery of health services (Addai & Gaere, 2001). Other intended benefits of SWAP are promotion of health sector policy coherence, budgeting and actual results, and reduction in transaction cost of utilizing external donor funding due to systems harmonization (EU, 2004). Furthermore, it creates the framework to assess the combined impact of key stakeholders including the private/NGO sector (EU, 2004)

Appraising SWAP, the European Union (EU)-2004, views it as a remedy against the

" *breakdown of budgetary, organizational and management structures in the public sector of aid dependent countries* ".

In essence, SWAP converges on harmonization and integration of the health system through integrated planning, budgeting, reporting, financial management and procurement of goods and services. Similarly, the Paris declaration (2005) on aid effectiveness affirms harmonization and alignment of aid delivery to countries' priorities, systems and procedures in order to improve development performance.

The EU (2004) and DFIEC (1999) outline the components of SWAP as an existing National strategy, Medium Term Expenditure Framework (MTEF), Agreed Donor Coordination under the leadership of MOH, Common Management Arrangements and Administrative Procedures/Systems, Common Review Process with sector wide indicators and Health Management Information systems (HMIS).

SWAP in Ghana

As a result of uncoordinated vertical programmes, Ghana experienced wide regional inequalities in health investments and outcomes. Thus the health sector SWAP was adopted with a Medium Term Health Strategy in 1996. The distinguishing features of SWAP in Ghana are donor coordination/collaboration and common financial management arrangements (Yankey et al, 2004).

There is a Memorandum of Understanding (MoU) between the Government and Development Partners that provide a framework for budgeting and resource allocation for the MOH. Under the MoU, Donor Pooled Funds (DPF) - are earmarked to fund overall activities outlined in the agreed annual Programme of Work (POW). To ensure joint progress monitoring and evaluation, both MOH and Development Partners organize half-year and annual review meetings using 20 sector-wide indicators. The agreed indicators, according to Addai & Gaere (2001), include:

"*indicators of health service output, surveillance, available health resources (financing, human resources and drugs), management systems(planning, procurement, financial management, equipment management, contracting with other partners and reporting), and quality of care initiatives*".

Ghana has enacted the legal framework for financial governance and management under SWAP. These are the Financial Administration Act, 2003(Act 654), Internal Audit Agency Act, 2003(Act 658) and the Public Procurement Act, 2003(Act 663)

These Acts provide the basis for common assessment, disbursement, auditing and reporting arrangements. Consequently, all government funded health facilities at all levels - tertiary hospitals to rural health post- undergo periodic assessment and reviews against defined financial management negotiable and non-negotiable criteria (see appendix 2). Those who pass the assessment test are certified as Budget and Management Centres (BMCs). These BMCs function under performance contract to plan and manage DPF (DFIEC, 1999). DPF for the uncertified health facilities are given to the next higher certified BMC that manages the funds in trust of its dependant. BMCs are required to submit annual budgets and quarterly cash flow plans as basis for DPF disbursements. Regarding financial reporting, the Accounting, Treasury, Financial Reporting Rules and Instructions (ATF) manual are used to account for both DPF and Internally Generated Funds (IGF). The Government Auditor General (GAG) is mandated to audit the financial operations of all BMCs on Government subventions (GoG), DPF and IGF. In addition, annual procurement and resource utilization audit are conducted to recommend remedial actions.

Consequences for CHAG Members

CHAG Member Institutions (CMIs) depend largely on GoG for staff salaries and some recurrent expenditure. Therefore, CMIs are statutorily required to comply with the provisions of SWAP. In particular, they are supposed to:

- Undergo periodic accreditation and certification assessment as BMCs
- Use the sector-wide indicators as basis of their service provision and performance monitoring/evaluation
- Comply with government financial governance and management regulatory framework. This means CMIs planning and budgeting

should be guided by the MTEF and POW, use the ATF manual for financial reporting, and fully declare and submit their financial operations to the GAG.

In essence, SWAP pre-supposes CMIs realignment within the harmonized MOH/GHS system regarding service provision and management/administrative systems. Therefore, CMIs comply with the accreditation, performance monitoring and some of the financial regulations. However, they still maintain their unique management and administrative systems concurrently. For instance, government accounting rules are used to account for only GoG and DPF, whilst CMIs' Internally Generated Funds (IGF) and other Donor inflows operate under their individual Church accounting systems. Similarly, the GAG is only allowed to audit GoG and DPF, whilst the CMI owners-Church leadership-appoints their own Auditors for the IGF and other donations.

Consequently, the parallel/double management and administrative systems overburden CMIs with extra workload. At the same time, it raises transparency and mistrust issues due to the half compliance with the accounting and auditing instructions contained in Government's financial regulatory framework.

2.2 Introduction to National Health Insurance Scheme (NHIS)

Rationale

Since 1985, Ghana in fulfilling World Bank structural adjustment conditionalities, implemented a cost recovery health delivery system that required out-of-pocket payment for health care at the point of service delivery. Dubbed 'Cash and Carry System', it was considered a key financial barrier to healthcare access especially for the poor. The National Health Insurance Act (2004), Act 650, with its Legislative Instrument, LI 809, therefore, emerged as a response to the prevailing inequities in access to health care (GPRS II, 2005).

Subsequent to the promulgation of the NHIS, new accreditation, performance assessment and payment systems for healthcare providers have been introduced.

Accreditation: The NHIS obliges healthcare providers to apply and pass renewable accreditation appraisals in order to qualify for service provision under the scheme. In addition to fulfilling general conditions, health facilities have other specific requirements to fulfill including having a functional quality assurance programme. The National Health Insurance Regulations (NHIR), 2004, also requires professionals working in applicant health facilities to be legally qualified.

Performance monitoring: The National Health Insurance Council (NHIC) is mandated to institute performance monitoring system of accredited healthcare facilities. The methods for performance monitoring outlined by the NHIR (L.I. 1809), 2004, includes

" *periodic inspections of health facilities and other offices; collection of data from health care services rendered by health care facilities; periodic review of collected data to determine the quality, cost and effectiveness of service and adherence to accepted and known standards of health care practice; peer review; and a mandatory reporting mechanism approved by the Council*".

Provider Payment Mechanism: Under the NHIS, healthcare providers are required to operate under contract with pre-determined tariff structure, file timely claims in adherence to specific guidelines in order to obtain re-imbursement for contracted services rendered. Payments are made within the limits of a defined benefit package and medicines list, beyond which the patients bear the cost.

Portability System: The NHIS accredited service providers are to be integrated into a national database, which gives registered clients the right to access healthcare in all parts of Ghana. Nevertheless, the gate-keeper system would operate alongside the portability system. Patients are supposed to access healthcare from the Health Centres through the District Hospitals up to the Regional and Tertiary levels. Experience, however, shows that clients in the cities usually have access to healthcare at higher facilities without necessarily going through this strict gate-keeper regimen. Therefore, inequities in access to healthcare facilities would still exist between urban and rural dwellers.

Consequences on CHAG Members.

Prior to the advent of the NHIS, CMIs pioneered various provider/community based mutual health financing schemes. The purpose was to increase affordability for its services and, also, to reduce mounting unpaid bills provided to poor clients. CMIs were not under any pressure to conform to any stringent requirements. The NHIS with its Provider-Purchaser dichotomy, however, assigns specific service provision responsibilities for CMIs under contract terms. Therefore, CMIs are affected by the coming into force of the NHIS.

Apart from the BMC certification, CMIs need to undergo an NHIS accreditation process before being declared eligible for service provision for insured clients. Due to acute shortage of professional staff, CMIs have been using auxiliary health staff for professional duties. Furthermore, dilapidated infrastructures, sub-standard quality assurance systems and laxity in performance monitoring had persisted prior to the NHIS. Naturally, therefore, the accreditation obligations and performance monitoring role of the NHIS have raised unease amongst CMIs.

Additionally, CMIs comply with the NHIS provider payment conditions. Service billing procedures, claims processing difficulties and delayed re-imbursements have been associated with the NHIS provider payment mechanism. This has led to frequent freezing of CMIs recurrent expenditures. CMIs are also responsible for screening eligible beneficiaries of NHIS. Hence, fraudulent patients with identification cards sometimes cause loss of income to CMIs. Often these problems have caused shortage of essential medical supplies, drugs, equipment, and the need for extra staff. Hence, service availability, which affects health seeking behaviour is impacted. Consequently, CMIs have been affected by changes in service provision, financial administration and management systems as a result of the NHIS.

2.3 Significance/rationale of study

As BMCs, CMIs operate within the health policy environment of the government. Hence, they are affected by health reforms as well as changing policy developments initiated by the MOH. Anecdotal evidence suggests that the potential access to CHAG health services provision have been affected by

both SWAP and NHIS. CMIs would have to fulfill dual SWAP and NHIS accreditations periodically, and harmonize its service delivery and management systems with governments. Accordingly organizational/institutional reforms, investments and extra work are still on-going.

Despite the harmonization orientation, CMIs have experienced lower government budgetary allocations as compared to their analogous GHS counterparts. Additionally, the NHIS accreditation requirements, performance monitoring role and payment conditions have also affected CMIs. Often CMIs have complained of corrupt and bureaucratic government systems in the course of fulfilling the SWAP conditions (CHAG 2007). Subsequently, the adverse impact of these reforms has often led CMIs to disapprove the CHAG National Secretariat (CNS) as irrelevant and ineffective in addressing their pertinent concerns (CHAG, 2003).

