NICE International's work on priority setting/HTA and improved quality in Ghana, Philippines and Vietnam

Narrative report July 2013 - December 2013

Ghana

Report by NICE International and the Thai Health Intervention and Technology Assessment Programme

1. Executive Summary

1.1 Between July and December 2013 we have:

a) Successfully completed a scoping visit to Ghana, where we had the opportunity to engage with many key players within the Ghanaian health sector. We have identified two areas where NICE expertise may be able to add value to ongoing reforms: First, priority setting process and methods for reconfiguring the benefit package, to improve both allocative and technical efficiency and reduce inequalities. Second, Quality improvement, which could be linked with ongoing in-country provider payment reforms.

b) Begun the process of planning a study tour to NICE for key players within the system, to allow them to see first-hand how NICE operates, and to develop a plan of action for joint collaboration in the medium to long term, to include discussion of hands-on training for Ghanaian colleagues, the third project deliverable.

1.2 There are strong links between the objectives and working methods of NI's interaction in Ghana and the Rockefeller Foundation's Transforming Health Systems Strategy, including the adoption of a systemic view of care design and delivery, an emphasis on institution building and promoting the efficient and equitable use of healthcare resources.

1.3 NI hopes to be able to continue to build on the links forged in Ghana to date, and to continue to collaborate with a wide range of government and non-government partners. NI is actively pursuing further funding to allow this work to continue.

2. Summary of Activities

2.1 Introduction

Between July and December 2013 we have (a) successfully completed a scoping visit to Ghana, where we had the opportunity to engage with many key players within the Ghanaian health sector, and to identify areas where NICE expertise may be able to add value to ongoing reforms (b) begun the process of planning a study tour to NICE for key players within the system, to allow them to see first-hand how NICE operates, and to develop a plan of action for joint collaboration in the medium to long term, to include discussion of hands-on training for Ghanaian colleagues, the third project deliverable.

Furthermore, this work will help scope out additional activities in conjunction with the World Bank, DFID and other partners, in the context of the Rockefeller Priority Setting grant currently being discussed.

This section of the report summarises the key findings from our scoping visit, and details our plans for the study tour.

2.2 Scoping visit – October 2013

2.2.1 Background

NICE International (NI) has been engaged with the Ministry of Health of Ghana (MOH) since 2009, and have explored how our organisation may be able to collaborate in the use of evidence and social values in setting priorities for funding in health policy and practice in Ghana, through applying tools such as development and use of Health Technology Assessment (HTA), the development of quality indicators and quality standards along pathways of care, and the strengthening of multi-stakeholder processes. Following an early scoping visit in 2009/10 and a series of exchanges and meetings with major stakeholders within and outside platforms such as the Rockefeller funded Joint Learning Network, NI undertook a scoping visit to Accra from 29th October – 1st November 2013 in partnership with the Thai Health Intervention and Technology Assessment Programme (HITAP). The visit was organised with the support of the World Bank regional office in Accra and funded by the Rockefeller Foundation. HITAP contributed their own time and resources to participate in the scoping work.

During the visit, NICE and HITAP met with experts from across the Ghanaian health system, including the main payer organisation, providers and health policy academics. A full list of colleagues can be found in appendix II. The interview discussions were complemented with reading of peer-reviewed and grey policy literature, sourced from interviewees and web searches both before and after the visit.

Here we summarise the key findings from the discussions and document reviews, and outlines areas where NICE and HITAP may be able to collaborate with Ghanaian partners.

A draft of this section was shared with the colleagues met, from both the Ghana health system and funders including the World Bank, UK DFID and the Rockefeller Foundation. All feedback received has been incorporated and additional meetings have been scheduled with DFID and WB on taking a demonstration project forward.

2.2.2 Visit Objectives

Through our visit we aimed to:

1. gain an understanding of the key stakeholders within the Ghanaian health system, the current situation and the challenges they face in transitioning towards Universal Healthcare Coverage (UHC)

2. identify areas where the expertise/experience of NICE and HITAP may be relevant to Ghana, to help overcome some of the current challenges on the way to UHC.

3. raise awareness among stakeholders in Ghana on the role and value of using evidence-based processes in healthcare decision-making and priority setting.

2.2.3 Key findings

2.2.3.1 Work and successes since 2003 reforms

National Health Insurance Scheme

In 2003, in response to growing public dissatisfaction with the "Cash and Carry" payment system, which required advance out-of-pocket payment for all treatment, the government of Ghana implemented the National Health Insurance Scheme (NHIS), to "provide financial risk protection against the cost of quality basic health care for all residents in Ghana"[1] The Scheme is funded by a combination of an earmarked Value Added Tax, which accounts for around 60% of NHIA's revenue; a premium from sections of the population considered able to pay (around 4% of revenue); and support from international donors. Enabling movement towards UHC is a stated aim of the NHIS. Five new laws were recently issued to support this progression including a Mental Health Act, a Health Institution and Facility Act mandating the licencing of all health facilities, and an update to the National Health Insurance Act. In addition, Health Facility Accreditation was established to address healthcare safety and quality at both primary care and hospital levels.

