

Aligning exemption policy and practice with poverty reduction goals

A report of the Annual Health Sector Review 2002

Accra, May 2003

Preface and acknowledgments

This report was drafted by Di McIntyre, Health Economics Unit, University of Cape Town. She was a member of the External Review Team for the Ministry of Health 2002 Programme of Work and this report is one of four that were produced as a result of the review.

The team wishes to thank the many government and aid agency staff, in Accra and in the Regions, who gave of their time and knowledge. The team wishes to record special thanks to Ms Janet Kwansah, Ministry of Health for backup support and to the staff of the Danida HSSO, Accra who provided a resource base and support for the team's work.

The review team bears collective responsibility for the findings presented in this report. The views expressed are not necessarily those of the health partners, nor of the Ministry of Health.

Acronyms

ANC	:	Ante-natal care
CHPS	:	Community-based Health Planning and Services
DA	:	District Assembly
DPF	:	Donor Pooled Fund
GPRS	:	Ghana Poverty Reduction Strategy
GoG	:	Government of Ghana
GHS	:	Ghana Health Service
IGF	:	Internally generated funds (user fees/cash and carry)
IMR	:	Infant Mortality Rate
MDA	:	Ministries, Departments and Agencies
MHO	:	Mutual Health Organisations
MMR	:	Maternal Mortality Rate
MoH	:	Ministry of Health
PoW	:	Program of Work
U5MR	:	Under 5 Mortality Rate

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SUMMARY

User fees were re-introduced at public health facilities in Ghana in 1969. Over the years, various services and categories of people have been deemed eligible for fee exemptions. The majority of exemptions relate to particular services (e.g. immunisations, malaria treatment and ante-natal care), sometimes restricted to particular groups (e.g. children under five and the elderly). The only individuals that are eligible for exemption from fees for all services are the poor.

The Ghanaian fee exemption system has some innovative aspects to it, particularly the commitment to reimburse health facilities for fee revenue 'lost', which provides a powerful incentive for appropriate implementation of the fee system. However, the exemption system is not functioning effectively at present, with a growing number of facilities no longer providing fee exemptions, other than in exceptional circumstances. The main reason for this break-down in the exemption system is that reimbursements have not reached most facilities for more than 8 months and facilities are heavily reliant on IGF revenue for continued service provision.

The other aspect of current fee exemption implementation that is of considerable concern is that the major beneficiaries are children under 5, pregnant women and the elderly with almost no exemptions being granted to the poor. With almost 40% of the Ghanaian population being defined as poor and 27% as extremely poor (i.e. cannot even meet their basic nutritional requirements), the current lack of targeting of the poor is unacceptable. While this is partly attributable to difficulties in identifying the poor, it is also due to the attempt to do too much with too few resources. In particular, it is not feasible to exempt all people in particular groups (e.g. under-fives and the elderly) from certain services and to exempt all services for the poor within the constraints of resources currently available for funding exemption reimbursements.

Based on the analysis presented in this paper, the following key recommendations are made:

- The primary beneficiaries of fee exemptions, and subsidies for insurance contributions as health insurance coverage expands, should be the poor. Other potential exemptions (e.g. limited and strictly prioritised exemptions for key public health services or for truly catastrophic health care costs) should only be identified once it has been determined what resources are required to effectively exempt (or subsidise insurance contributions for) the poor.
- In contrast to the current system of waiting for the poor to present at health facilities and apply for exemption status, there should be a process of pre-identification. This should be done by local committees with significant community representation, and can equally be used to identify beneficiaries of fee exemptions and subsidised insurance contributions. Poor household members can be issued with a card confirming their exemption status. This status should be re-evaluated every few years. Constraints can be imposed on the number of households identified for fee exemption or insurance subsidies through the budget allocated to individual districts and communities for this purpose.

- Adequate resources should be made available to fully cover the costs of fee exemptions and insurance contribution subsidies. This requires detailed costing based on the number of potential beneficiaries, average utilisation rates and fee levels in the case of fee exemptions and potential beneficiaries and average contribution rates in the case of insurance subsidies. This may require that an increasing share of non-salary GoG and DPF resources be directed to this activity.
- These resources must be equitably allocated. The primary indicator to determine allocations between regions, and to individual districts and communities within regions, should be the number of poor (or extremely poor) individuals in each area.
- Appropriate and effective mechanisms for distributing these resources must be identified. In the short-term, it is critical that the existing fee exemption reimbursement channel (from GHS headquarters to regional offices and then to individual facilities) is improved as a matter of urgency. However, this channel may not be appropriate for insurance contribution subsidies. Thus, in the medium-term, it may be feasible to consider routing resources both for fee exemption reimbursements and insurance subsidies via District Assemblies, *if* financial management capacity at this level is dramatically improved. In the long-term, it is intended that the entire population be covered by some form of health insurance and it may be more appropriate to direct these resources through a channel more closely linked with the health insurance system.
- Finally, clear information on the new exemption system, and on insurance contribution subsidies, should be widely disseminated to health service providers and to communities to strengthen effective implementation.

Aligning exemption policy and practice with poverty reduction goals

1. Introduction

User fees at public health facilities in Ghana were abolished at independence in 1957, but reintroduced in 1969. The main legislation governing fees and exemptions are the Hospital Fees Act (No. 387) of 1971 and the Hospital Fees Regulation (L.I. 1313) of 1985. L.I. 1313 specified fee levels for consultations, various diagnostic procedures, specific medical, dental and surgical services, inpatient accommodation and that cost recovery fees should be charged for drugs. The latter proposal led to the use of the term ‘cash and carry’ for fees in Ghana. Importantly, these changes added exemptions for classes of people to exemptions for certain services. In doing so, it made an important design change but introduced a new objective, namely a reduction in the cost of health care for poor people.