Consequently, CHAG, as a key stakeholder with its share of 40% in total public service delivery, needs to analyze the impact of these reforms/policies. Such analysis would enable CNS to formulate commensurate strategies in dealing with the identified challenges and opportunities. Regrettably, however, health policy analysis does not feature prominently in CHAG's core business. Green et al (2002) echoes this concern by admitting that Church health services have been neglected in policy analysis and research, in spite of the major role they continue to play in health care delivery in sub-Saharan Africa. Similarly, studies on CHAG-MOH collaborative relationship (a founding strategic pillar of CHAG) has not been well explored in academic circles.

This study, therefore, seeks to review how CMIs are affected by the 2 recent major health reforms in Ghana: SWAP and NHIS.

2.4 Objective

General Objective

To review the experiences, role and performance of CHAG Member Institutions in the context of recent Ghanaian health reforms, and discuss the implications of these challenges for the CHAG National Coordinating Secretariat.

Specific Objectives

1. Describe and review current and past role and performance of CHAG Members within the national health system.
2. Discuss the challenges and opportunities for CHAG Member Institutions that derive from the recent major health reforms in Ghana: SWAP & NHIS.
3. Review the role of CHAG National Coordinating Secretariat in addressing the identified challenges.
4. Formulate recommendations for the CHAG National Coordinating Secretariat.

2.5 Methodology

Information was collected on health system functions and management areas, which constitute harmonization outline, and as indicated in the following conceptual framework:

Table 1: Conceptual framework: health systems functions and management areas

	Functions	*Components*
1	Health Planning & Budgeting	MTEF Planning cycles, budgeting systems, yearly action plans aligned to POW priorities, consolidated plans, etc.
2	Financing	Mode of financing, sources, financial access for the poor and exemption policy
3	Provider Payment System	Service contracts, mode of payment and claims administration.
4	Service Delivery	Service package, minimum benefit package, Sexual, Reproductive Health & Rights(SRH&R)
5	Performance monitoring systems	Supervisory authorities, Health Management Information System(HMIS), Frequency and timing of service output data submission, Quality assurance systems, Progress assessment for sectoral objectives

6	Accreditation	Designation as a BMC to receive Donor Pooled Funds, NHIS clearance for service provision, checklist availability.
7	Financial Management systems	Compliance with government financial regulations, statutory reporting, accounting system, auditing requirements, procurement regulations and payment systems
8	Procurement of goods and services	Rules and regulations for purchase of drugs and equipment, local capacity for procurement functions
9	Human resource policies	Recruitment practices, personnel procedures, remuneration system, promotion, staff training and development policies.
10	Accountability relations	Financial, organizational and technical/operational liabilities
11	Coordination	Regulatory/policy framework and structure

Sources of information were:

1. Documentary review of MOH/CHAG.
2. Interviews of 5 CMI Senior Health Managers using telephone and e-mail communications.
3. Experiences gained from 12 years of working life in CHAG.

Purposeful sampling technique was used for selection of key informants. Therefore, respondents represented a cross-section of senior health service managers in the major church affiliated hospitals. These key informants were selected in consideration of their (1) requisite experience 2) representation, and 3) convenience. Experience in this case considers a minimum of 5 years stint as a Head of BMC. Representation meant being a CHAG Member Institution (CMI) belonging to the Catholic, Protestant and Pentecostal blocks. Convenience denotes willingness to share practical information in the study.

Limitations of the Study

Since the study relies mostly on information and evidence adduced from documents and personal communications, there was no opportunity to verify the authenticity of answers through triangulation. A field interview of Church owners, more Senior Health Service Managers, MOH officials, assessment of strategic management documents and situational appraisal would have been most preferred. Furthermore, the lack of literature on the impact of SWAP and NHIS on faith-based health services or the Not-for-Profit Providers limits the broader perspective of the study.

CHAPTER 3. CHAG: Role and Functioning of Member Institutions.

3.1 History

The Christian Health Association of Ghana (CHAG) was founded in 1967 under the auspices of the Ghana Catholic Bishops Conference (GCBC), Christian Council of Ghana (CCG) and the World Council of Churches. CHAG's primary aim was to provide competent total healthcare by fostering partnerships amongst Christian health service providers and promoting collaborative relationship with the MOH. CHAG was registered as a Non-Governmental Organization (NGO) in1968. As an NGO, CHAG has corporate objectives, which are humanitarian oriented and has an autonomous status. However, CHAG maintains formal relations with the MOH that is regulated by an MoU (2003) and Administrative Instructions (2006).

With 40% share of total public health service delivery, CHAG is the single largest health service provider, second only to government. Most CMIs are usually located in neglected rural areas, and serves as the only source of healthcare for most rural dwellers. Furthermore, CMIs have pioneered many health reform initiatives such as user charges, community based health insurance scheme, home-based care, outreach services, etc. Experiences and lessons of such reforms have served as inputs and guides to the MOH in the replication of these reforms. Therefore CHAG has been, and still is, an major stakeholder in the Ghanaian health system.

3.2 Vision/Mission

The collective vision of CHAG members is

"*to improve the health status of people living in Ghana, especially the marginalized and the poorest of the poor, in fulfillment of Christ healing ministry*".

Therefore, the primary beneficiaries of CHAG services are clients with both spiritual and physical needs especially the very poor, marginalized, deprived and vulnerable segments of the population. CHAG believes that health service delivery is a core tenet of the Christian religion from which it draws its inspiration and mission.

3.3 Membership

All health oriented institutions owned by a Christian Church have the right to join the CHAG fraternity. There are 3 types of CHAG Memberships: Founding, Institutional and Associate Members. The Founding Members are GCBC and CCG, whilst the Associate Members are the other Christian denominations with shared CHAG aims and objectives. The Institutional Members are the Hospitals/Clinics and Health Programmes with ties to the Founding and Associate Members. As at 2005, CHAG had 152 Institutional Members comprising 56 Hospitals, 83 Primary Health Care bodies and 8 Health Manpower Training Centers, as detailed below:

Table 2: Membership by Church affiliation

Denomination	**Number of Institutions**
Catholic	78
Presbyterian	21
Evangelical Presbyterian	7
Anglican	8
Methodist	5
Salvation Army	8
Baptist	1
Assemblies of God	3
World Evangelical Crusade	1
Seventh-Day Adventist	10
Church of Pentecost	7
Church of God	1
Church of Christ Mission	1
Siloam Gospel Mission	1
AME Zion Mission	1
Global Evangelical Church of Ghana	1
Total	**152**

Source: CHAG Annual Report, 2006.

3.4 Sources of Funding

Traditional sources of funding have been GoG, user charges, external donations and Church own contributions. Apart from direct donor cash sources, donations have also been in the form of drugs, equipment, volunteers and training sponsorships. CMIs also benefit from tax

exemptions on import duties and tax rebates, due to their NGO status and non-profit motives. Generally, these traditional sources of funding have been typical for health NGOs in most countries (Green & Matthias, 1997; Gilson et al, 1994; Dejong, 1991). The CNS is funded by membership dues, GoG and Donor inflows. Upon coming into being of SWAP, CMIs began to receive a share of the DPF allocations for service, administration and capital investment expenditures. Below is the 2005 and 2006 aggregate budget overview showing major sources of funds for both CMIs and the CNS.

Table 3: PROPOSED BUDGET FOR 2006

INCOME	**BUDGET 2005**	**ACTUAL 2005**	**BUDGET 2006**
Internally Generated Funds(IGF)	459,740,000	445,701,869	599,740,000
Government subventions-GoG (including DPF)	2,533,848,302	2,707,790,276	1,770,998,586
Direct Donations[1]	2,222,968,788	2,309,793,670	2,223,065,000
Grand Total	**5,223,269,090**	**5,463,185,815**	**4,593,803,586**
Personnel Emoluments	773,648,302	818,722,407	835,133,085
Administration	395,200,000	268,725,118	353,960,501
Service Activity	3,855,620,788	3,935,613,232	3,456,220,000
Fixed Assets	198,800,000	16,340,000	
GRAND TOTAL	**5,223,269,090**	**5,036,400,757**	**4,645,313,586**
BUDGET SURPLUS/DEFICITS		426,785,058	

Source: CHAG Annual Report, 2006

[1] Mostly receipts from Church related external donors such as Cordaid, Misereor, MIVA, Caritas International, Manos Unidas; CMIs often do not dispose of a complete picture of all those monetary and non-monetary donations.

Budget explanations

The GoG portion represents 45-60% of total recurrent expenditures, which mostly covers the salaries of about 7,000 CHAG personnel. DPF is included in the GoG, whilst Donors represent direct inflows from CHAG Development Partners for programmes and capital expenditures. In 2005, CHAG received barely 2% of the total DPF against its 40% share of total public health service delivery. Significantly, there was a drop in 2006 GoG budget as compared to 2005. The CHAG Financial Manager explains that CHAG received only one quarter of DPF disbursements in 2005. This was followed with indicative warnings of possible cancellation of further DPF disbursements. Hence, CHAG had to scale down the DPF budget in 2006. Indeed in 2007, DPF allocations for CMIs did not happen at all.