In 2011, the NHIS had a budget of over 760 million Cedis (499 million USD (2011 exchange rates))[2], and in 2013 has achieved a coverage level of 36% of the total population of Ghana. The scheme appears to have strong commitment from stakeholders across the Ghanaian healthcare system, has survived changes in political leadership at both presidential and parliamentary levels, and appears to have widespread, multi-party support.

Benefit package and medicines lists

The NHIA offers a health benefit package covering ambulatory care and inpatient treatment for approximately 95% of diseases prevalent in Ghana. Exclusions include diseases considered to be adequately covered by existing vertical donor programmes, such as HIV/AIDS; elective aesthetic procedures; and expensive, low disease burden conditions such as end stage renal failure.

The Ministry of Health maintain a National Essential Medicine List (EML), adapted from the WHO list, defining which drugs are expected to be available in public facilities. The list contains 563 medicines and is a guidance document. A commission meets regularly to update the list, based on international cost-effectiveness data, clinical trials and Cochrane reviews, and expert opinion. Manufacturers are involved in the processes through stakeholder consultation processes, and are also asked to contribute evidence and develop economic models. In the absence of a fully recorded process for making inclusion /exclusion decisions it is difficult to ascertain to what extent decisions are based on evidence and how much is negotiation / preference based, and to what extent Conflicts of Interest are declared and

[1] Ghana National Health Insurance Scheme website http://www.nhis.gov.gh/nhia.aspx. Accessed 30 November 2013

[2] National Health Insurance Authority, *2011 Annual Report*, Accra: National Health Insurance Authority; 2011

managed. Separately, the Ghana College of Physicians has carried out training courses in pharmacoeconomics with physicians, with aim of helping them select drugs on the basis of cost and effectiveness.

The EML provides the basis for a separate list developed by the NHIA which defines which drugs will be fully reimbursed under the health insurance scheme. In 2012, the NHIS medicine list consisted of 548 items. This list is updated by an expert commission led by senior clinicians, with representation from the MOH, NHIA, medical specialists and other stakeholders. Some high-cost treatments such as anti-cancer drugs, and drugs for treatment of end-state-renal disease and organ transplantation, are excluded from the NHIS.

NI, HITAP and World Bank colleagues at the Ministry of Health, where discussions took place on where support would be beneficial in the areas of evidence-informed policy making and care quality improvement

Quality Improvement programmes

Both the state-run Ghana health service (the largest care provider organisation in Ghana) and the Christian Health Association of Ghana (CHAG, the second largest) have been active in the area of Quality improvement.

The GHS have developed and are implementing a health sector development plan, which places particular emphasis on ensuring patient safety and the monitoring of surgical care. GHS also work with NHIA to develop accreditation standards.

CHAG have adapted international monitoring models for use in facilities, and systems are in place to monitor the availability of essential drugs and other technologies. Monitoring in both CHAG and GHS facilities has been helped by the presence of functional information systems, developed by the MOH, which provide disaggregated data at national, regional and district levels. In addition, CHAG have developed their own data systems to be able to extract and analyse CHAG-specific data. CHAG and GHS have some communication to share best practice in monitoring and evaluation (M&E), and are developing a Memorandum of Understanding to define their relationship and district and regional levels.

National Standard Treatment Guidelines (STGs) are developed by a committee consisting of physicians and pharmacists identified by the MOH. A number of colleagues reported, however, that implementing guideline recommendations had been difficult, due to a lack of buy in from providers, and conflicts with the reimbursement levels of NHIA.

Civil society involvement

Ghana has a number of active civil society organisations in the healthcare field, represented by the umbrella organisation "Coalition for NGOs in health". These carry out data collection and research and use this information to influence government policy. The coalition is recognised by the MOH, and coalition members sit on working groups across government departments, including in health and education. The coalition successfully campaigned for civil society involvement in the government's 5 year plan on maternal health, and contributed to the development and communication of the Oxfam report[3], which questioned the NHIA's reported coverage level and led to coverage figures being revised.

2.2.3.2 Stated challenges and priorities

Expanding coverage and extending financial protection to patients, whilst ensuring the financial sustainability of the NHIS

In spite of the success of the NHIS in providing financial protection to many citizens[4], challenges remain. Out of pocket payments still account for around 37% of health spending in Ghana[5], and expanding coverage from the current levels of under 40%, particularly to the poorest and most vulnerable populations, is one of the key priorities for the NHIA. In parallel, it is seen as critical to ensure financial

[3] Oxfam International, *Achieving a Shared Goal: Free Universal Health Care in Ghana.* Oxford: Oxfam; 2011
[4] See http://www.equityhealthj.com/content/10/1/4, http://www.brookings.edu/research/books/2011/theimpactofhealthinsuranceonlowandmiddleincomecountries and http://www.hsrc.ac.za/en/research-data/view/5328 for some empirical evidence of the effect of the NHIS on reducing OOP payments
[5] The World Bank. Japan-World Bank Partnership Program on Universal Health Coverage – Ghana Case Study Summary. Washington, DC: The World Bank; 2013

stability at this time of scale up. This is expected to be achieved through a combination of increasing revenues and rationalising expenditure.