The exemptions specified under these regulations focused on key diseases regarded as being of public health importance (e.g. leprosy, TB, cholera etc.), immunisations, antenatal and post-natal care, services at child welfare clinics and services provided to health personnel (see Appendix A for a complete list). Exemptions were later extended to victims of snake-bites and dog-bites and to broad demographic and socio-economic groups, namely children under five years, pregnant women, the elderly (defined as people above 70 years) and paupers or indigents. These changes were mainly introduced through a Presidential address to Parliament in January 1997. While it appears that this announcement intended that all services be provided free of charge to these categories of patients, MoH guidelines released in November 1997 for the implementation of the Presidential announcement limited exemptions for these groups of patients to specific services (see Appendix A). These service restrictions were mainly related to the limited amount of funding available to support these exemptions. The most recent amendment to the exemption policy is the introduction of free deliveries, which was authorised by the President on 2 May 2003.

The MoH has instituted a mechanism for funding exemptions in that facilities can submit a statement of fee revenue (called internally generated funds or IGFs) ‘lost’ through exemptions and request reimbursement. This was a major innovation. Exemptions are ‘unfunded’ in many countries, leaving providers with weak incentives to forgive fees. However, now there is routinely insufficient funding to cover all reimbursement claims, an issue discussed later in this paper.

The main context for this review of exemption issues in Ghana is two-fold. Firstly, the government has indicated its commitment to moving away from the ‘cash and carry’ system towards comprehensive health insurance coverage. However, fees will continue to be levied for some time to come. Health insurance is relatively new in Ghana and despite a government preference for rapid implementation, it is unlikely that universal coverage will be achieved in the short-term. As insurance membership is currently voluntary, the existence of fees, and hence the risk of incurring potentially substantial medical costs, provides an incentive to join an insurance scheme. Thus, on the one hand it is important to assess how existing fee exemptions can be improved while on the other it is important to consider how exemptions (or at least substantial subsidies) for insurance contributions could be introduced. The second contextual factor of importance to this review is the Ghana Poverty Reduction Strategy (GPRS) which dominates all sectoral policies and has informed the Ministry of Health’s second Programme of Work (PoW 2). It is against the template of the GPRS health sector goals and targets that exemptions are reviewed.

The next section considers how the exemptions policy has been implemented, particularly in relation to who are the major beneficiaries of this policy, how this relates to the GPRS goals and what the key obstacles are to effective implementation. Section 3 focuses on how the achievement of GPRS goals through exemptions (either for facility level fees or for contributions to health insurance) could be improved.

2. Exemption implementation practice

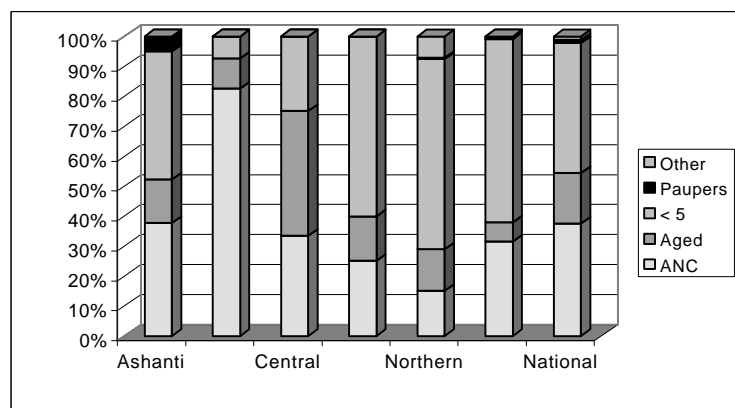
Interviews with key informants, field trip observation and previous research all point to wide variation in fee policy implementation between regions, districts and individual facilities. In general, facilities appear to be erring on the side of providing fewer exemptions than envisaged in the policy. The notable exception to this trend is the initiative of the 3 northern regions (Upper West, Upper East and Northern) to broaden exemptions, for example to include deliveries and post-natal care ¹. The Northern Region has also reduced the cut-off age for the elderly to 60 years.

Previous research indicates that the exemption policy is poorly implemented. For example, one study in the Volta region found that 84% of patients who were eligible for exemptions did not receive them ². A more recent national study of exemptions ³ found that almost half of the clients interviewed who were eligible for exemptions had in fact paid for services. The highest percentage of eligible patients who paid for services was found in Ashanti and Greater Accra, while, encouragingly, the lowest percentages were found in the 3 most deprived northern regions. It is of considerable concern that some patients who were correctly exempted by the facility were required to pay informal fees to individual health workers. It has been “conservatively estimated” that informal fees may comprise as much as 40% of actual payments by patients ⁴.

2.1 Distribution between exemption categories

Limited data are available on the distribution of exemptions between the different categories, which makes monitoring and evaluation of the implementation of this policy difficult. However, previous research has highlighted that the poor receive a tiny share of exemptions while the demographic categories (under-fives, elderly and pregnant women) receive the lion’s share ⁵. This general pattern is

Fig 1: Exemption spending by category



1. Adams I, Darko D, Accorsi S, Tetteh I, Anemana S, Agongo E, Banka F. Effects of the exemption policy on utilization of hospital services in the three northern regions of Ghana (1998-2000). *Bulletin of Health Information* 2002; 1(2&3): 14-18.
2. Nyonator F, Kutzin J. “Health for some? The effects of user fees in the Volta Region of Ghana”. Paper presented at the CERDI conference on Health Systems Financing in Low-income African and Asian Countries Conference, Clermont-Ferrand, 30 November – 1 December 2000.
3. Garshong B, Ansah E, Dakpallah G, Huijts I, Adjei S. A study on factors affecting the implementation of the exemption policy in Ghana. *Bulletin of Health Information* 2002; 1(2&3): 22-31.
4. Adams I. Implementation of user fee policy in Ghana: A review of the issues (Part 1). *Bulletin of Health Information* 2002; 1(2&3): 3-13.
5. Adams et al (2002), *op cit*.

evident from data provided in the regional reviews of the 2002 POW, although there is significant regional variation in the distribution of exemption spending on different categories (see Figure 1).