3.5 Service Provision

CHAG is recognized in Ghana as the single largest health care provider second only to the GHS/MOH. Most CHAG hospitals are designated by the MOH as level C district hospitals and serve as referral centres for level A & B Health Centres/Clinics. Conservative estimates apportion 40% share of total public health service delivery for CHAG, with an aggregated total of 6,500 bed capacity and average 60 beds per hospital. CMIs provide comprehensive package of healthcare services composed of curative, preventive, promotive and rehabilitative services. Available records show that CHAG provided 46% of hospital beds and 40% of inpatient care in 2005. The next page gives a tabular presentation of CHAG's 2005 contributions at the district level:

Table 4: Proportion of CHAG's contribution to District Level Health care

Proportion of CHAG's Contribution to District Level Health Care

		GOVT District Hospitals	CHAG District Hospitals	Total	Proportion of CHAG
1	Beds	7,026	5,874	12,900	45.53%
2	Inpatients	357,507	241,478	598,985	40.31%
3	Inpatients Days	1,186,240	1,168,552	2,354,792	49.62%
4	Out Patient Days (2004 figures)	6,904,045	2,092,239	8,996,284	23.25%

Source: CHAG Annual Report, 2006

CMIs also provide other services including family planning, antenatal care, expanded programme of immunization, supervised deliveries, home-based care for HIV/AIDS, TB & Leprosy and buruli ulcer patients, health education etc.

3.6 Comparative Strengths & Weaknesses

Strengths

Rural reach: CMIs are mostly located in rural and unreached areas of the country. Most CMIs have outreach services to villages beyond their increasingly urbanized locations. In most disadvantaged rural areas, CMIs serve as the only source of healthcare. Therefore, CHAG contributes to bridging the health equity gap by increasing accessibility to quality health services in the neglected parts of Ghana.

Distinctive competencies: There are also notable specialized services associated with some CMIs at the periphery. For example, the Catholics are reputed for orthopaedic, surgical, obstetrics and gynecological services, whilst the Presbyterians have a niche for ophthalmic specialties. Some CMIs have also been designated as centres of excellence, and serve as post-graduate training sites for the Ghana College of Surgeons and Physicians.

Quality of care: CMIs in Ghana are generally perceived by clients to be compassionate in the delivery of better quality of care. In addition to the

empathetic attitude to patients, facilities at CMIs are generally in better conditions. In comparison with government facilities, Bennet et al (1997) cites CHAG as performing better on structural quality indicators such as tracer drug and laboratory reagents availability. However, evidence on CHAG's technical quality of care would be needed to validate this long held quality perceptions.

Pro-poor: Due to CHAG's pro-poor mission, targeted beneficiaries of its services are the indigents, marginalized and the deprived segments of the population. Recognizing the growing phenomena of urban poverty, some CMIs are also being located in slum areas of cities in order to serve the vulnerable. All CMIs have poor and sick fund solely dedicated for those who cannot afford healthcare bill. Nonetheless, CHAG has no definite criteria for the identification of the poor. Often, CMIs proportion of unpaid bills has been used as a proxy indicator of their pro-poor commitment. Even so, CMIs successful administration and reliance on user charges cause people to cast aspersions on their pro-poor claims.

Ethical Care: CHAG is reputed for its ethical care, discipline and rational use of health resources. Illegal practices such as euthanasia, abortions (except therapeutic), under the table payments, moonlighting, pilferages etc. are not tolerated in CMIs. This could be explained by CMIs autonomy, absence of bureaucratic systems in management and personnel matters coupled with strong Church leadership control/ownership.

Innovations: CHAG has introduced many innovative health reforms which have been replicated by the MOH. Reforms such as health insurance, user charges, home-based care, primary health care and outreach services were pioneered by CMIs before their adoption by the MOH.

External funding: CMIs have maintained special relationships with external donors for their capital projects and other programmes. The ability to attract donor funds and maintain such relationships has made CMIs trustworthy to many external donors. Paradoxically, this advantage had also been a source of suspicion and mistrust in CHAG's relationship with the MOH/GHS.

The aforementioned strengths of CHAG have also been observed on faith-based organizations in many developing countries (Dejong, 1991; Gilson et al, 1994, Green & Matthias, 1997; Green et al, 2002)

Weaknesses

Nevertheless, there are problems and challenges confronting CMIs regarding resources, human resources**,** documentation, community participation and ideological predilections.

Resources: CHAG depends heavily on GoG and Donor funding for both recurrent and capital expenditure including expatriate staff. This predisposes CMIs to the policy agenda/interest of both governments and Donors that weakens its autonomy. Consequently, long term planning, operational sustainability, or continuity of care may also be derailed due to dwindling donor support, recall of serving highly skilled expatriate workers or end of projects (Dejong, 1991). Government may also reduce budgetary allocations which could also have similar effects.

Documentation: A credible Health Management Information System (HMIS) has eluded CHAG awhile. The collection of data, production of acceptable reports, documentation of best practices and assessment of CMIs contributions/needs have been problematic for CHAG. Decision making amongst CMIs are mostly made on intuition other than credible evidence. Furthermore, the situation affects CMIs accountability obligations due to lack of adequate information. Moreover, the weaknesses in CMIs' HMIS do not make documentation of best practices feasible for replication. As a result of these documentation challenges, coordination and negotiation with government and other stakeholders have also been hampered. Dejong (1991) observes that these weaknesses are a common feature of NGOs. Additionally, CMIs also lack the capacity to conduct baseline studies or evaluations. The CNS has lately recognized these weaknesses, and has subsequently committed itself to improved data collection and management as basis for decision making, advocacy and lobbying (CHAG, 2007). Green et al (2002) extols Health Management Information thus

" *Competent negotiators(with necessary authority to commit their organizations) need to be supported by good information systems, both to provide detailed figures on human resources, patient activity and finance, and also to communicate with constituent members who need to be part to evolving agreements*".

Human Resources: CHAG is bedeviled with shortage of professional staff and general under-staffing problems. The locations of CMIs in rural areas and

lack of enabling environment have made CHAG unattractive to professional cadres. As an improvisation, some nurses concurrently function as laboratory technologists, X-ray and dispensing technicians. In some cases, auxiliary staff perform professional services. These persistent practices, innovative as they might be, render CMIs quality of care questionable.

Community participation and accountability: In spite of its pro-poor commitment and rural locations, community involvements in decision making or projects/programmes design have not always been a feature of CMIs. External Donors usually see CMIs as trustees of donations primarily meant for the community. However, CMIs' management structures and financial reporting systems have always been exclusive to the Church leadership and other external stakeholders. Accordingly, CMIs accountability to the community has been non-existent.

Ideological predilections and attributions: Within CHAG, some denominational blocks refuse to implement some government health policy directives due to their beliefs, dogmas and unique identities. For instance, the Catholics do not endorse artificial family planning methods, whilst some Protestant groups accept the practice. Common drug procurement, personnel policies, management and administrative structures differ amongst CHAG affiliations. Some also run parallel projects and programmes with the CNS in order attest their mission/relevance and claim credits for their individual activities. This heterogeneity and duplication undermines uniformity and waste resources amongst CMIs. Ultimately, it weakens the CNS's cohesiveness and mandate in dealing with the government.

3.7 CHAG National Coordinating Secretariat

The CHAG National Secretariat (CNS) serves as the coordinating body for CMIs. The CNS also serves as the main link between the CMIs and the MOH. In its 2003 annual report, the CNS outlined its functions thus:

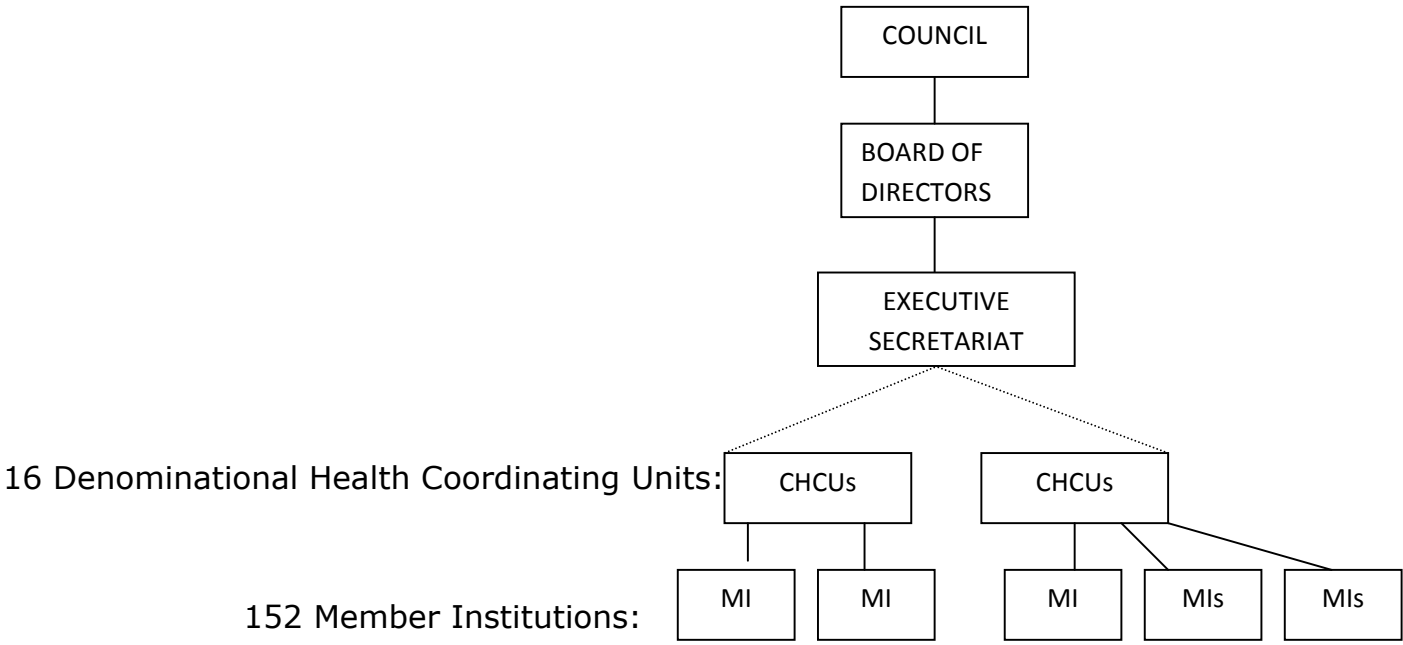
- Promotion of holistic and affordable health care based on good ethical and moral standards, professionally competent and motivated staff.
- Policy Analysis, Advocacy & Lobbying
- Capacity building of Members:- Health Coordinators and CMIs
- Networking & Public Relations(Public Image Building)

- Translating government policies in operational terms for CMIs to implement

In 1980, the Secretariat established a national drugs and medical supply programme, whose activities included quantification of CMIs essential drug needs, coordination of overseas drug donations and drug/logistics policy formulation (Hogerzeil, 1984). Presently, the programme is now defunct, and the denominations have assumed those functions. For instance, the Catholics operate a national and diocesan drug/logistics supply system for their members.