Increased revenues may come from tax funds, or increased premium contributions. Setting taxation levels is outside the scope of the NHIA, however they are actively engaged in discussions with the Ministry of Finance with the aim of securing additional funding. Increasing income through premium contributions is seen as problematic as it may exclude the poor from joining the scheme, and increase existing inequalities in access. Although the poorest are exempted from paying any kind of premium, premiums are unaffordable to many of those just above the payment. This may be contributing to the fact that less than one-third of the poorest quintile are benefiting from the protection offered the by NHIS. Higher rates of scheme registration are observed in the richest quintile.[6]

In terms of NHIA expenditure, there is potential for efficiency savings[7] Provider payment reform is also central in ensuring the inflationary impact of the current fee-for-service model is addressed. Although a Diagnostic Related Group (DRG) system that pays per care episode was introduced in 2008, it has not managed to contain costs, and in some cases has led to DRG-creep (upcoding towards more profitable DRG codes). Changes to the provider payment system have been extensively considered, and following a pilot program in Ashanti province, a capitation system is set to be rolled out across the country. Finally, on commodity procurement, providers can make a profit by procuring medicines at a lower price to the reimbursement rates set by NHIA. This may lead to over prescription of medications with high margins, for instance the use of artesunate injections to treat malaria. NHIA spends over 50% of its operating budget on medicines.

A lack of established health priority setting processes in Ghana appears to have led to allocative and technical inefficiency. In terms of allocative inefficiencies, curative interventions seem to have been prioritised over disease prevention and health promotion, even though international experience suggests that the latter are cheaper and offer higher health gain. The fee-for-service method of provider payment also may have led to technical inefficiencies due to the incentives created for providers to offer treatment options (e.g. medical treatments) that can make higher profit from the reimbursement system and ignore more effective alternatives (e.g. health education and behaviour modification) that are not currently reimbursed.

In addition, a number of colleagues felt the benefit package offered by the NHIA was too generous given the scheme's budget. Re-engineering the benefit package, with defined criteria for including reimbursed products to ensure greater value for money was stated as a priority. There was widespread support for an inclusive, multi-stakeholder approach to any redesign.

Rationalising expenditure through reducing wasteful and cost-ineffective practices could potentially free up funding to be reinvested in expanding coverage and reducing OOP. There are concerns that local technical capacity and the institutional framework required to carry out such a process are lacking

[6] Schieber, G., et al., *Health Financing in Ghana*. Washington DC: The World Bank; 2012
[7] Oxfam, ibid note 3.

(though there is some health economics and critical appraisal expertise both at the University of Ghana, and within provider organisations).

Increasing care quality

There is a perception that issues about quality of care have been neglected in a system often seen as fragmented and lacking in patient-focus. Improving the quality of care provision is a key priority for both the NHIA and for provider organisations. Three strategies to achieve this were discussed: provider accreditation; the development and use of standard treatment guidelines and quality standards; and strengthening the collection, analysis and management of M&E data and monitoring systems, including audit.

The NHIA carries out audit and accreditation, although it is not clear whether these are intended to increase care quality, or to regulate claims and payment, or both. In addition it is not clear whether these activities are carried out systematically or on an ad hoc basis. Some providers have questioned the legitimacy of existing accreditation programmes, which are perceived as having been added to NHIA's remit without adequate consultation. A recent law has moved responsibility for provider accreditation to the MOH.

Both GHS and CHAG are keen to strengthen the development and use of treatment guidelines within their respective facilities. Both organisations felt that the adaptation of international guidelines could be helpful in driving quality improvement, and standardising levels of care across facilities, which is known to vary widely. Both providers and the MOH however, noted existing guideline recommendations are often not followed, and recognised the need to develop support and/or incentives for implementation. Stated barriers to implementation include (1) a lack of buy-in from physicians, who often perceive guidelines to run counter to their preferred treatments and erode their autonomy, (2) inconsistencies between the cost of implementing recommendations and NHIS reimbursement levels, and (3) questions over the applicability of guidelines to different communities. A lack of a home-grown consultative process for developing and continuously updating clinical guidelines is another concern.

Providers expressed a need to agree common standards of care to be applied nationally, and it was thought the MOH would be best placed to convene and drive this process. There was interest in developing NICE-style quality standards to help improve quality of care and to inform monitoring programmes through an inclusive and transparent process, insulated from vested interests.

Another challenge is data availability and reliability. The NHIA routinely collect administrative and operational data, but the lack of a fully functional electronic claims system means data have a significant time lag and are prone to error or manipulation by transcribers. Clinical and cost data seem to be less readily available. In addition, the capacity to analyse such data and use them to inform policy at MOH or NHIA, is lacking.

Strengthening primary care

There is a growing realisation that the NHIS does not pay enough attention to primary health care, and many Ghanaians do not have access to NHIS services near to home[8]. This occurs in spite of the fact that primary health care facilities can offer a cheaper service with equal health outcomes for majority of diseases[9]. In contrast, NHIA allow private hospitals to be reimbursed at a higher rate than public hospitals and primary health care facilities.

Combining primary care with capitation and strict quality control may be one way for improving access, and quality and managing cost escalation.