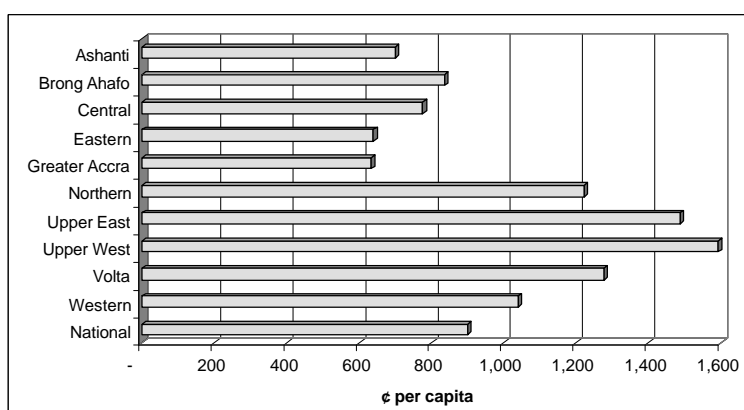
This distribution of exemption payments, relative to the size of the respective beneficiary populations translates into approximately c¢2,800 devoted to exemptions per member of the beneficiary population for key demographic groups (particularly children under-five and people over 70 years) but a mere c¢32 per poor person in 2002. Even if one uses the more constrained extreme poverty definition of people with a standard of living insufficient to meet basic nutritional requirements, only c¢44 was spent on exemptions per extremely poor person. This means that 87 times more is being spent on exemptions for children and the elderly than on the poor, or 64 times more than is spent on the extremely poor, relative to the number of people who should be eligible for these benefits.

2.2 Distribution between regions

Clearly the awarding of exemptions is closely tied to the amount of money made available to reimburse for the IGF revenue ‘lost’ through exemptions. Thus, in relation to the distribution of exemption reimbursements between regions it is extremely encouraging that priority was generally given to the three most deprived regions. Data for 2002 indicate that nearly c¢18 billion was disbursed to regions for paying exemption reimbursements to individual facilities, which is nearly two-thirds of the budgeted amount of c¢26 billion. This is equivalent to a national average of approximately c¢900 per capita. The Upper West, Upper East and Northern regions received disbursements equivalent to c¢1,595, c¢1,488 and c¢1,223 per capita respectively, highlighting the relative priority given to the most deprived regions (see Figure 2). The other regions, with the exception of Volta and Western regions, received per capita exemption reimbursement funding below the national average level.

It should be noted that the data used relates to disbursements from national level to regions. Unfortunately, it was not possible to obtain information on how much of this funding was actually used to reimburse individual facilities for exemptions. However, other investigations have revealed that most regions pay out less to facilities than they receive for exemption reimbursements⁶. While these funds are included in a separate line-item and should only be used for exemption reimbursement purposes, they may sometimes be regarded as fungible and directed to other purposes by regional offices.

Fig 2: Per capita exemption reimbursement per region



2.3 Evaluation of exemptions in the context of GPRS

Given the prominence awarded to the GPRS in all sectoral plans and programs, it is useful to assess how the exemption policy and the current exemption implementation practice match up to GPRS targets and priorities (see Appendix B for summary health sector related aspects of GPRS). A heavy emphasis has been placed on maternal and child health issues in the health component of the GPRS with priority being awarded to services such as immunisations and supervised deliveries. In addition, most of the key targets, both in the overall GPRS and in

6. Garshong et al (2002), *op cit*.

the health component, relate to young children and pregnant women such as reductions in the MMR, U5MR and IMR. Hence the current practice of prioritising exemptions for these groups (see Figure 1) is in line with the GPRS. The recent decision to exempt deliveries from user fees could potentially make a considerable contribution to reducing the MMR and hence to achieving one of the core poverty reduction targets, given that it is estimated that only half of deliveries are presently supervised. The one demographic category currently included in the exemptions policy that receives limited attention in the GPRS is that of the elderly, although they are seen as potentially being a vulnerable group.

The GPRS highlights the importance of improving the targeting of poor groups. This is the key area where current implementation of the exemption policy is failing, with an unacceptably low level of exemptions being provided to the poor. As noted in the introduction to the health section of the GPRS, “improving the health status of the poor is crucial for poverty reduction, given that ill health is both a consequence and cause of poverty.”⁷ There is growing international evidence that the likelihood of a poor household ever moving out of poverty diminish once confronted with illness-related costs, and that a vicious cycle of poverty and ill-health easily sets in once a vulnerable household slides below the poverty line as a result of illness⁸. While this particularly relates to catastrophic illness, even ambulatory care can worsen the situation of extremely poor households. Inadequate efforts to protect the poor from health care costs is possibly the biggest challenge facing the Ghanaian health service in relation to exemptions.

2.4 Key factors influencing implementation of the exemption policy

The above sections have indicated that the poor are being inadequately targeted for exemptions at present, with priority being given to specific services for certain groups such as children under-five. However, a significant number of people in these groups are also not receiving the exemptions that they are entitled to in terms of the policy.

Field visit interviews and published research indicate that several factors contribute to the lower than desirable effectiveness of current exemption implementation practice. One factor is the lack of clarity among health service providers about aspects of the exemption policy. There are certain exemption categories that are most frequently cited by providers during interviews, usually under-five children, ANC and the elderly⁹. There is considerable confusion about which services are exempt within these broad categories, for example whether under-five children should be exempted for certain curative services or not and whether they are exempted from paying for drugs or only from consultation fees. Another factor is that certain patient categories, such as pregnant women, are easier to identify than others. While there is sometimes a difficulty in establishing the exemption eligibility of patients on the basis of age, the most serious problem relates to identifying ‘paupers’.

There are also obstacles on the health service user side. There is evidence of serious gaps in users’ knowledge and understanding of the exemptions policy. A national survey of patients found that while most patients knew of the policy, the level of awareness of specific exemption categories was poor¹⁰. It is worth noting that not one of the health facilities visited during the field trips displayed information about exemptions. Possibly of even greater concern is that patients who are aware of their eligibility for exemption sometimes do

7. Ghana Poverty Reduction Strategy 2002-2004: An agenda for growth and prosperity. Analysis and Policy Statement. February 2002.