The CNS functions within a complex structure, organization and power relations as illustrated in the organogram in the next page:

Picture 1: Organogram of CHAG



Source: CHAG Report, 2007.

Narration of CHAG organogram.

- The Governing Council is the highest policy and decision-making body comprising representatives of all Founding and Institutional Members. They meet annually for deliberations.

- The 17 member Executive Board is composed of representatives appointed by the GCBC (10), CCG (6) and Associate Members (1), plus 2 non-voting members (MOH and CHAG Executive Secretary). It is responsible for management, policy formulation, monitoring, statutory responsibilities and oversight responsibilities on the CNS.
- The Executive Secretariat (CNS) is headed by the Executive Secretary, 4 Schedule Officers in-charge of Administration, Finance, Projects & Programmes and Information Technology. There are also 12 support staff of various categories.
- Directly below the Executive Secretariat are the Church Health Coordinating Units (CHCU). These 16 CHCUs belong to the Founding and Associate Members, with similar functions, responsibilities and capacities comparable to the Executive Secretariat. In-between the CHCU and the CMIs are Diocesan Health Secretariats and Area Managers in the case of the Catholics and Presbyterians respectively. These are provincial/regional health coordinating offices of each autonomous Diocese that serve as a link between CHCU and the CMI. Hence, within CHAG, coordination of CMIs has 3 parallel levels: Provincial/Regional, CHCU, & CNS. Some of the advantages of having one central coordinating body are cost reduction due to economies of scale, specialization and enhanced impact (Green & Matthias, 1997). In contrast, this 3-tier overlapping coordination mechanism has been duplicative, and often been very divisive.

3.8 CHAG-Government Relationships

Government's regulatory relationship with the private sector is intended to ensure equitable access to quality health and in realizing health sectoral policy objectives (Bennet et al, 1997; Harding & Preker, 2003).

Historically, the MOH had maintained operational relationship with CHAG since the latter's formation in 1967. Government started paying about 80% of CHAG staff salaries in 1975, whilst some government owned facilities (Agency Hospitals) were handed over to CHAG. Following the operationalization of the Ghana Health Service and Teaching Hospitals Act 525, (1996), some MOH/GHS Regional and District Directors signed performance contracts with some CMIs.

In 2003 a Memorandum of Understanding (MoU) with its Administrative Instructions (1996) to formalize CHAG-MOH/GHS relationships within an agreed regulatory framework was signed. The MoU outlines CHAG-MOH cooperation in service provision, financing, human resource management, reporting, information and management/administrative arrangements. Consequent to the MoU, CMIs are supposed to sign contract/performance agreement with GHS District Directorates with respect to service delivery, administration and investment programmes. They are also expected to comply with MOH human resource policies, financial management rules and submit to MOH/GHS reporting guidelines as basis for collaboration. Hence, the MoU provides the framework for intimate CMI and MOH/GHS working relationships at the district levels. Following the MoU, a Partnership Steering Committee comprising CHAG-MOH/GHS representatives has been established to oversee implementation progress.

The CNS only operates at the national level with no analogous regional and district structures like the GHS. However, denominations such as the Catholics and Presbyterians have Diocesan/Area Directorates that are supposed to deal with the GHS on behalf of its constituents. However, they are usually understaffed and ineffective. Consequently, the collective concerns of all CMIs lack coordination at the regional and district levels.

CHAPTER 4. Reforms: Challenges and Opportunities for CHAG Member Institutions.

Introduction

Based on the methodology outlined in Chapter 2, this section discusses the impact of the two health sector reforms (SWAP & NHIS) on CMIs. In the context of harmonization with MOH/GHS, the chapter appraises CMIs application of the reforms, identifies related opportunities and reviews prevailing challenges.

4.1 Planning & Budgeting

For planning and budgeting preparations, CMIs use the MOH Medium Term Expenditure Framework (MTEF) - an integrated three year estimates based on the annual Programme of Work (POW) and clearly defined sector-wide performance indicators. As a corollary tool to the MTEF is the use of Budget and Public Expenditure Management Systems (BPEMS) **-** a **c**omputerized accounting system for budget preparation. CMIs also prepare separate IGF and donor budgets to their respective Church Health Boards for approval. As a result, the MOH do not obtain consolidated or accurate global budgets of CMIs, and consequently of the whole health sector.

Nonetheless, CMIs derive some benefits from the MOH guided budgeting and planning regimen. The application of MTEF, BPEMS formats/software and budgeting cycles enable CMIs to cull their annual action plans by using sectoral objectives and benchmarks contained in the POW. It also ensures performance-based and comprehensive budgeting, which links planned activities to budgets. Subsequently, it facilitates performance review and remedial actions for non-performance based on sector wide indicators.

Yet still, there are concerns amongst CMIs that their role has mainly been implementational. They would have preferred consultation on the preparation/design of these budget and planning guidelines in order to make it more relevant to their local needs. Given CMIs contribution to public health service delivery, one may endorse their concern/demand in this regard as legitimate. Even though the stewardship function of the MOH affirms its leadership role in policy planning, setting of sectoral goals and objectives, CMIs should be able to input into their formulation.

CMIs also complain of unfair distribution of resources by MOH. Despite the comprehensive budgeting, funds for investments, service and non-wage items have never been disbursed for CMIs. A senior manager puts it more succinctly:

"*In principle CHAG facilities qualify for funding from the MOH investment budget (line Item 4), but this is not common practice yet*"

The disbursement records of the DPF to CHAG further elucidates the problem of inequitable resource allocations. In 2006, barely 2% of the total DPF was disbursed to the entire CHAG fraternity. However, GHS facilities are fully funded and comparatively receive higher DPF allocations irrespective of service volume or catchment populations. At the district level, there is a grimmer picture of this start inequity for CMIs. Analysis of the financial reports of St Elizabeth Hospital-Hwidiem shows that the proportion of DPF to total income in 2006 was a negligible 0.17%, whilst nothing (0%) was received in 2007. Below is a table showing a 5-year income trend of the St. Elizabeth Hospital-Hwidiem:

Table 5: INCOME PATTERN, 2003 – 2007

SOURCES OF FUNDS	**2003**	**2004**	**2005**	**2006**	**2007**
	GH ¢	**GH ¢**	**GH ¢**	**GH ¢**	**GH ¢**
Internally Generated Funds (IGF)	267,386.90	368,202.90	525,408.41	610,248.77	907,393.78
Government Grant (Salaries)	142,419.48	180,728.35	272,364.00	295,808.60	395,991.72
Government Grant (Donor Pooled Fund)	6,982.53	12,022.01	7,550.09	1,598.50	-
Other Income	12,783.70	12,042.14	8,260.10	32,512.67	58,509.50
TOTAL INCOME	**429,572.61**	**572,995.40**	**813,582.60**	**940,168.54**	**1,361,895.00**

Table 6: PROPORTION TO TOTAL INCOME

SOURCES OF FUNDS	2003	2004	2005	2006	2006	2007
	(%)	(%)	(%)	(%)	(%)	(%)
Internally Generated Funds (IGF)	62.24	64.26	64.58	64.91	64.91	66.63
Government Grant (Salaries)	33.15	31.54	33.48	31.46	31.46	29.08
Government Grant (Donor Pooled Fund)	1.63	2.10	0.93	0.17	0.17	-
Other Income	2.98	2.10	1.02	3.46	3.46	4.30
TOTAL	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

Source: Financial Reports, 2003-2007, St Elizabeth Hospital-Hwidiem

Whilst some Regional and District Directors integrate CMIs in their global budgets and allocates resources equitably, the reverse is the case in most places. CMIs are treated according to the orientation and preferences of the MOH/GHS Regional and District Directors in resource allocations. On the whole, GHS facilities receive more resources from DPF than CMIs irrespective of their volume of work.

The situation has been partially blamed on non-familiarity of the CHAG-MOH signed MoU and Administrative Instructions at the regional/district levels, which were supposed to redress these problems. There could be other reasons for this persistent phenomenon. Firstly, the dual budgeting system engenders mistrust and suspicions of double dealing by CMIs. Secondly, CMIs receive various local and external donations both in cash and in kind. These donations include expatriate medical specialist, drugs, consumables, equipment and project funds. The failure to fully declare these resources to the MOH/GHS often affirm the perception that CMIs are adequately resourced from undeclared sources. Subsequently, it engenders tension of reciprocal mistrust between MOH/GHS and CMIs. Hence, the MOH/GHS

rationale for giving preferential treatment to government facilities in resource allocations.