Demonstrating impact

As the NHIS is likely to require increased levels of public resources and, at least in the short term, continued international support, demonstrating impact and value for money of the scheme are most important. Data from all of the areas described in this section can potentially be used to provide evidence of impact:

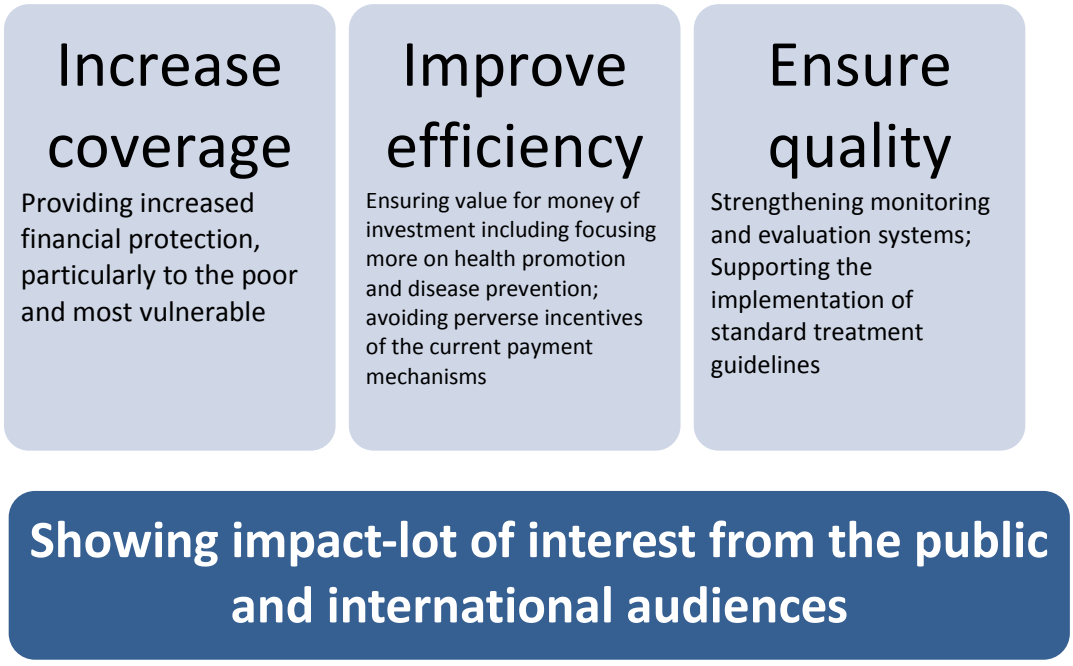

Figure 1: Challenges of the Ghanaian health system

[8] Oxfam. Ibid ref 3

[9] World Health Organization, *The World Health Report 2008 - Primary Health Care Now More Than Ever*. Geneva: World Health Organization; 2008

2.2.4 Possible areas for future collaboration

Based on our discussions and the stated priorities of Ghanaian colleagues, we have identified three areas for potential collaboration, where the experiences of NICE and its partners, such as HITAP, may be able to add value.

Re-engineering priority setting process and methods for benefits package adjustment to improve both allocative and technical efficiency and reduce inequalities

This area aligns with the extensive expertise of NICE and its partners, such as HITAP, in informing and making investment / disinvestment decisions and defining packages/bundles of care.

(a) Technical Input

In the first instance, NICE and its partners, such as HITAP who have experience informing the Thai EML, could work with NHIA and National Drugs Programme (MoH), with support from partners such as WHO and local universities, such as the University of Ghana, to help refine the decision making process on inclusion of new technologies into the benefits package and assist in building up a Health Technology Assessment function (incl process and criteria definition, pilot hands-on exercises, technical and administrative training and awareness raising, institutional twinning). In this context, a more systematic, transparent, participatory and evidence-based process for the development of the essential medicine list issued by MOH and the NHIA reimbursement list would help ensure that drugs available under UHC are assessed for their clinical and cost effectiveness and local acceptability and feasibility of application (the latter two, in the context of clinical guidelines for best practice), before being included in the lists (see figure 2).

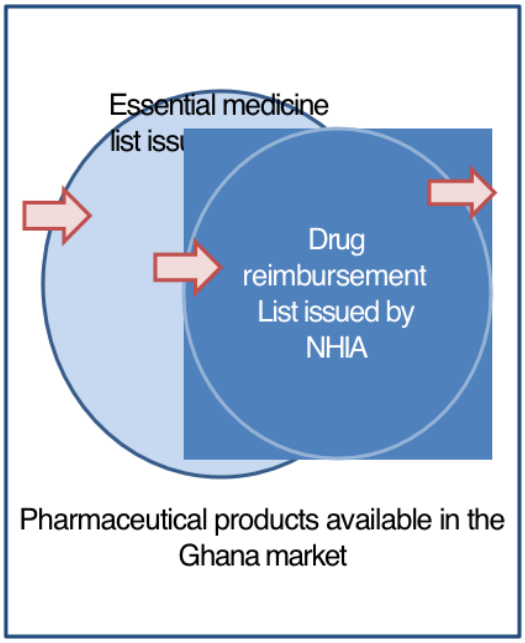

Figure 2: Potential use of health technology assessment for setting priority of medicines in Ghana