8. Whitehead, M., Dahlgren, G., & Evans, T. (2001). Equity and health sector reforms: Can low-income countries escape the medical poverty trap? *Lancet*, 358, 833-836.

9. Garshong et al (2002) *op cit*.

10. Garshong et al (2002) *op cit*.

not exercise their rights due to fear of negative confrontations with providers¹¹. Barriers to seeking and obtaining exemptions are likely to be particularly severe for the poor given the stigma attached to applying for pauper status in a crowded health facility. As there is lack of certainty about whether an exemption will be granted, poor people may not be able to afford to seek care, particularly if they have to incur transport costs in getting to the health facility. Some facilities are even charging ₵1,000 for a pauper exemption application form!

The factor that possibly has the most profound influence on exemption practices is the availability of exemption reimbursement funds and timeliness of disbursement of these funds. It is evident that insufficient funds have been set aside to permit *comprehensive* implementation of exemptions.

For example, it was estimated that the revised exemption criteria introduced by Presidential announcement in January 1997 would require ₵44 billion to cover reimbursements to health facilities if the target sub-populations were appropriately exempted. However, only ₵10 million was allocated for exemption reimbursements in 1999¹². This leads to facilities informally rationing exemptions. It appears that this rationing is quite severe as recent research indicates that the amount of funds budgeted and disbursed to regional offices for exemption reimbursements far exceeded the amount claimed by facilities¹³. The key issue when the research was conducted appeared to be excessive delays in regions reimbursing facilities. This can lead to drug shortages as facilities may have insufficient funds to replenish supplies, which in turn compromises quality of care and can exacerbate problems of health staff willingness to provide exemptions.

It is evident that there is currently a crisis with respect to exemption reimbursements. All facilities visited during the field trip reported delays of 8 months or more in receiving reimbursements. Some facilities, particularly in Eastern Region, reported that they had not received any exemption reimbursements since the beginning of 2002. As a result, many facilities have stopped granting exemptions or are severely rationing exemptions. Unfortunately, the team was unable to determine if the problem is one of insufficient exemption funds at the regional level, as regions did not provide information on the value of reimbursement claims submitted by facilities, or related to regions not forwarding available funds to facility level. Most facility managers indicated that the regional office had indicated that there were insufficient funds for these reimbursements. Some stated that regional offices were concerned that some facilities were “abusing the system” and submitting inflated reimbursement claims and that all exemption reimbursements had therefore been stopped. This situation requires urgent investigation to ensure that the exemption policy is once again implemented in all facilities. This includes CHAG facilities, which seem to be particularly disadvantaged in terms of exemption reimbursement delays and receiving the full amount claimed. This approach is inconsistent with the health GPRS commitment to forging “effective partnerships with not-for-profit private providers”¹⁴.

This situation highlights the importance of critically evaluating the incentives created by a particular policy design. International experience has demonstrated that, where user fee revenue is retained at facility level and comprises a significant component of available funding, there is little incentive for health service managers to exempt patients. That is why the Ghanaian policy of reimbursing facilities for ‘lost fee revenue’ arising from exemptions is

11. *ibid*

12. Danida Health Sector Support Phase II Ghana: Mid-term review of three components (Improving access to health care; strengthening district and sub-district capacity; improving collaboration with the private sector). 2001

13. Garshong et al (2002) *op cit*.

14. Ghana Poverty Reduction Strategy 2002-2004: An agenda for growth and prosperity. Analysis and Policy Statement. February 2002.

so critical; it provides a very powerful incentive for providers to implement the exemption policy. However, if a facility has insufficient core service funding, the exemption reimbursement mechanism can create a perverse incentive to over-report exemptions granted. In order for the system to function well, there needs to be adequate resources for full and timely reimbursement of claims, combined with an effective mechanism for monitoring claims. At present, districts are expected to review facility claims before they are submitted to the region, but this monitoring does not appear to be functioning adequately. Initial monitoring of claims can be desk-based where facilities' claims are compared with their overall utilisation patterns, information on relative need for exemptions (e.g. poverty levels, demographic composition, number of births etc.) in the catchment area to identify outliers for detailed investigation. This can be backed up by regular random spot checks.

3. Improving current fee exemptions and forging links with insurance

Given the challenges to effective implementation of fee exemptions outlined above, this section considers ways in which exemption practice could be strengthened. This has been identified as a priority by the Ghana Health Service (GHS), which commits itself to “making the current exemption practices more responsive to the needs of the vulnerable”¹⁵. The GHS has also indicated that “proposals to use exemptions as subsidies of premiums for the poor / vulnerable in prepayment schemes will be explored vigorously”. As the issues of exemptions from fees and subsidies for insurance contributions¹⁶ are linked, they will be considered jointly and only key differences highlighted when appropriate.

3.1 Important principles

While some countries have been able to achieve a near fully publicly funded health system, most countries have a complex mix of public and private health care financing. There has been considerable debate, sometimes drawing on economic theory, about what services or population groups should receive the benefit of limited government resources. Some argue that public funds should be directed to certain health services that could be regarded as what economists call ‘merit goods’. Because the benefits of these services are shared by people other than the service user (such as with immunisation against communicable diseases), there may be insufficient demand for these services if full cost recovery fees are charged. However, it may be possible to stimulate demand if there is adequate public education about the individual benefits of these services. There is widespread agreement that at least some of the available public funds should be used to ensure health service access for the poor, and possibly certain other extremely vulnerable groups. However, in the context of extremely limited public resources in many low- and middle-income countries, it is often not feasible to adequately fund both merit goods and services for the poor. A decision has to be made on which approach to prioritise within available resources.