4.2 Financing

SWAP and NHIS have changed the financing systems of CMIs. The DPF allocation was incidental to SWAP, whilst the re-imbursement mechanism of the NHIS represents a new mode of financing. So far, the contribution of DPF to CHAG has been insignificant. The NHIS is also beset with delays in re-imbursements and other difficulties associated with the payment system. This raises financial sustainability concerns for CMI given the suspicion that the NHIS may have liquidity problems.

Nevertheless, CMIs see better prospects with the NHIS. At least, it guarantees payment for its registered clients and pre-empt mounting unpaid bills of absconded patients. This optimism is encapsulated in a Manager's declaration thus

"With all the challenges, it still guarantees a substantial amount of money as payment contrary to the previous arrangement under the Cash and Carry where people easily absconded with unpaid medical bills".

With SWAP, exemptions for paupers and pregnant women are budgeted for re-imbursements. However, with the introduction of NHIS, eligible pregnant women are required to register as clients, after having paid the premium. Non-insured pregnant women are denied maternal care services, except when they pay out of pocket. Similarly, it is hardly possible to be declared an indigent given the stringent criteria administered by the Department of Social Welfare for validating a pauper status. Thus the premium and exclusion criteria limit access to healthcare for pregnant women, the potentially poor and needy. Given CHAG's pro-poor mission and familiarity with poverty indicators, an innovative intervention package to redress this problem is an obligation thereof.

4.3 Provider Payment Systems

After experimenting with the Fee-For-Service system (FSS), the NHIS presently uses the Diagnostic Related Groupings (DRG) as payment mechanism for service providers. In the case of CMIs, a customized

additional tariff structure for miscellaneous expenses operates alongside the DRG. This negotiated tariff structure serves to fill the gap in resources resulting from MOH's exclusion of CHAG in investments and service vote allocations. The challenge in this case is the requisite capacity for costing services, accurate and timely use of HMIS for lobbying and negotiation. Whilst CHAG welcomes this preferential treatment, it could justify the perceived inequitable resource allocation practice/formula applied by MOH. Furthermore, the switch from FFS to DRG compels CMIs to provide comprehensive service package for disease episodes in order to merit full re-imbursements. This has considerable implications on CMIs for resource needs including personnel, equipment and drugs.

Generally, the NHIS provider payment mechanisms highlight CHAG's capacity for contract management. Associated challenges of the NHIS payment system identified by CMIs include:

negotiation and signing of service contracts, claim processing difficulties such as billing, documentations, unresolved complaints/conflicts on submitted claims leading to frequent rejections, high administrative cost of preparing claims, delays in reviewing obsolete tariff structures, and general delays in re-imbursements.

4.4 Service Delivery.

Amongst the strategic objectives of the Ghana health sector POW (2007-2011) are healthy lifestyle and environment, and coverage of high quality reproductive and nutrition services. Some of the service indicators comprise % of condom use, access to safe water sources, per capita alcohol consumption, prevalence of tobacco use, obesity. Conversely, the NHIS from which CMIs mostly derive their IGF, focuses primarily on a minimum healthcare benefits that are clinical. Hence, CMIs are increasingly pre-occupied with providing the NHIS basic services, which guarantees tangible financial incentives.

Consequently, CMIs appear to have neglected health promotion initiatives, HIV/AIDS home-based care, outreach services and disease control activities, which they used to be involved. This observation was made from the examination of annual action plans of some CMIs, which shows a substantial bias for clinical care. The reason may be due to inadequate/lack of financial

incentives for public health activities, which are all excluded benefit package. Such attitude could raise doubts about CHAG's commitment to population health.

Again, the beliefs and dogmas of some CHAG denominational blocks have also affected the delivery of certain delicate SRH&R services, which normally would have been part of basic services. For example, the Catholics do not permit artificial contraceptive services such as abortion, condom distribution, birth control pills, etc. Such opposition undermines health sectoral priorities, and deprives patients from services that may be sorely needed. Therefore, CHAG would need a revision of its service provision package in the light of the priorities contained in POW.

Service utilization in most CMIs has dramatically increased due to the NHIS. At the St Anthony's hospital-Dzodze, 75% of visiting patients are covered with health insurance. Following the implementation of the NHIS, the hospital's OPD attendance increased significantly by almost 60% as at 2007. This trend highlights the need for investments in infrastructures to expand service provision. Furthermore, with acute staff shortage, there have been increased staff agitations for more incentive packages due to the increasing workload.

The NHIS is introducing a portability system- a free choice of clients to access services from accredited services countrywide. This would remove geographical barriers and expand access to healthcare for patients. Consequently, CMIs would have to make its services more acceptable to clients since it would no longer enjoy monopoly over its catchment areas, or guarantee patronage of its services. The challenge for CMIs would be how to improve both structural and technical quality of care to the satisfaction of patients. Public relations should also be given the necessary attention in order to improve CMIs image and rapport with patients.

Closely related to preceding issue is the introduction of Community-based Health Planning and Services Initiative (CHPS) by the MOH/GHS. This is part of SWAP strategy to bring integrated healthcare delivery to the doorsteps of village communities in Ghana (Nyonator et al, 2003). The establishment of CHPS compounds in rural communities is narrowing the catchment areas and outreach services of CMIs. Consequently, some CMIs have decried the MOH/GHS for systematically marginalizing them in service delivery. Such attitudes expose CHAG's organizational rigidity and inability

to respond to change. Rather, these developments should prompt CHAG to re-examine its role in the health system in order to diversify into other needy areas.

4.5 Performance Monitoring

As level C facilities, CHAG hospitals are statutorily required to submit monthly reports to the District Directorate of the MOH/GHS on template formats. These reports include Out-patients attendance, In-patients morbidity/statement, Surgical operations, Midwife's report, Mortality, Communicable disease surveillance, HIV/AIDS etc. In some CMIs, the District and Regional Health Directorates of MOH/GHS, conduct quarterly and annual supervisory visits. Such support visits are meant to be avenues for collaboration, and facilitates CMIs quality assurance programmes. At both district and regional levels, CMIs participate in the MOH/GHS half year and annual review meetings. Usually recommendations of such visits are generally non-prescriptive, but sometimes compelling.

However, CMIs complain that GHS performance monitoring visits have not been regular and supportive. Service data submitted to the district/regional GHS often receive no feedback to input into target revision and planning. Rather, data provided are used to claim district resources for which CHAG is discriminated against. Furthermore, recommendations of supervisory visits are not given the commensurate technical and logistical support for implementation. The checklist or standard guidelines for performance monitoring have not been disseminated to CMIs. Concurrently, CMIs submit quarterly and annual reports to the CHCU and CHAG Secretariat respectively. They are also supervised by their Diocesan/Provincial coordinating bodies. This practice is superfluous given the existing GHS/MOH reporting systems. CMIs would have preferred inter-institutional and joint CHAG-GHS performance audits to share best practices. Nevertheless, CMIs agree that should the performance monitoring role of MOH/GHS be well structured and supported, service provision would be enhanced.

4.6 Accreditation

CHAG facilities mandatorily undergo BMC certification appraisal as well as accreditation processes of the NHIS. Most CMIs are now BMCs, having satisfied the entire non-negotiable criterion whilst making amends for the negotiable checklist (appendix 2). All CMIs now possess provisional NHIS accreditation certificates due to having minimum structural and technical quality assurance systems. The utilization reviews, essential drug list, standard treatment guidelines/protocols, medical technology and equipment assessments by the NHIS have institutionalized quality systems amongst CMIs. With certified BMC status and NHIS accreditation, CMIs receive GoG and DPF, and provide contracted services. The inherent challenges are the maintenance and upgrading of the required capacities to ensure re-certification.

4.7 Financial Management

As publicly funded organizations, CMIs are obliged to use the provisions of the Financial Administration Act, 2003 (Act 654) and the Internal Audit Agency Act, 2003 (Act 658) for financial management. The Accounting, Treasury and Financial reporting rules and instruction (ATF) provide the accounting basis for CMIs. The ATF standard accounting forms, books, ledgers and reporting formats are used for financial reporting to the Controller and Accountant General's Department (CAGD). However, The ATF manual is only used to prepare and submit quarterly/annual accounts for GoG and DPF allocations. All the 16 CHAG denominations operate their own accounting systems and software, which even differs within individual denominations.

The NHIS has similarly brought major changes in CHAG's financial administration. CMIs prepare monthly claims to the NHIS for services rendered to insured clients. The processing and vetting of these claims require more administrative work and cause delays in re-imbursements. Subsequently, CMIs complain that the delayed re-imbursements hold up urgently needed revenues to procure essential supplies.

The Government Auditor General (GAG) is statutorily mandated to audit IGF, DPF and other income/expenditure sources of all BMCs. Nonetheless, CMIs only submit the DPF and GoG accounts to the GAG for auditing. Individual Church leaderships appoint separate private Auditors for the IGF and Donor

inflows. It is the belief amongst most Christian circles that accountability is primarily based on conscience and faithfulness to God, which is better disposed from and within the Church hierarchy. Hence, full financial accountability to the state may not be realized on the basis of such delicate religious positions.

Consequently, the use of parallel accounting and auditing systems require CMIs to prepare separate reports, possess 2 accounting competencies and concurrently submit to 2 auditing regimen. Thus CMIs are inundated with extra work, duplication and incoherence in their financial management systems. This lack of harmonization also accentuates government's perceived lack of transparency in CHAG regarding finances. Given these associated problems, therefore, it would rather be in the interest of CMIs to fully act towards a consolidated budget and financial statements in compliance with stated regulations.

