

GHANA: Striving toward universal health care by transforming care systems with Networks of Practice

Country Context

Through the years, Ghana has undertaken major steps to improve health outcomes, particularly by strengthening PHC. These include committing to PHC in 1978, adopting the Community-Based Health Planning and Services (CHPS) strategy in 1999, and implementing the Community Scorecard in 2018. More recently, Ghana has committed to achieving universal health care (UHC), with PHC at its core and funded by the National Health Insurance Scheme (NHIS) to minimize the impact of catastrophic health spending, especially among the poor.

The past two decades have seen Ghana strengthening PHC by investing in district hospitals and operating CHPS. Less investment was provided to health centers, which inadvertently broke down the critical referral link between the community and district health services. As a result, health centers became the weakest link in health service delivery. As of 2018, only 43% of health centers were fully equipped to provide PHC and by 2020, only 4% of health centers provided Basic Emergency Obstetric and Neonatal Care (BEmONC).¹ Moreover, the three layers of PHC facilities (i.e., district, health centers, and CHPS) were working in silos, only providing services to communities within their jurisdiction.

Cognizant of the breakdown in Ghana's gatekeeping system, the Ghana Health Services (GHS) proposed to upgrade health centers into Model Health Centers and set these facilities as the hub of networks of sub-district facilities. This idea of organizing PHC service delivery through Primary Care Provider Networks was piloted in ten networks in two districts from 2017 to 2019 with the goal of efficiently using resources to improve quality and coverage of PHC services. The pilot phase generated lessons that PCNs can:

- Be an effective mechanism to deliver quality PHC services to its communities
- Promote collaboration instead of competition, thereby resulting in cohesive services across facilities
- Create an environment for effective task-shifting
- Facilitate effective technical support and promote mentoring
- Increase and result in more effective NHIS reimbursements
- Re-establish and improve referral arrangements and feedback rate, which promote greater client satisfaction

Building on these lessons, GHS was tasked to scale up PCNs by organizing 52 networks in ten districts between 2020 and 2021. Now called Networks of Practice (NOPs), GHS has identified that community participation in the network is critical in generating demand while also strengthening the capacity and leadership of health centers as effective hubs of the network. GHS created core resource teams and developed tools to support the networks. The agency also commissioned implementation research on the equity value of PCNs.

¹ Ghana Health Service and Ministry of Health. Concept Notes on Networks of Practice. March 2022.

Currently, GHS is leading the nationwide implementation of NOPs, described as groups of facilities (both public and private) organized as hubs-and-spokes, connected to each other functionally to maximize efficiencies, and designated to serve specific geographic areas. This design is founded on Ghana's three-tier district health system, with particular focus on subdistrict health facilities (health centers and CHPS) while keeping the District Health Management Teams and district hospitals as key support in technical matters and referral system.

Despite current efforts in scaling up PCNs, health centers continue to work in silos without any support from surrounding facilities. Each facility is focused only on its specific catchment population, which is the basis for its performance target. There is no policy that compels them to work together. On the contrary, they compete with one another in getting more clients, since they are paid through capitation as individual facilities and not as a network. District-level leaders also deal with sub-district level facilities directly since these facilities have weak leadership. This further supports the individualistic behavior sub-district health facilities. Health center managers are supposed to oversee CHPS, pharmacies, infirmaries, health work force in marketplaces, sick beds in schools, etc. Finally, community members themselves reinforce the idea that health centers operate in silos by being possessive with their own health facility.

The Implementation Case

The Ghana NOP IC team joined the PHCPI COP in March 2022 with a vision of health facilities at the sub-district level working together as one entity to meet the health needs of the people by providing a package of quality essential health services within five years. To achieve this end, the IC team wanted to learn how to (1) transform the sub-district structure to promote leadership in a network arrangement; (2) shift the culture among health workers to promote co-responsibility in attaining the health outcomes; (3) change the appraisal mechanism from a facility- focused system to network-focused system; and (4) organize the facilities into a network and improve how facilities and health providers are paid in such an arrangement.

The IC team also set out the following short-term goals in this Learning Exchange:

- Develop policy guidelines to guide the operations of NOP within Ghana's health system.
- Mobilize community leadership to provide support for the NOP.
- Improve the capacity of district and sub-district leadership to provide better coordination for all facilities within NOP and at the district level.
- Improve resource allocation for NOP rather than facilities within sub-districts to enhance shared needs and distribution.

The IC team discussed the causal chain for each of these outcomes to establish a collective understanding between the IC team members and the peer learners on critical activities to achieve them. For instance, developing the operation guidelines for the NOP implementation would require creating a team who would review related policies, draft the policy, and disseminate it for stakeholder comments before finalization. Mobilizing community leaders meant identifying them, orienting them on the objectives of the NOP (particularly in terms of resource sharing), and signing a Memorandum of Understanding with them. Improving the capacity of district and sub-district leadership to lead and manage the NOP would require designing the training program and training the identified district and sub-district leaders. Resource allocation for NOP would require a needs assessment for the entire network and the prioritization of component facilities' needs. Each of these outcomes became the theme of the monthly Learning Checks with the IC team and assigned peer learners.