Prioritising merit goods may be appealing given the relative ease of identifying exemption beneficiaries (e.g. those receiving immunisations). However, this is a very blunt targeting instrument as many people who could pay for these services do not have to. In contrast, identification of the poor can be very difficult and may be administratively costly, but is likely to be most effective in ensuring that there is equitable access to health services. Some international organisations have suggested a combination of these approaches by suggesting that government resources should be directed to cost-effective health interventions that are

15. Ghana Health Service. 2003-2005 Policies and Priorities: Draft. 2003.

16. It is yet to be determined whether vulnerable groups, particularly the poor, will be completely exempted from insurance contributions or not. However, many interviewees stressed the importance of all insurance members making some contribution, even if minimal. For this reason, the term ‘subsidy’ is used when referring to insurance contributions rather than ‘exemptions’.

most needed by the poor (e.g. the World Bank's essential service package approach). Unfortunately, there is a lack of convincing evidence on the effectiveness of this strategy in promoting equitable access.

Against this background, options for improving the effectiveness of the Ghanaian exemption system can now be considered.

3.2 Who should be the beneficiaries of exemptions?

Clearly preferences for categories of services and/or users to exempt must be reconciled with resource availability. At present, there is a wide range of exemption categories in Ghana. Some exemptions focus on services, which can be considered to be 'merit goods'. Some exemptions combine demographic groups with disease or service categories (e.g. free treatment of malaria, diarrhoea and upper respiratory infections for children under-five and the elderly, and ANC for pregnant women). The final category of exemptions relates to individual socio-economic characteristics, namely 'paupers'.

This complex array of exemption categories has resulted in considerable confusion among providers as to who is exempted for what services. Given resource constraints, and in order to minimise confusion and exemption administration costs, it is likely that a trade-off between providing exemptions to all for particular services and providing exemptions to all services for particular groups is required. In this regard, it is important to note that there appears to be a preference among health workers and managers for the latter option. Interviewees during the field trips routinely commented that all elderly people and children under-five were benefiting from exemptions while many of them could pay. In contrast, the poor and other vulnerable groups such as people living with AIDS were either not accessing services or having to incur debt to cover user fees. It is evident from the review of current practice that the poor are currently the losers in the context of a lack of prioritisation between exemption categories within resource limits.

The key challenge would therefore appear to be to find more effective ways of protecting the poor from the health care costs of illness. It is recommended that priority be given to addressing this challenge and that the poor be the primary recipients of exemptions. Once this group is effectively protected from direct health service costs, consideration could be given to other exemptions (e.g. for a limited number of prioritised public health services or for catastrophic service costs for other groups) *if* adequate resources can be made available. This would be in line with the Ghana government's emphasis on poverty reduction. It also provides a useful linkage with the transition to wider health insurance coverage, given that poverty is the major criteria for exempting or subsidising individuals in insurance schemes. The remainder of this section will focus on how exemptions for the poor could be strengthened.

3.3 Who should identify beneficiaries of exemptions (or insurance subsidies) and when?

At present, a senior health facility officer approves fee exemptions for the poor, sometimes with input from a social worker (if one is employed by the facility). Given the heavy reliance on IGFs and the inadequate reimbursement of exemptions, there is a clear incentive for health service managers to minimise the number of exemptions granted¹⁷. One commentator has noted that identifying those who currently do not gain access to the health service due to inability to pay has "proven elusive in the hands of health workers alone"¹⁸. It may therefore

17. Ministry of Health and Health Partners (2000) *op cit*.

18. Adams I. Implementation of user fee policy in Ghana: A review of the issues (Part 1). *Bulletin of Health Information* 2002; 1(2&3): 3-13.

be worthwhile giving serious consideration to other mechanisms for identifying the poor, which could be used both for fee exemptions and for insurance contribution subsidies.

Others have previously suggested that the social welfare sector or department focusing on poverty alleviation, district assemblies and/or community-based organisations could be involved in this beneficiary identification and decision-making process¹⁹. It is unclear which decentralised MDA works most directly with poverty alleviation initiatives and interviewees indicated that social welfare officers in the district focus mainly on “marital problems and orphans”. Such an MDA would be ideal to involve in identification of potential recipients of exemptions or subsidies on the basis of poverty, particularly in large urban areas where communities are fragmented.

A number of mutual health organisations (MHOs – i.e. community based insurance schemes) provide cross-subsidised exemptions for a limited number of poor households. In these cases, the village or community has been requested to identify those in greatest need of contribution exemptions. It would be inappropriate for the insurance scheme itself to determine who should receive subsidised contributions, as scheme managers are unlikely to have adequate knowledge of who is most vulnerable within a community. There may also be an incentive for scheme managers to over-state the number of households requiring such subsidies in order to generate more contribution revenue. There is a concern that subsidising insurance membership for certain households when insurance membership is voluntary may provide a disincentive for others to join. This is probably best addressed by attempting to sign up entire communities for insurance membership and asking the community to determine if there is anyone requiring subsidisation.

Internationally, exemption schemes that are most successful involve a mixture of these approaches. A social welfare officer may assist in identifying likely candidates, but the final decision is made by a committee comprised of community members, one or more respected community or local government leaders and sometimes a representative of the local health facility. Such a committee could work equally well for considering fee or insurance contribution exemptions.

The present fee exemption system waits for potential beneficiaries to apply at the time when services are needed. In the case of the few MHOs that provide contribution exemptions or subsidies, a more active approach is adopted and beneficiaries are identified at the time when other village members decide to join. This could be extended to other areas covered by MHOs if and when funding for subsidised or exempted insurance contributions becomes available. Given the many barriers faced by the poor in accessing health services at present, there is considerable merit in proactive identification of fee exemption beneficiaries in areas not currently covered by MHOs before health services are required. Such individuals could be issued with a card, similar to that issued by MHOs. The key problem with this system is that holders of ‘poor’ cards may receive discriminatory treatment at health facilities. While all holders of such a card should automatically be exempted from fees when they seek care, consideration of fee waivers may also be required for other patients in the case of catastrophic illness and associated health service costs (i.e. there should be a route of appeal for financial assistance in exceptional circumstances).

19. Adams (2002) *op cit.*; Garshong et al (2002) *op cit.*; Danida Health Sector Support Phase II Ghana: Mid-term review. 2001; Anemana S. Improving the uptake of exemptions in the Northern Regions. *Bulletin of Health Information* 2002; 1(2&3): 19-21.