(b) Process input

Furthermore, using evidence and inclusive transparent processes to make benefit-package inclusion and exclusion decisions may be useful in conferring legitimacy on decisions to rationalise the benefit package (including disinvestment), which could, in turn, help in free up resources and expand coverage and access, through lower OOP payments. In this context, we could, with additional support from DFID and WB, revitalise the existing stakeholder dialogue through MeTA Ghana (Medicines Transparency Alliance) and establish it as a forum for meaningful exchange with civil society on medicines policy issues. This module is of particular importance when the expectation is that there will be future modifications of the NHIS benefit package in order to ensure financial sustainability and enable expansion beyond the current 36% of population, especially when over half of the NHIA budget goes on drugs and most of OOP spending is also directed towards pharmaceuticals, adversely affecting the poorest. Ghana is the favourable position that, as a MeTA pioneer, it has an existing platform for stakeholder dialogue; NICE has worked with MeTA partners in the Philippines and in Jordan and would be willing to serve as a catalyst for reopening the discussion on procedural fairness, equity and governance.

Quality improvement linked with provider payment reform and provider education

NICE has extensive experience of developing clinical guidelines for the UK NHS, as well as supporting their implementation. This experience could be shared as part of Ghanaian efforts to develop new guidelines, adapt international guidelines or to update existing ones. In addition, NICE could share experience of developing quality standards from guideline recommendations. Quality standards are sets of evidence-based, measurable indicators which may be linked to payment schemes to incentivise implementation and/or used as a basis for monitoring quality of care within a capitated environment.

NICE could work with MoH, providers and NHIA, to convene multistakeholder groups and establish long-running processes for identifying priority conditions (or practices) and developing evidence-informed quality standards for measuring and rewarding (or penalising) provider performance. The capitation pilots offer a unique opportunity to test out quality standards for major diseases and conditions, whereby providers sign up (with MoH's and NHIA's steer) to delivering on basic quality metrics within their capitated budgets and payers (and stewards of the system such as MOH) commit to monitoring performance and responding accordingly.

Strengthening capacity of local staff for monitoring and evaluation of health initiatives.

This is an important element health development and also relevant to major challenges facing in Ghana, as described above. Capacity to monitor impact is needed amongst decision makers, public health managers, as well as researchers and it involves several disciplines including epidemiology, health economics, and health service and system research. Such skills can be applied in, for example, impact evaluation of any initiatives to include the poor in the NHIS, assessment of advantages and risks of introducing any incentive measures to improve NHIS efficiency, and measurement of quality of care, as part of the initiatives suggested earlier.

Sharing experience and on-the-job-training (learning from case studies) may be useful, given that the Ghanaian health care system is significantly different from the health systems of the UK and Thailand. It is also necessary that capacity for such monitoring and evaluation is placed in not only NHIA (as a purchaser who wants to monitor and the impact of their investments) but also MOH (as a health system regulator), GHS (as a healthcare provider), academic institutes (as independent bodies with high academic integrity), and civil society (as a watchdog). We also suggest that international donors such as DFID and the WB can play an important role in supporting such capacity building activities amongst local stakeholders.

2.2.5 Joint initiatives to be considered

Funded activities

In order further to understand the issues, raise awareness amongst key stakeholders and scope out the feasibility, interest in and potential for impact of the benefit design/HTA, quality improvement/capitation and M&E training initiatives listed earlier, we propose the following activities in the short-term:

- A study tour to NICE, following on from the originally planned and twice cancelled tour of 2011/12, with a focus on quality and on HTA as well as the institutional infrastructure linking NICE to the NHS. A detailed outline for the study tour is in section 2.3 below

- Technical training, subject to needs identified during UK study tour, delivered in Accra and aimed at awareness raising as much as capacity building

- Regional awareness raising events such as AfHEA in March 2014 (on UHC) and Ghana National Health Service summit in April 2014

Activities for which funding is being sought

- Participation of Ghana NHIA and MOH in Gates/DFID/Rockefeller funded priority setting working group, led by the Centre for Global Development and aimed at developing, based on local experiences of policy makers from across the globe, a guide to the design and adjustment of benefits packages, drawing on the UK, Thailand and Chile amongst other countries.

Unfunded activities to be further scoped out

- A demonstration project in a specific high priority disease area for Ghana, bringing to together all key stakeholders in the Ghanaian system with NICE and its partners working alongside a local team to pilot evidence-based, inclusive processes in one or more of the following areas:

    - Benefit package design and adjustment, applying HTA methods and processes, with an additional parallel project on MeTA and governance. This may concentrate initially on exclusion and inclusion of products on the National Essential Medicines List or NHIA list

    - A quality improvement initiative, aiming at informing the capitation pilot and supporting the provider payment and fiscal sustainability reforms, in a key priority area, possibly incorporating HTA , (see above) and defining expected standards for high quality care and measurable quality indicators which may be used for monitoring or payment purposes.

Both demonstration projects would involve all stakeholders and include an implementation and impact evaluation plan.