4.8 Procurement of Goods and Services

Presently, the Public Procurement Act 2003 (Act 663) regulates purchase of goods and services in all BMCs. There are Procurement Committees in all CMIs that use the standardized procurement procedures in purchasing good and services. Nonetheless, the application of the standard operating procedures for procurement in BMCs occurs only within CMIs management systems. For instance, the Catholics source their medical supplies, drugs and equipment from their own Drug Centres first, and then the open market. Contracts for civil works are awarded by the Church leadership without recourse to the District/Regional Tender Review Boards as specified in the Procurement Act. One may, therefore, argue that CHAG does not fully comply with the specified procedures in the procurement law. Hence, the often held perception that CHAG is not transparent in the conduct of public business seems grounded.

4.9 Human Resources

CMIs use MOH/GHS human resource policies, practices and procedures, and conform to the Labour Act 651, 2003 and Fair Wages and Salaries Commission Act 651, 2003. Accordingly, government salary scales, MOH job/occupation classification code, incentive packages, performance

appraisal and promotion patterns, sponsorship and bonding guidelines, job descriptions, leave and retirement claims, disciplinary and most personnel procedures, all pertain in CMIs. The MOH also second professional staff to work in CMIs. Employment details of newly recruited CMI staff are submitted to the MOH and CAGD, as precondition for being included on government payroll. In some regions and districts, the MOH/GHS includes CMI staff in their in-service training programmes. CHAG is also given a quota of government fellowships for serving officers, albeit very limited. There is also a collective agreement between the Health Services Workers Union of Trade Union Congress and CHAG that regulate personnel matters.

In most CMIs, the proportion of professional staff at post is barely 30%. The use of MOH/GHS human resource policies as standards, therefore, engenders professionalism for quality of healthcare. CMIs also provide salary top-ups, free accommodation and utilities for some senior staff, pays insurance premiums for staff and their dependants, staff loans, career development sponsorships, etc,. Promotions within CMIs are also generally faster as compared to the GHS.

Nonetheless, the use of the supposedly best MOH/GHS practices has culminated into problems. These include complains of delays in accessing the bureaucratic services of the government machinery especially staff mechanization (government payroll access), promotion and retirement claims. CHAG staff also feels a part of GHS, and have identity crises since all the personnel practices in MOH/GHS are also applicable in CHAG. In periods of strike actions initiated by MOH staff, some CHAG staff join in solidarity owing to potential accrued benefits. In the MOH/GHS, appointments, postings and inter unit transfers are effected at the national levels. On the contrary, CMIs staff can not have the opportunity of such transfers. They are obliged to resign their post first, and initiate fresh employment applications in order to join other CMIs. This situation makes CMI staff feel they are in perpetual bondage and stagnate within CHAG. Surprisingly, the CNS has no mandate in the appointment of BMC heads, staff posting/distribution or transfers amongst its members. This would have enabled the Secretariat to ensure that only qualified professionals are appointed to management positions. The transfer and posting role would also rationalize the use of scarce human resources amongst the CMIs.

4.10 Accountability

Green & Matthias (1997) define accountability as

"*an obligation or requirement to give an explanation for all actions, including, but not restricted to, the use of resources*"

Accordingly, this sub-section discusses CMIs accountability from the financial, organizational and technical/operational perspective.

Financial accountability: Looks at CMIs' adherence to government's financial and auditing regulations. Discussions at the financial management sub-heading established that financial accountability as specified by government regulations are not fully adhered to by CMIs.

Organizational accountability: This reviews CMIs at the state, institutional and community levels as discussed below:

State/political: CMIs obligingly register with the government under the Private Hospitals and Maternity Homes Decree, 1969(NLCD 395). Additionally, CMIs comply with the provisions of CHAG-MOH MoU (2003), Labour Act 651, 2003, Fair Wages and Salaries Commission Act 651, 2003 as well as the NHIS and SWAP accreditation requirements. Consequently, these state legislative frameworks compel CMIs to adhere to health and safety rules, conditions of employment, equal opportunities and reporting systems. It also entitles CMIs to the benefits of government budgetary resources including tax concessions. Nevertheless, CMIs failure to provide some delicate SRH & R services and submit to a full state audit, as discussed previously, has often caused frictions and reciprocal mistrust. At the district level, the Local Government Act of 1993(462) entitles the Local Assemblies to consolidate and support district-wide health plans. For the reasons afore-mentioned, most Local Assemblies consequently, withhold financial/investment support to CMIs or build their own health facilities thereof.

Institution: Internally, CMIs are registered as non-profit organizations with essentially pro-poor mission. They submit to an oversight Boards appointed by the Church leadership at the diocesan/provincial levels, followed by the CHCU and the CNS. In practice, however, the Bishops and Congregational Superiors retain/wield all executive powers, whilst the Boards, CHCU and CNS roles are merely advisory. Hence, one could not agree more with Green & Matthias (1997) that most NGO Boards merely serve as facades of probity

to enhance profile and attract funding. With regards to the pro-poor mission, the absence of a commensurate checklist makes CHAG's accountability to their declared mission difficult to validate.

Community: Virtually all the CMIs do not have any formal mechanism of direct accountability to communities within their catchment areas. Very few CMIs have Advisory Committees with representations from the communities. Nonetheless, CMIs embrace the GHS patients' charter and code of ethics in the manner of service delivery. However, since many patients do not even know the existence and significance of the charter/code of ethics, they fail to exact any accountability from CMIs. This may also be due to lack of culture of entitlement and awareness of the right to demand explanation from CMIs who are trustees of government and donor resources.

Technical/operational accountability**:** This form of accountability represents CMIs obligations to government. It is intended to ensure equity, access and pre-empt duplication. In this regard, CMIs adhere to the national health sectoral policies, POW and quality assurance standards, which were previously explored under planning/budgeting, performance monitoring and accreditation sub-headings. Nonetheless, some denominations establish clinics within affluent cities or in close proximity with existing GHS or a CHAG facility without consultation with the MOH/GHS. This has often led to exclusion from government funds, training, technical support and formal relationships. Moreover, with decentralization most Local Assemblies, in collaboration with the GHS, are expanding health facilities, some within close distance to CMIs. Even though this is intended to improve access and health status, it leads to waste, duplication and unhealthy competition between CMIs and GHS.

4.11 Coordination at Operations Level

The Ghana Health Service and Teaching Hospitals Act 525, (1996) mandates the GHS to manage district and regional health services. As a result, CMIs should sign a performance bond with the GHS and function under the direction of the GHS Regional/District Health Directorates (RDHD). However, such required relationships have not yet been operationalized. Even though the MoU of CHAG-MOH/GHS exists, the RDHD are not familiar with its contents and implications. Nonetheless, in some districts the CMIs and DHDs have cross representation at Management Teams. CMIs also

participate in RDHD half-year and annual review meetings. Some RDHD also cede some sub-districts to CMIs for outreach services. With regards to planning, still there are parallel action plans. CMIs submit their plans to their Boards for approval. All the CHAG denominations maintain their coordinating structures as previously discussed under CHAG-MOH/GHS relationships, planning/budgeting, performance monitoring and service delivery sessions.

The RDHD, therefore, do not have consolidated district and regional health plans. Consequently, this situation is often cited as a cause of non-inclusion in regional/district budgetary allocations to CMIs.

Comment

From the foregoing discussions, it is evident that CMIs harmonization and alignment with the MOH/GHS remain elusive. Consequently, the benefits of national ownership and domestic accountability, reduced transaction costs, better policy, planning, resource allocation and implementation for better results have not been fully realized as anticipated for SWAP in most sub-african countries (Walford (2007). This is further corroborated by Chansa et al (2008) finding that SWAP has not been able to realize the anticipated administrative, technical and allocative efficiencies in Zambia, after 15 years of implementation.

CHAPTER 5. Implications for CHAG Executive Secretariat as a National Coordinating Body.

Introduction

This section reviews the role of CNS in addressing the challenges and opportunities confronting CMIs in the light of SWAP and NHIS. The session follows the components of the conceptual framework outlined in Chapter 2, and thoroughly discussed in Chapter 4.

5.1 Planning & Budgeting

Common challenges confronting CMIs comprise:

- Lack of MOH consultation with CMIs in the design of planning and budgeting guidelines, which fails to consider local context.
- Inequitable budgetary allocations after extensive budget preparations
- Absence of a formalized/operational CHAG-MOH/GHS relationship at the district and regional levels, which leads to marginalization of CMIs in global resource planning and allocation.
- Transparency concerns due to CMIs failure to fully integrate its planning and budgeting systems into MOH/GHS consolidated budgets.

Presently, the CNS disseminates the MOH planning and budgeting directives to CMIs, and collates their BPEM budgets into a composite document for onward submission to MOH. The advocacy functions of the CNS mainly target the MOH/GHS headquarters for increased resource allocations for CMIs. Regrettably, the CNS fails to recognize the leverage/power of the MOH/GHS District and Regional Directorates in the implementation of headquarters decisions at the local operational levels. Thus, the MoU is either unknown or inactive at the district and regional levels. There are also no analogous CNS district and regional structures to engage the GHS/MOH on behalf of CMIs. Therefore, the CNS needs to structure its advocacy engagements with the MOH/GHS along the challenges discussed beforehand. Furthermore, the operationalization of the MOU at the regional and district levels should be expedited as a matter of urgency. Moreover, the essence of transparency and full disclosure of CMIs' sources of funds should be stressed as basis for requesting further resources from MOH/GHS.