3.4 How should eligibility be determined?

At present, there are no guidelines on how to identify ‘paupers’. It would be useful to at least provide some broad national guidelines, while recognising the need for local discretion based on the community and local leaders’ understanding of poverty in the local context. An important mechanism for exerting national influence on this decision-making process is to allocate the resources available for funding exemptions and/or subsidies to districts on the basis of need, in this case defined as poverty levels. Local committees’ will then be able to determine how many people or households can be exempted within this financial constraint and can prioritise the allocation to those in greatest need.

3.5 What should be the duration of the exemption benefit?

Individuals’ socio-economic circumstances can and do change over time with some managing to achieve higher living standards and others slipping into poverty. For this reason, it is inadvisable to provide permanent exemption status on grounds of poverty. However, the shorter the exemption status renewal period is, the greater the administrative costs involved. In the case of insurance, it may be feasible to review contribution subsidy status annually, particularly if annual rather than monthly contributions are made. A longer duration, possibly two to three years, should be considered in the case of fee exemptions.

3.6 How should exemptions be funded?

As illustrated above, if resources are insufficient to cover fee revenue ‘lost’ through exemptions, health facilities will ration or stop exemptions. The reason for this, as has been noted in many previous sector reviews and research publications, is that IGFs currently represent the most reliable and one of the largest single revenue sources for non-personnel health service costs²⁰.

To ensure adequate incentives for health service providers to implement an exemption policy, the exemption package must be aligned more closely with resource availability. This requires accurate information on the likely cost of exemptions, i.e. information on both the expected utilisation by exempted patients (in this case the poor) and the fee levels. Given the differences in fee levels between facilities, this will not be an easy exercise. There is some debate about what fees should be included in exemption reimbursement claims. Some have argued that only the cost of drugs should be included, as all other costs (e.g. the cost of staff, diagnostic test supplies etc.) are theoretically covered under GoG and DPF allocations to facilities²¹. However, L.I. 1313 explicitly makes provision for levying fees for consultations, diagnostic tests and a range of other services which would suggest that these could be eligible for reimbursement for exempted patients. This is particularly the case when GoG and DPF are currently inadequate to fund health services.

There are various ways of addressing this problem. One approach would be to improve the overall *level and reliability* of health service funding from GoG and DPF to adequately cover the costs of all non-drug costs and only charge cost-recovery fees for drugs. However, this is unlikely to be feasible within the existing resource availability. An alternative approach is for GoG and DPF resources to be focused on covering health facilities’ fixed costs (mainly staff salaries) and increasingly allocating all other available resources to exemption reimbursements. In this way, facilities’ variable costs could be covered either through user fees, health insurance reimbursement for services used by their members and exemption

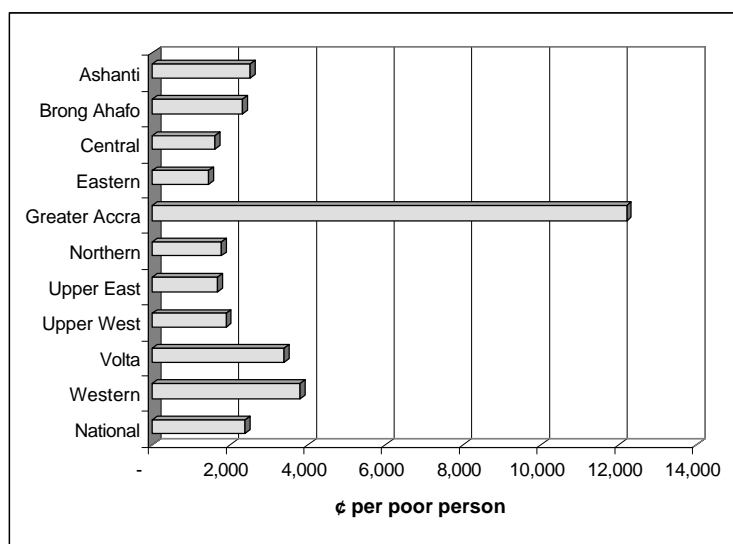
20. Ministry of Health and Health Partners. Consolidating the gains: Managing the challenges, 1999 health sector review. April 2000.

21. Adams I. Containing cost of exemptions: What should constitute the bill? *Bulletin of Health Information* 2002; 1(2&3): 49-52.

reimbursements for the poor. The latter approach is particularly desirable given that Ghana is committed to gradually moving towards universal insurance coverage, which will require that government funds are allocated more and more towards paying for insurance contribution subsidies and insurance schemes becoming the main purchasers of health services.

In addition to increasing the share of GoG and DPF resources devoted to fee exemption reimbursement and insurance contribution subsidies, it is critical that the mechanism for allocating these resources be improved. In particular, differences in poverty levels between regions should be taken into account when determining these allocations if fee exemptions and insurance subsidies are to be targeted increasingly to the poor. If the 2002 regional distribution of exemption reimbursement funds is compared with the number of poor people in each region, it is evident that current allocations are not sufficiently well targeted to support a policy of prioritised exemptions for the poor (see Figure 3). The three most deprived regions (Northern, Upper East, Upper West) receive less exemption reimbursement funds per poor person than the national average, while four of the least deprived regions (Greater Accra, Western, Volta and Ashanti) receive considerably more than the national average per poor person.

Fig 3: Exemption reimbursement allocations relative to poverty levels



While there are pockets of deprivation in peri-urban areas of the metropolises, the overall poverty levels in metropolitan areas are extremely low (e.g. 5% in Greater Accra) compared with some of the more rural regions (e.g. 88% of the population in Upper East are considered to be poor). Thus, GoG and DPF funds devoted to fee exemptions and insurance subsidised should be dramatically redistributed on the basis of need (using the number of poor people per region as the primary indicator).