- NICE support in one or more of these areas could be embedded within existing funders' projects, to help further ensure government ownership and longer term sustainability.

- Discussion with funders including Rockefeller who are currently supporting this work, as well as the World Bank, DFID and USAID about potential future collaboration is ongoing.

2.3 Study tour to NICE for Ghanaian colleagues

2.3.1 Background

Following the scoping visit, in conjunction with the Ghanaian colleagues we identified two key areas where NI experience could be applicable to Ghana, adding value to existing initiatives:

1. Helping to ensure the long term sustainability of the National Health Insurance Scheme at a time of coverage expansion, by strengthening processes and methods for making decisions on what is included in - and excluded from – the basic package of care, including through taking account of evidence of comparative clinical and cost effectiveness by applying HTA methodology to the Benefits Package design and adjustment.

2. Improving care quality, through the implementation of standard treatment guidelines, and the development and implementation of quality indicators and standards, drawing on international and Ghanaian guidelines of best practice and helping build a process for continuous improvement in quality in high priority services, through institutionalising decisions of what is considered good quality and how good quality can be enforced.

During the scoping visit, several Ghanaian colleagues expressed interest in visiting NICE, in order to learn about methods and processes in these two areas and share their experience. Furthermore, the proposed study tour follows on from discussions had with the MoH and NHIA of Ghana throughout 2012 and 2013, with a view to forging strong institutional links between our two countries' healthcare systems and addressing issues of technical priority in the context of the reforms.

We have begun the process of identifying and contacting the most appropriate colleagues to participate in the tour including key policy makers, and plan to hold this in London in mid-2014. A proposed outline of the study tour is given below.

2.3.2 Aims and objectives

The aim of the study visit is to learn about the institutional, procedural and technical aspects of priority setting and quality improvement in the British NHS as through specifically exploring the methods and processes of health technology assessment, clinical guideline and quality standard development and implementation and their applicability to the Ghana setting

The objectives will be to:

- Develop a draft road map for a set of activities jointly run between NICE and its partners and the Ghanaian leads, in the above areas, including identifying lead institutions on the Ghanaian side

- Discuss practical steps of how NICE can work with Ghana stakeholders to implement these activities in the context of the Rockefeller support

2.3.3 Suggested topics to cover

We will work closely with attendees to ensure the programme for the visit meets their needs, and helps address the healthcare challenges they face, in areas in which NICE has expertise. This might include:

- Assessment of the effectiveness and cost-effectiveness of health technologies (including, but not limited to pharmaceutical products), to inform both the national essentials drugs list and the National Health Insurance Scheme's (NHIS) reimbursement lists / basic package

- Development of quality standards to inform and facilitate the monitoring of care quality improvement initiatives in high priority (for Ghana) disease areas. The standards may include the appropriate use of health technologies

- The use of multi-stakeholder processes in the context of both of the above areas, with an emphasis on how technical support can help strengthen existing governance structures and ensure long term sustainability of the reforms.

We will plan for an array of colleagues, including senior management, academic and professional partners and technical experts to discuss their work with the Ghanaian delegation. If possible we will also aim to allow for a subset of delegates to attend a NICE decision making committee meeting and to discuss the role of NICE with the British Department of Health. In addition, we will allocate one day during the visit for all participating colleagues to discuss and develop an action plan/roadmap for implementing high-priority activities identified during the visit. The discussions will be facilitated by NICE International and the Rockefeller Foundation.

2.3.4 Proposed attendees

We propose to invite colleagues from the following organisations who, based on our discussions in Accra, we consider to the key players within the Ghana health sector, particularly in the areas of evidence-informed decision making and priority setting:

- Ministry of Health pharmaceutical services / Ghana National Drugs Programme
- National Health Insurance Agency
- Christian Health Association of Ghana
- Coalition of NGOs in health
- Ghana College of Physicians and Surgeons
- Ghana Health Service
- Ghana University School of Public Health

We also propose to invite senior colleagues from the World Bank office in Accra who are major partners in our work.

Duration: 3-4 days

Location: London, UK

2.4 Actions and next steps

Action	Who	By
Convene study tour to NICE for MOH, NHIA, GHS, civil society organisations and other relevant partners	NICE/HITAP	Summer/Autumn 2014
Review potential for longer term pilot incl lead Ghanaian institutions and funding sources	All. Working closely with MoH, NHIA and WB, DFID and Rockefeller	Throughout 2014

Other organisations identified, which it was not possible to meet during this visit, but which would provide useful further insight in the Ghanaian health care environment are:

- Centre for Health and Social Services (CHESS), University of Ghana – we have already had discussions with the head of CHESS in the context of the JLN
- Ghana Research Institute

We will make attempt to contact the Ghana Research Institute organisations for their views on any collaboration and, if appropriate, seek to include them in any joint work.

3. Success/Challenges

Success	What factors contributed to the success?	What can we learn for the future?
Have been able to meet with, and engage the interest of, a variety of organisations and individuals with the Ghana health sector	Ability and funding to visit in person. Support of local colleagues and funders (Rockefeller, DFID, WB) with knowledge of local environment to make relevant connections.	Scoping visits are useful means of gaining and updating knowledge of a country setting, and of building a strong contact base.