During the monthly Learning Checks, the Ghana IC team highlighted their progress towards achieving their identified goals for this Learning Exchange. Achievements included:

- Director of PPMED and team visiting two implementation sites to assess practical inputs into draft guidelines.
- Drafting, then socializing NOP operational guidelines among Regional Directors for input and to draw from lessons in piloting NOP in their area.
- Mobilizing community leaders to support the implementation of the networks.
- Improving leadership capacity within the NOP.
- Drafting guidance for resource allocation across health facilities in the network.

Key Lessons and Insights

The IC team identified several milestones in scaling up the NOP during the Learning Exchange, including:

- An increased sense of ownership/commitment by policymakers and implementers in the NOP/PCN strategy. Stakeholders who support the implementation of NOPs include Regional Directors of Health Services, District Directors of Health Services, Medical Directors, Health Center leads, Private Facilities, communities, civil society organizations, and agencies of the Ministry of Health. Commitment and buy-in are particularly important since the NOPs are purely functional arrangements and not administrative.
- Improved collaboration and sharing of resources (e.g., human resources, supplies) among public, private, and faith-based facilities thereby promoting teamwork.
- Reduced NHIS-denied claims as each network jointly vetted their claims resulting to increased revenue for the facilities.
- Improvement in referral system through use of common communication platforms (e.g., WhatsApp, teleconsultation, and written and oral feedback).
- Large scale consultation with over 400 participants from professional and governance clusters in three regions to finalize the operational guidelines.

Key Lessons

The IC team realized that **consultation with various stakeholders was crucial** to the development of the operational guidelines. The consultative process was interactive, with the goal of getting everyone's inputs. The consultation process also illuminated issues that were originally not included in the subdistrict package, including telemedicine, task shifting, and outreach services.

The IC team also found that **an adaptive approach in establishing NOPs was useful** as it allows the implementors to tailor services according to local context. This approach was particularly effective as the implementors faced challenges in setting up NOPs in areas like sensitization/orientation of participating facilities, building skills and competencies, provision of infrastructure or equipment, appropriate mix of skilled staff, as well as leadership and governance issues. Communicating changes being made in an adaptive approach is particularly important when setting up NOPs.

Engaging the community in the design and implementation of NOPs was also identified as a crucial element of success. Community participation is not only important in generating demand for health services but also important in holding the NOP accountable through the Community Score Card.

While funding for the NOP remains a challenge, the team has been collaborating with many partners including World Bank, USAID, and Ministry of Finance to explore financing options.

Insights from Peer Learning Process

The IC team appreciated the inputs received during the bi-monthly Learning Exchanges and monthly Learning Checks. They referenced these presentations during consultations with stakeholders as they worked to fine-tune the NOP operational guidelines. They applied some of the questions in the learning sessions to evaluate their implementation sites. The IC team also appreciated learning from other countries' experience, which validated what the team was doing and gave them the patience to proceed progressively. They are confident that they will continue to use the discussions and experiences that were shared in shaping the implementation of their NOP policies.

The IC team expressed appreciation of the safe peer learning environment, where they felt encouraged to share their challenges without fear or embarrassment.

Next Steps

Moving forward, the IC team will continue to:

- Finalize the NOP operational guidelines,
- Work with Regional Directors of Health Services, development partners, other government agencies, civil society organizations, service providers, faith-based organizations, National Health Insurance Authority, and other state agencies to scale up the implementation process,
- Collaborate with various stakeholders to enhance the service capacity of health centers and other facilities, build capacity of NOP leaders, and strengthen community participation,
- Advocate for policy change with other government agencies (e.g., group credentialing and accreditation of NOPS with the National Health Insurance Authority and the Health Facilities Regulatory Agency),
- Develop policies in funding NOPS as a unit along with capacity building for fundholding and financial management,
- Strengthen research and documentation to guide the nationwide roll-out and to improve for global learning.

Future Learning Agenda

The IC team has identified three future learning topics to support the implementation of the NOP:

1. **Exploring financing for PCNs and identifying suitable provider payment mechanisms.** This will support their continuing engagement with NHIA to align the benefit package with NOP design, particularly in terms of task sharing, revenue sharing, and financing of preventive services.
2. **Understanding PCN governance and fund management,** particularly in defining the roles of component facilities of the network, establishing the decision-making process in the network, and identifying accountability in financial management and service delivery. This is particularly important since NOPS are functional arrangements and not administrative. Member facilities of the network find the arrangement difficult to separate, making implementation murky.
3. **Methods for operationalizing and scaling up PCNs.** This is topic is of interest as GHS leads the nationwide roll-out of NOPS in the country.