How should these funds be channelled? Previous sections have highlighted the considerable problems experienced with the current procedure of routing exemption reimbursements from the GHS to regional offices and then on to individual health facilities. It is unclear whether this situation can be improved in future, but it is evident that the existing funding problems are contributing to a breakdown in the exemption system. In addition, this particular way of channelling funds is unlikely to be appropriate for district level MHOs.

There has been a recent proposal by the International Labour Organisation to establish the ‘Ghana Social Fund’ as a mechanism for identifying insurance contribution exemption or subsidy beneficiaries and channelling funds to MHOs²². However, the exact mechanism for funding flows is still somewhat uncertain, it may not be advisable to have separate funding channels for fee and insurance contribution exemptions and it is inappropriate for an insurance-related organisation to be responsible for fee exemption disbursements.

An alternative approach, which has been suggested by others previously, is to route exemption funds via District Assemblies: “It is recommended that all District Assemblies

22. International Labour Organisation. *The Ghana Social Trust: A draft concept developed by the Ghana Social Trust Pilot Project. Discussion Paper.* Geneva: ILO, 2003.

create a Health Fund into which the exemptions vote for the district will be lodged. The Health Fund will be managed by an Inter-Agency Co-ordinating Committee for Health Development which will have the District Director of Health Services as its secretary”²³. This proposal may be worth revisiting given that the funds for the recently agreed exemption of institutional deliveries will be channelled via DAs. The MoH and GHS will input to the process by advising on the distribution of funds between DAs, presumably on the basis of an indicator of relative need, such as number of births in each district in the previous year. However, there are considerable concerns about the financial management capacity of district assemblies and hence their ability to effectively manage health service exemption and insurance subsidy funds.

The best solution may be to adopt a phased approach. In the short-term, the priority should be to address the problems in the existing exemption reimbursement disbursement system. In the medium term, as financial management capacity improves within DAs, it may be feasible to channel both fee exemption reimbursement and insurance subsidies via the DAs. It will be important to monitor and evaluate progress with DA disbursements of the institutional delivery exemption funds in the interim to assess their readiness to take on more responsibility in this regard. In the long term, as a greater proportion of the population is covered by health insurance, funding channels more closely linked with insurance mechanisms may be preferable.

3.7 How can a more effective exemptions system be promoted from the provider perspective?

Given the current lack of clarity on who is exempted for which services, it is critical that health personnel and facility managers are provided with simple and clear guidelines on the fee exemption policy. It is necessary to do more than simply provide this information. There is often resistance among health workers to implementing exemptions, even where ‘lost revenue’ is reimbursed and it is therefore important to explain the importance of the particular exemptions contained in the policy. The fundamental issue is one of addressing individual provider perceptions; for example, one interviewee stated that ANC should not be exempted, as “pregnancy is not a disease”. Such motivation can also reduce discriminatory practices towards exempted patients.

Clearly in a system of fee exemption reimbursements, accurate recording of utilisation by exempted patients is critical. As indicated earlier, there appears to be a perception in some regional offices that facilities are abusing the reimbursement system by submitting inflated claims. In order to guard against this occurring and the consequent freeze on reimbursements, a more effective system for auditing claims should be developed. Such a system would also be necessary for monitoring claims for subsidised insurance contributions.

Finally, efforts should be made to address the problem of informal fees. One approach would be to empower communities (see next sub-section). It is also important to take measures such as posting information on official fee levels in all health facilities and having a single point for the payment of fees²⁴. However, it is unlikely that a major impact can be made until health personnel conditions of service are adequately addressed.

23. Anemana (2002), *op cit*.

24. Garshong et al (2002) *op cit*.

3.8 How can a more effective exemptions system be promoted from the health service user perspective?

Considerable attention should be paid to adequately informing communities about fee exemption and insurance contribution subsidy policies. The experience of the Northern province in informing the community when exemptions were broadened in 1999 provides some insight into how this could be achieved. The policy was advertised to the community via radio and public address systems mounted on district health office vehicles. In addition, information was provided to DAs and District Assemblymen were requested to inform their communities about the policy²⁵. Posters explaining the policy could also be posted in all health facilities and in other public places.

Information dissemination should be accompanied by efforts to empower communities to exercise their rights. In particular, there should be mechanisms for reporting failure by health personnel to implement exemptions, discriminatory service practices for exempted patients and the charging of informal fees. Such reporting mechanisms should not be linked to health facilities given the potential for victimisation.

4. Summary and key recommendations

The Ghanaian fee exemption system has some innovative aspects to it, particularly the commitment to reimburse health facilities for fee revenue 'lost', which provides a powerful incentive for appropriate implementation of the fee system. However, the exemption system is not functioning effectively at present, with a growing number of facilities no longer providing fee exemptions, other than in exceptional circumstances. The main reason for this break-down in the exemption system is that reimbursements have not reached most facilities for more than 8 months and facilities are heavily reliant on IGF revenue for continued service provision.

The other aspect of current fee exemption implementation that is of considerable concern is that the major beneficiaries are children under 5, pregnant women and the elderly with almost no exemptions being granted to the poor. With almost 40% of the Ghanaian population being defined as poor and 27% as extremely poor (i.e. cannot even meet their basic nutritional requirements), the current lack of targeting of the poor is unacceptable. While this is partly attributable to difficulties in identifying the poor, it is also due to the attempt to do too much with too few resources. In particular, it is not feasible to exempt all people in particular groups (e.g. under-fives and the elderly) from certain services and to exempt all services for the poor within the constraints of resources currently available for funding exemption reimbursements.