Challenges	How did/will you address it?	What can we learn for the future?
Ensuring the right mix of colleagues and organisations are present at the study tour.	The scoping visit allowed us to meet many influential figures, some of whom we plan to bring to London. We are also seeking advice from those with good local knowledge to ensure the right people, and mix of people are present.	
Maintaining the interest and engagement of local players	We continue to be in contact with key local figures, and have several local 'champions' who are keen to pursue a longer term collaboration with NICE, and who are well respected within the Ghanaian system. Investing in champion individuals and champion institutions is a key mechanism of delivering on our agenda.	

4. How it all fits together

4.1. Our proposed approach to working in Ghana reflects our overarching aims of strengthening institutions and processes to improve decision making, and ultimately health outcomes. It is consistent with RF's THS strategic objectives, in a number of key areas:

- NI adopts a systemic approach to its engagement, consistent with the approach outlined in the THS strategy. We have identified and will aim to work with organisations from across the entire health system, and promoting a multi-stakeholder approach to decision making, in particular in the key areas (for Ghana) of ensuring systemic financial sustainability of system, and improving systems for incentivising and implementing improved care quality.

- Building institutional capacity is an important focus of NI's work, and central to the THS strategy. Ghana is in a strong position, relative to other countries in SSA, in that it has existing and relatively long-standing institutions dedicated to the design, purchasing and delivery of healthcare. Through the work outlined here, we seek to

strengthen both technical a procedural capacity for setting healthcare priorities, and improving care quality, within these existing institutions. Furthermore, we will ensure Ghanaian leaders participate actively and benefit from the global public good and advocacy work planned under a Priority Setting grant currently under discussion with the Foundation.

- Fairer and more equitable allocation of resources is a key objective of the NHIA, lies at the core of NI's work, and aligns with THS aim of sharing the benefits of globalization more widely. Through further discussions with, and possibly training for colleagues at NHIA and other relevant organisations, we aim to strengthen technical and process capacity in this area. Such work, by freeing up resources currently utilised by wasteful and/or cost ineffective care practices, has the potential to improve availability, assess and affordability of care in Ghana generally and to improve equity of access to services under Ghana's NHIS, both stated key aims of THS.
- Overall, our work links well with additional initiatives funded by DFID and Gates (International Decision Support Network); can help leverage resources from other donors locally (DFID Ghana and World Bank) and is well aligned to the global agenda-setting and advocacy for priority setting led by the Rockefeller Foundation.

5. Links to top up funding

5.1. We anticipate that the knowledge gained and the connections made during both the scoping visit and the upcoming study tour will enhance the chances of a successful and fruitful long term partnership between NICE and colleagues in the Ghanaian health sector. With the continued support of the Rockefeller Foundation, and subject to sufficient demand being articulated by Ghanaian colleagues, we hope to be able to leverage these relationships and to continue to build momentum behind our joint work, by:

(1) Carrying out further awareness raising activities targeting senior policy makers and scoping out institutional partners. Such events include running a session at the African Health Economics Association (AfHEA) conference in March 2014
(2) Scoping the existing process for priority setting and the interface between payers, providers, universities and NGOs , to identify possible entry points for more extensive priority setting in Ghana especially in the context of the newly launched health financing reform
(3) Carrying out further training and awareness raising focusing on the process of evidence-informed priority setting on technologies (for NDP) and services (for NHIA) building on existing know-how of Ghanaian policy makers and previous work by LTM/SUPPORT (DFID, WHO) and also MeTA (DFID)
(4) Involving Ghanaian colleagues in the Priority Setting Working Group, to be convened jointly

through the RF top-up grant and iDSI grant contributing to global public goods and global advocacy events.

Appendix I – NICE and HITAP team

- Francoise Cluzeau, Associate Director, NI
- Derek Cutler, Assistant Project Manager, NI
- Yot Teerawattananon, Leader and Senior Researcher, HITAP
- Sripen Tantivess, Senior Researcher, HITAP
- Inthira Yamabhai, Researcher, HITAP
- Benjarin Santatiwongchai, Research assistant, HITAP
- Andreas Seiter, Senior Pharmaceutical Policy Specialist, WB

Appendix II – list of Ghanaian organisations and individuals met

Organisation	Individuals met
National Health Insurance Agency (NHIA)	• Mr. Nathaniel Otoo, Ag. Deputy Chief Executive (Operations) • Dr. Lydia Dsane-Selby, Director Claims • Dr.Anthony Gingon, Ag. Director, Quality Assurance • Mr Alex Nartey, Ag. Deputy Chief Executive (Finance and Investment) • Mr Edward Nunoo, Ag. Deputy Chief Executive (HR/Admin) • Mrs Constance Addo-Quaye, Ag. Dep. Dir, Credentialing &Quality Assurance • Mr Nicholas Osei-Afram, Ag. Deputy Director, Claims • Diana Oye Ahene Board Secretary
Ministry of Health and Ghana Health Service Directors	• Isaac Adams, Director RSIM, MOH • Dr Erasmus E A Aguno, PPME, Ghana Health Service • John Appiah, MOH • Samuel Boateng, Director Procurement and Supply, MOH • Alhaj Shaka Dumba, CTM, MOH • Herman Dusu, Director Finance, MOH • Martha Gyansa-Lutterodt, Chief Pharmacist, MOH/GHS