5.2 Financing

In addition to the operational challenges identified under the planning/budgeting sub-heading, the other issue is:

- The exemption policy's exclusion of the poor and needy due to the stringent criteria and stigma for identification of indigents.

At the moment, the CNS does not have any checklist to guide CMIs in dealing with the poor constituency, who form the core of CHAG's collective mission.

5.3 Provider Payment System

Of utmost concern for CMIs are**:**

- The re-imbursement delays, billing procedures, claims processing and performance contract management, which have emerged as the major difficulties associated with the NHIS payment system.

The CNS has been responsible for costing and special tariff structure negotiations on behalf of CMIs. The other operational challenges are handled by CMIs who do not have the requisite expertise in engaging the NHIS individually. The GHS have an Insurance Directorate (GID) for such purposes. Given the importance of NHIS to CMIs financial sustainability and service delivery, the CNS could replicate such an arrangement. Negotiations with the GID to assist CMIs would have been preferred on the platform of harmonization. However, experience shows that GHS institutions are primarily focused on their institutional interest. Besides, CMIs have a unique set of NHIS problems that necessitated the granting of special tariff structure. Hence, CMIs need an effective coordinating body to deal with related problems of the NHIS.

5.4 Service Delivery

The issues discussed included the following:

- The clinical focus of the NHIS has led to the neglect of public health activities and initiatives amongst CMIs. Denominational beliefs and dogmas of some CMIs have also stalled comprehensive reproductive health services. Consequently, the MOH strategic objectives for health service delivery have been largely ignored amongst CMIs.

- The NHIS portability policy signals the need for CMIs to be innovative in service delivery. The wide choice and access offered to patients could potentially cause downsizing of CMIs catchment area and service volumes in clinical care. The settings up of the CHPS compounds also have similar effects. As a result, CHAG needs to conduct health needs assessment in order to devise essential interventions, and accentuate its distinctive competencies.
- The stringent conditions attached to the implementation of exemption policies for indigents challenges CHAG's pro-poor mission. CHAG needs to devise innovative means of covering the poor in service delivery.

The CNS role in service delivery matters have mainly been dissemination of Heath Sector POW to CMIs. In spite of its leverage and experience, the CNS has not been able to formulate or influence the health policy direction of the MOH. Again, the lack of expertise in health policy and strategic focus are to blame for this inertia at the national and international levels.

5.5 Performance Monitoring

The challenges discussed include**:**

- CMIs relate more with GHS/MOH at the district and regional operational levels. However, the dual reporting obligations to GHS/MOH and CNS/CHCU are duplicative. In the same vein, the performance monitoring mandates of the trio: NHIS, GHS/MOH and CNS/CHCU, renders CMIs susceptible to varied standards.
- The GHS supervisory role over CMIs has not been supportive and regularized. There is lack of feedback and assistance for CMIs to implement recommendations. Quality assurance systems and performance audits have not been institutionalized at CMIs.
- The non-involvement of CHAG in the design of performance monitoring indicators highlights the CNS's inertia in health policy formulation/planning. The limited capacity for policy analysis, advocacy/ lobbying and negotiations have been cited for this deficiency(CHAG, 2007)

The CNS's only supportive monitoring and evaluation tool has been Peer and Participatory Rapid Appraisal for Action (PPHRAA), which is undertaken barely once a year in selected CMIs. Thus, CMIs lack effective supervision from either the GHS/MOH or CHAG systems.

5.6 Accreditation

The NHIS/SWAP requirements for periodic re-certification of CMIs necessitate an on-going service and management capacity building programmes. Presently, the CNS disseminates information received from the NHIS/MOH to CMIs for implementation. The CNS has no programme or system dedicated for facilitating or following up on these accreditation obligations of CMIs. This could adversely affect CMIs eligibility for fulfilling their accreditation requirements with.

5.7 Financial Management

The cross-cutting issues of transparency and duplication amongst the CHAG fraternity is evident in the challenges outlined below:

- CMIs parallel use of government and denominational accounting systems highlight their accountability deficits as publicly funded institutions.
- Similarly, CMIs inability to submit fully to the GAG for a comprehensive auditing of its financial transactions has engendered mistrust.

A review of the organogram and decision making dynamics of CHAG indicates that the CNS has no mandate in enforcing CMIs full compliance with government accounting/auditing regulations. At best, it can raise the issue with recommendations for consideration by the denominational leadership. This observation underscores the fragmentations within CHAG, which undercuts CNS leverage and mandate in negotiations with the MOH/GHS.

5.8 Procurement of Goods and Services

CMIs application of the Procurement law has not been fully compliant. Once again, this practice affirms perceptions of mistrust in transactions. In reviewing the CNS 2008 strategic plans, no action plans have been made for the dissemination of the Procurement Act to CMIs. This gap is suggestive of CNS disorientation with operational matters at the CMIs levels.

5.9 Human Resources

Common concerns discussed were**:**

- The inability to rationalize human resource use by transfers, postings, appointments amongst CMIs. This underscores the problem of fragmentations and duplication within the CHAG fraternity.
- The use of CAGD and MOH centralized/bureaucratic procedures for CMIs' personnel matters, especially salary issues, has led to frustrations. CMIs have to travel from their rural locations to follow up on administrative matters often without success. However, GHS facilities do not have to experience such problems to such magnitude due to the responsiveness of their headquarters. This has led CMIs to view the CNS as unhelpful to their problems.

Presently, the CNS does not perform any significant role in redressing these challenges. For most CMIs, the CNS should assume the responsibility for such administrative matters given their leverage at the national capital, where the CAGD and other relevant government departments are located.

5.10 Accountability

In addition to the challenges identified under financial management, performance monitoring and service delivery sub-headings, the following issues also arise:

- Absence of formal systems for CMIs accountability to the community.
- Lack of executive powers for CMIs Boards.
- The non-existence of checklist to validate pro-poor mission.
- Relationships with the RDHD and Local Assemblies.

At the moment, the CNS do not exercise any function with regards to these accountability challenges. Given their impact on CMIs identity, credibility, values and organizational effectiveness, then CNS could raise the issue with the Church leadership, and advocate appropriate reforms.

5.11 Coordination

The discussions under all the previous sub-headings also apply in this session. The key issue that requires a review is the parallel and multiple,

but ineffective, coordinating structures for CMIs. Consequently, the lack of harmonization with the MOH/GHS structures has been duplicative. The CNS recognizes this situation in its 2007 review. Nevertheless, the authority and power to effect reforms ultimately rest with the Church Leadership whose ideological orientations make it hardly possible to harmonize with government systems.

Therefore, the CNS would have to raise the issue for discussions and continuous advocacy for CHAG internal reforms. In that case, CMIs coordination could be effective.

CHAPTER 6. Conclusion & Recommendations

Context

In a globalized world, everyone is affected by the impact of socio-economic developments. The growing budgetary constraints of the developed world, chronic under-development of donor dependent countries, demographic and epidemiological transitions, have all motivated health reforms. Reforms such as SWAP and NHIS in Ghana were intended to streamline the health system and mobilize resources for improved health outcomes. These reforms have had a mixture of intended and unintended consequences on different stakeholders including CMIs. Hence, the study sought to explore CMIs experiences, role and performance with SWAP and NHIS in order to formulate appropriate recommendations for the CNS to act.

6.1 Impact of Reforms: SWAP & NHIS

As the second largest service provider, CHAG was supposed to effectively harmonize and align its system with that of the MOH/GHS. Consequently, challenges and opportunities have emerged out of these reforms for CMIs. The inherent opportunities include:

- ✓ The use of common planning and budgeting systems, financing, accreditation, procurement guidelines, human resource practices and financial management directives could potentially integrate CMIs into the MOH mainstream provider agencies. Hence, CMIs could benefit equitably from the MOH resource pool just like the GHS.
- ✓ The MoU (2003) and Administrative Instructions (2006) act as a framework that regulates CHAG's relationship with the MOH/GHS. It also acts as a unifying platform for CHAG's fragmented and multifaceted systems by institutionalizing a common statutory management system for CMIs.
- ✓ The NHIS provides a rare opportunity to affirm CHAG's pro-poor mission, build financial sustainability and be concerned with acceptable/standard quality of care. Consistent with their compassionate values, CMIs could register and pay the NHIS premium for the poor constituencies and to entitle them to free healthcare. The NHIS guaranteed payments of authorized service delivery, decreases

in unpaid bills and absconded patients, have all contributed to improved revenue base of CMIs. Hence, CMIs financial sustainability appears promising. Similarly, the need to satisfy NHIS accreditation requirements has institutionalized both structural and technical quality assurance systems amongst CMIs.