Based on the analysis presented in this paper, the following key recommendations are made:

- *The primary beneficiaries of fee exemptions, and subsidies for insurance contributions as health insurance coverage expands, should be the poor. Other potential exemptions (e.g. limited and strictly prioritised exemptions for key public health services or for truly catastrophic health care costs) should only be identified once it has been determined what resources are required to effectively exempt (or subsidise insurance contributions for) the poor.*

25. Anemana (2002) *op cit*.

- *In contrast to the current system of waiting for the poor to present at health facilities and apply for exemption status, there should be a process of pre-identification. This should be done by local committees with significant community representation, and can equally be used to identify beneficiaries of fee exemptions and subsidised insurance contributions. Poor household members can be issued with a card confirming their exemption status. This status should be re-evaluated every few years. Constraints can be imposed on the number of households identified for fee exemption or insurance subsidies through the budget allocated to individual districts and communities for this purpose.*
- *Adequate resources should be made available to fully cover the costs of fee exemptions and insurance contribution subsidies. This requires detailed costing based on the number of potential beneficiaries, average utilisation rates and fee levels in the case of fee exemptions and potential beneficiaries and average contribution rates in the case of insurance subsidies. This may require that an increasing share of non-salary GoG and DPF resources be directed to this activity.*
- *These resources must be equitably allocated. The primary indicator to determine allocations between regions, and to individual districts and communities within regions, should be the number of poor (or extremely poor) individuals in each area.*
- *Appropriate and effective mechanisms for distributing these resources must be identified. In the short-term, it is critical that the existing fee exemption reimbursement channel (from GHS headquarters to regional offices and then to individual facilities) is improved as a matter of urgency. However, this channel may not be appropriate for insurance contribution subsidies. Thus, in the medium-term, it may be feasible to consider routing resources both for fee exemption reimbursements and insurance subsidies via District Assemblies, if financial management capacity at this level is dramatically improved. In the long-term, it is intended that the entire population be covered by some form of health insurance and it may be more appropriate to direct these resources through a channel more closely linked with the health insurance system.*
- *Finally, clear information on the new exemption system, and on insurance contribution subsidies, should be widely disseminated to health service providers and to communities to strengthen effective implementation.*

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Appendix A: Exemption categories

Exemptions under the Hospital Fees Act (No. 387) of 1971 and Hospital Fees Regulation (L.I. 1313) of 1985:

- 1) Exemption from all fees for:
 - a) Leprosy and TB
 - b) Immunization (except for international travel)
 - c) Storage of bodies at request of a state department
- 2) Exemption from all fees except the cost of prescribed drugs for:
 - a) Meningitis
 - b) Cholera
 - c) Malnutrition
 - d) Typhoid
 - e) Venereal disease
 - f) Rabies
 - g) 18 other 'diseases of public health importance'
- 3) Exemptions from all fees except the cost of hospital accommodation and catering services for:
 - a) Ante-natal and post-natal services
 - b) Treatment at child welfare clinics

In addition, free care was to be available for all services rendered in a hospital for health service personnel including trainees.

Current situation, based on the January 1997 Presidential announcement and November 1997 MoH guidelines:

- 1) Exemption for diseases of public health importance (should include all 24 conditions in L.I.1313)
- 2) Exemption for antenatal services (first 4 ANC visits)
- 3) Exemption for children under five years (immunisations, services at child welfare clinics, malaria, measles, diarrhoea and upper respiratory infection)
- 4) Exemption for the elderly, defined as people above 70 years (malaria, diarrhoea, degenerative joint pain, upper respiratory infection and urinary tract infection)
- 5) Exemption for paupers and indigents
- 6) Exemption for snake bites and bites by dogs suspected or confirmed to be rabid.

Source: Adams I. Containing cost of exemptions: What should constitute the bill? *Bulletin of Health Information* 2002; 1(2&3): 49-52.

Appendix B: Targets and priorities for the health sector from the Ghana Poverty Reduction Strategy (GPRS)

Overall GPRS targets that relate to the health sector (2000 situation and 2004 target):

Core poverty indicators

- Under-five mortality rate to improve from 110/1,000 to 95/1,000
- Maternal mortality rate to reduce from 200/100,000 to 160/100,000
- Children under-five underweight to reduce from 25% to 20%
- Total fertility rate to reduce from 4.6 to 4.2

Supplementary indicators

- Infant mortality rate to reduce from 56/1,000 to 50/1,000

Targets for the health sector component of the GPRS (2000 situation and 2004 target):

- Under-five mortality rate in Northern Region to improve from 171/1,000 to 130/1,000
- Under-five mortality rate in Upper East Region to improve from 155/1,000 to 116/1,000
- Under-five mortality rate in Upper West Region to improve from 156/1,000 to 117/1,000
- Under-five mortality rate in Central Region to improve from 142/1,000 to 107/1,000
- % Total government expenditure on health to increase from 5.7% to 7%
- % Recurrent spending on districts and below to increase from 42% to 44%
- % Recurrent spending on sub-districts to increase from 21% to 30%
- % Capital spending on sub-districts to increase from 7% to 15%
- % Recurrent spending on 3 northern & central region to increase from 32% to 39%
- % People consulting qualified health personnel when ill to increase from 30% to 50%
- At least 10% increase in budget for fee exemptions, from ₵12bn to ₵13.2bn
- Per capita OPD attendance at public facilities to increase from 0.49 to 0.55
- Uptake of antenatal care to increase from 96% to 98%
- Post-natal care coverage to increase from 52% to 58%
- DPT 3 coverage to increase from 75% to 90%
- Proportion of supervised deliveries to increase from 49% to 55%
- Ratio of population per nurse in Northern:Greater Accra regions from 4:1 to 3:1
- Ratio of population per doctor in Northern:Greater Accra regions from 5:1 to 4:1

Overall GPRS priorities that relate to the health sector

- Improvements in human resource development such as education, safe water, sanitation and population management
- Improved HIV/AIDS prevention and treatment
- Special programs for the vulnerable and excluded (including people living with AIDS, the elderly who have no pension or family support, people with chronic diseases)

Priorities in the health sector component of the GPRS

- Improve targeting of poor groups and geographic areas
- Cost-effective interventions such as immunisations and supervised deliveries
- Priorities for fee exemptions:
 - Obstetric emergencies
 - Life-threatening pregnancy-related conditions
 - Childhood diseases that have a high mortality
 - Poor elderly citizens
 - Link to insurance to protect the poor
- Effective partnerships with not-for-profit private providers
- The respective roles of the MoH, GHS and DAs must be identified and collaboration between them strengthened

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