	• Dr Gloria Quansah Asare, Ghana Health Service • George Kumi Kyeremeh, Director of nursing and midwifery, MOH / GHS • Salemta Adbul Salem, Acting Chief Director MOH • Dr Afishah Zakariah, Director PPME, MOH
Ghana Health Service	• Dr Cynthia Bannerman, Deputy Director, Institutional Care Division (via telephone, 12 Nov 2013)
MoH Pharmaceutical services and Ghana National Drug Programme	• Martha Gyansa-Lutterodt, Director, Pharmaceutical Services, Ministry of Health/Ghana Health Service and member of the Expert Committee for the Selection of Medicines • Brian Adu Asare , Programme Officer, Ghana national Drugs Programme represented the Programme Manager, MOH • Prof Francis Ofei Physician Specialist and Chair of STG/EML review Committee University of Ghana medical School and head of department for Medicine at the University of Ghana Medical School • PhilipAnum - STG/EML Expert Committee member and Head of Drug information Resource Centre, MOH • Dr Albert Akpalu Specialist neurologist Member STG/EML Expert committee, university of Ghana medical School
Ghana Coalition of NGOs in Health	• Ken Wujangi, Coalition National Chairman • Cecilia Lodon-Senoo, Coalition National Vice-Chair • Patricia Porekuu, Coalition Coordinator
Ghana College of Physicians and Surgeons	• Prof. David Ofori-Adjei
School of Public Health, University of Ghana	• Prof. Irene Agyepong, Ghana University School of Public Health

Christian Health Association of Ghana	• Dr Gilbert Buckle, Executive Director, CHAG
Management Information Systems	• Perry Nelson , Dir Management Information Systems

<u>Donors / IFIs</u>	
DFID Ghana	• Ms. Susan Elden, Senior Health Adviser • Shamwill Issah, Health Adviser
World Bank Ghana	• Patricio Marquez, Lead Health Specialist and Human Development Sector Leader, Ghana • Lynne Margaret Henderson, Senior statistician • Evelyn Awittor, Senior Operations Officer • Andreas Seiter, Senior Pharmaceutical Policy Specialist • Erica Daniel, Operations Analyst
Rockefeller Foundation	• Mwihaki Kimura Muraguri, Associate Director

Additionally, Derek Cutler and Dr Sripen Tantivess attended and contributed to the NHIS 10th anniversary conference, held in Accra on 4th and 5th November 2013.

Appendix III – visit agenda

Agenda for the Visit of the UK NICE Delegation to Ghana, Sponsored by the Rockefeller Foundation and supported by the World Bank, October 29-31, 2013.

Meetings	
Tuesday Oct 29	
9:00-9:45 10:00-12:00	Meeting at WB to review agenda and discuss aspects of the visit. Mr. Sylvester Mensah, CEO, and Mr. Nat Otto, Deputy CEO, Ghana National Health Insurance Authority, and team. At GNHIA.
1:00-3:00	Dr. Marta Gyansa-Lutterodt, Director, Pharmaceutical Services, Ministry of Health/Ghana Health Service and members of the Expert Committee for the Selection of Medicines. At MOH.
16:00	Deputy Minister of Health, Dr. Ebenezer Appiah-Denkyira, Director General of the Ghana Public Health Service, and Directors of the Ministry of Health. The meeting would be at the Ministry of Health Conference room.

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Wednesday Oct 30	
09:00- 11:00	Ms. Susan Elden, Senior Health Adviser, DFID Ghana, and team. At WB office.
11:00-12:30	Dr (Mrs) Joan Awunyo-Akaba , Executive Director , Future Generations International (FUGI), Ho, Volta Region, GHANA. At WB office. This NGO is part of the WB Global NGO Consultative Group on Health, Nutrition and Population. A group of NGOs will also participate, including: Ken Wujangi - The National Chairman Ghana Coalition of NGOs in Health (The Coalition); Cecilia Lodonu-Senoo - Nat Vice-Chair, The Coalition; Patricia Porekuu - Nat'al Coordinator of the Coalition; Rosemary Anderson-Akolaa - Key player in the Oxfam NHIS Report; and Sidua Hor - Coordinator of Universal Health Campaign, for Ghana. Gabriel Dedu, Governance Specialist, WB.
14:00-15:30	Dr.Ofori Adjei, Rector, Ghana College of Physicians.
16:15-17-20	Lynne Margaret Henderson, Senior Statistician, WB. At WB Office.
Thursday Oct 31	
08.30	Dr Gilbert Buckle, Executive Director, Christian Health Association of Ghana
10:00-12:00	Dr. Irene Akua Agyepong, Health Systems Global Board Chair, University of Ghana School of Public Health. At University of Ghana.
15:00	World Bank team and wrap up. Evelyn Awittor, Patricio Marquez, Christabel Safe, Erica Daniel. At WB office