Nonetheless, CMIs failure to fully harmonize with the MOH/GHS has led to significant challenges including the following:

- ✓ Inequities still exist against CMIs in MOH/GHS resource allocations. CMIs are seriously marginalized in spite of their 40% share of the total public health services delivery and distinctive competencies. This situation has partly been blamed on CMIs undisclosed receipts of cash and in-kind donations from external sources. Thus justifying MOH/GHS presumed unfair resource allocation formula, which acts to the disfavour of most CMIs.
- ✓ There is also the burden of multiple reporting, supervisory and coordinating authorities for CMIs. Consequently, structured performance monitoring, evaluation and management support for CMIs are either inadequate or non-existent. The existence of the three-tier supervisory and coordinating bodies (MOH/GHS, CHCU and CNS) is duplicative and exact higher transaction cost for CMIs.
- ✓ There are practical problems confronting CMIs in their role as NHIS service providers with contractual obligations. Regrettably, no supportive body exists to provide technical support and direction for CMIs to deal with the difficulties associated with their obligations under the NHIS. Whilst GHS facilities have an Insurance Directorate (GID) precisely for such problems, CMIs do not directly seek GID's support due to their status as non-GHS facilities.
- ✓ CMIs relate more with the MOH/GHS at the district and regional level other than the CNS. Therefore, they are more affected by the ineffective implementation of the MoU (2003)/Administrative Instructions (2006) at the regional and district levels. Consequently, the CNS, which is more focused on MOH/GHS headquarters matters, is fast losing relevance for CMIs.
- ✓ The NHIS portability policy and the CHPS strategy of the MOH/GHS highlight the need for CHAG to embark upon organizational review. Both these measures have increased geographical access for patients, which have subsequently narrowed CMIs catchment areas and limited

patronage of their services. Hence, CHAG needs to be innovative and branch into other service delivery needs that remain largely unsatisfied.

- ✓ The CNS has been overly focused on resource mobilization from government other than evolving public health and pro-poor initiatives, a niche which has branded CHAG since its formation in 1967. This situation could undermine CHAG's leverage and standing as a Christian NGO dedicated to holistic health service delivery.

Observation

Judging from the afore-mentioned review, harmonization, as originally intended by SWAP and NHIS, has not been fully realized. This has caused reciprocal tensions, suspicions and mistrust between MOH/GHS and CHAG. Furthermore, there are functional overlaps amongst the NHIS, GHS/MOH, and CHAG/CHCU. Consequently, the multiple coordination functions have been duplicative, superfluous and ineffective. Nevertheless, despite the obvious benefits of harmonization, experiences and historical antecedents suggest that the ideal integration between Church and State institutions is hardly possible. CMIs have a unique identity, values/ethics, mission and common challenges, which differ from the MOH/GHS. Furthermore, given the experience of ineptitude, corruption and bottlenecks of the government machinery, CMIs deserve a functional coordinating system. Consequently, the effective functioning of CNS is still indispensable to the cause of CMIs.

6.2 Recommendations

In consideration of the afore-mentioned challenges, the following suggestions are offered:

Operationalization of the CHAG-MOH Agreement

In the light of the needs, concerns and challenges of CMIs, there is the urgent need to update, disseminate and operationalize the MoU (2003) and its accompanying Administrative Instructions (2006) at the regional and district levels. This would institutionalize effective CHAG-MOH/GHS relationship at the operational levels. In that case, both GHS and CMIs

would be aware of their responsibilities and rights as collaborators of the health system.

Operational Desk

At the CNS, there should be a Desk Office assigned for CMIs' administrative/operational matters. Cumbersome personnel matters such as staff recruitment, mechanization and submission of salary inputs, processing of retirement and pension claims at the CAGD should be handled. This intervention would relieve CMIs of the time and cost of following these issues at the national capital, often without success. Furthermore, CMIs would feel the tangible benefits of funding the CNS whose relevance has been questioned.

Institutional Care and Support Unit

CMIs performance review and facilitative supervision is a neglected, but important, function. The CNS should set up a supportive monitoring and evaluation team in conjunction with the MOH/GHS. Such a team could develop strategic plans with checklist and scheduled quarterly visits, half-year and annual performance reviews for CMIs. Problems and best practices identified during such sessions could be redressed, whilst best practices are disseminated to CMIs. Additionally, the needs and concerns documented during the M&E visits could serve as inputs for advocacy and policy formulation functions.

Provincial/Zonal Structures

Regional CHAG structures analogous to the GHS Regional Health Directorates are necessary in the light of intense functional relationship between CMIs and GHS/MOH. Nonetheless, due to overhead costs and feasibility considerations, 3 provincial CHAG structures could be set up for the southern, middle and northern sections of Ghana. These CHAG Provincial/Zonal offices could coordinate the concerns of CMIs and effectively engage the 10 regional GHS/MOH Directorates. By this institutional reform, the practical needs of CMIs would elicit the necessary action.

Institutional Reforms

Given the ineffective and duplicative coordinating roles of the CNS, CHCU and MOH/GHS, a review of CHAG is due. The CNS role, mandate and relationship with all stakeholders should be defined in the light of the operational needs, challenges and concerns of CMIs. This would clarify functional relationships, justify expectations, define responsibilities and enhance accountability of the CNS towards CMIs. The issue of transparency and reciprocal mistrust/suspicion and its impact on MOH/GHS-CHAG relationship should be raised for discussion with Church leadership. Furthermore, CNS should be mandated to institute feasible inter CMIs' staff transfers and postings. This would assist immensely in rationalizing the use of scarce human resources for the CHAG fraternity. It is hoped that the discussions of this thesis could serve as a platform for wide-ranging reforms at CHAG.

Health Insurance Directorate

The opportunities and challenges associated with the NHIS oblige CHAG to respond with sense of urgency. Therefore, the setting up of a Health Insurance Directorate (HID) is long overdue after three years of experience with the NHIS. The purpose of the HID should be to assist CMIs in renewal of accreditations, contract management, documentation, claims administration, networking, and application of tariff structure. Given the allotment of separate tariff structure for CHAG, the HID should undertake service costing and analyze service output data for feasible negotiations with the NHIS. On the other hand, a CNS liaison office for NHIS matters could still be set up to collaborate with the GID on issues affecting CMIs.

Pro-poor mission

There is the need for clear indicators for CMIs that can underscore their stated aim of reaching out to the poor. This would also enable stakeholders to validate CHAG's pro-poor mission and ensure CMIs accountability to its declared values. CMIs should use their local experiences to identify the poor, needy, deprived and the marginalized, and pay their NHIS premiums.

This would entitle the poor constituency to the NHIS minimum benefit package.

Capacity Build up

Given the gap between the needs of CMIs and the skills levels of the CNS, it is imperative that the CNS revamp its human resource base. Areas of urgent need for experts are: *Public Health, Health Policy/Planning, Health Management Information, Health Economist, Human Resource Development, Financial Systems and Development*, *and Advocacy, Lobbying and Negotiations.* These technical skills should help CMIs to retool itself and critically examine its current and future role in the light of health reforms in Ghana.

Closing

With an enabling environment it is hoped that the above measured recommendations would contribute significantly in ensuring:

- ✓ CMIs financial sustainability in an era of the NHIS challenges and inequities of SWAP
- ✓ Fulfillment of CMIs holistic services mission by active engagement in preventive and promotive health care.
- ✓ Fruitful CHAG-MOH/GHS relationships at all levels and;
- ✓ Ultimately strengthen the management systems of CMIs for quality health service provision.

6.3 Further Research

An independent evaluation of CHAG would help to find answers to the following puzzle confronting CHAG

CHAG's pro-poor mission: myth or reality?

- ✓ amount of unpaid bills
- ✓ proportion of uncompensated care to total revenue
- ✓ beneficiaries of charity of care

Latent competition between CHAG and GHS

- ✓ resource allocation
- ✓ CHAG staff drift to GHS

Perceived quality of care and best practices: CHAG's perspective

- ✓ Proportion of professional staff to auxiliary staff
- ✓ Technical and structural quality compliance
- ✓ Cost effectiveness
- ✓ Career development and professional development

CHAG management systems and its impact

- ✓ Management structure
- ✓ Power & authority relationship
- ✓ Responsiveness, effectiveness and efficiency

APPENDIX

1. Map of Ghana

2. BMC accreditation criteria

Non-Negotiable criteria

1. Budget and plans covering all sources of funding, including government budgetary allocation and internally-generated funds at the management location have been prepared and approved
2. Revenue collection procedures are complied with including complete and prompt banking of cash
3. Appropriate books of accounts are maintained accurately, are up to date and in the specified format
4. Accurate and prompt reconciliation of all bank accounts
5. Proper filing of all source documents, vouchers, receipts, etc
6. Latest monthly financial statements are accurate and have been submitted in a timely manner to interested parties
7. Commitment of management to have a good control environment in place
8. Proper and adequate Medical/Service records are maintained

Negotiable criteria

1. Remedial action taken for any prior serious adverse findings by internal and external auditors
2. Evidence of reconciliation procedures to ensure that financial reports reconcile with books of accounts and underlining records
3. The existence of sufficient accounting personnel of the required grade/experience.

3. Profile of CMI Managers Interviewed

Name	Qualification	Rank	Position	Experience
Mr Bernard Clement Kwesi Botwe	MA-Hospital Management, University of Leeds, UK	Deputy Chief Health Service Administrator	Head of BMC, Wenchi Methodist Hospital	20 years
Mr Akoto Brown	MA- Health Policy & Planning, University of Leeds, UK	Deputy Chief Health Service Administrator	Director of Health Services, Catholic Diocese of Keta Akatsi	20 years
Mr Alex Mensah	MPH-Health Economics, University of Cape Town, South Africa	Deputy Chief Health Service Administrator	General Manager, Alpha Medical Centre-Pentecost	10 years
Mr Dominic Effah Yeboah	MPA, University of Ghana	Deputy Chief Health Service Administrator	General Manager, Dormaa Presbyterian Health Services	10 years
Mr Christian Sappor	MBA-Health Services Management, University of Ghana	Deputy Chief Health Service Administrator	Chief Administrator, St Patrick's Hospital, Offinso	10 years

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