PRIMARY HEALTH CARE (PHC) FINANCING IN GHANA

Using The National Health Accounts 2023

A Policy Brief

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1 INTRODUCTION

1.1 Background and Context

Primary Health Care (PHC) emerged as a revolutionary concept in global health policy following the 1978 Alma-Ata Declaration. This landmark agreement, adopted by the World Health Organization (WHO) and its member states, defined PHC as essential health care based on practical, scientifically sound, and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford [1]. The declaration emphasized the importance of addressing social and economic determinants of health, promoting community participation, and ensuring equitable access to health services. In the decades following Alma-Ata, the implementation of PHC faced numerous challenges, including resource constraints, political instability, and the rise of selective primary health care approaches [2].

However, the WHO and health development partners have continued to advocate for comprehensive PHC, recognizing its potential to address health inequities, achieve Universal Health Coverage (UHC) and the Sustainable Development Goals (SGDs) through reforms in health service delivery, public policy, leadership, and universal

coverage [3, 4]. The COVID-19 pandemic has also highlighted the critical role of strong PHC systems in responding to health crises and maintaining essential health services. As a result, there is growing recognition of the need to invest in PHC to build resilient health systems capable of addressing current and future health challenges through an integrated approach [5] encompassing preventive, promotive, curative, rehabilitative, and palliative care.

1.2 Primary Health Care in Ghana

The PHC approach has garnered considerable attention from key health stakeholders in Ghana and many other developing nations. This focus on PHC has been instrumental in achieving significant progress towards UHC and improving both geographical and financial access to healthcare services. While some PHC activities are present within secondary and tertiary care settings through public health interventions, the Community-based Health Planning Services (CHPS) initiative, which was adopted in 1999, epitomizes PHC implementation in Ghana. This initiative represents a strategic shift in primary healthcare and family planning delivery [6] with an aim of transitioning the country from a reliance on clinical care at district and sub-district levels to a new emphasis on providing convenient, high-quality services directly within communities and at patients' doorsteps.

The primary strength of the CHPS concept has been discussed in some studies [7] as its efficacy in bridging geographical barriers to healthcare access across Ghana. In addition, it has been praised for ensuring that basic healthcare services are available throughout the country, with a particular focus on addressing local health conditions through essential preventive, promotive, and curative services. Consequently, CHPS has remained the flagship PHC implementation policy in Ghana and an integral component of the nation's healthcare delivery system.

Despite the clear benefits and strategic importance of PHC, a significant challenge in the design and implementation of PHC interventions, in LMICs like Ghana, has been the scarcity of resources, the ambiguity surrounding who bears the cost of these initiatives and lack of strategic coordination (content & implementation) of external aid [8, 9]. These challenges point to the dilemma paused by The Alma-Ata Declaration on PHC [1] which suggests that the cost of essential services should be affordable for the community and country to maintain at every stage of development. This therefore, creates a situation where each country needs to assess the resources attached to PHC in relation to who finances the interventions, how the resources are pooled, who provides these PHC services and how they are distributed amongst the population.

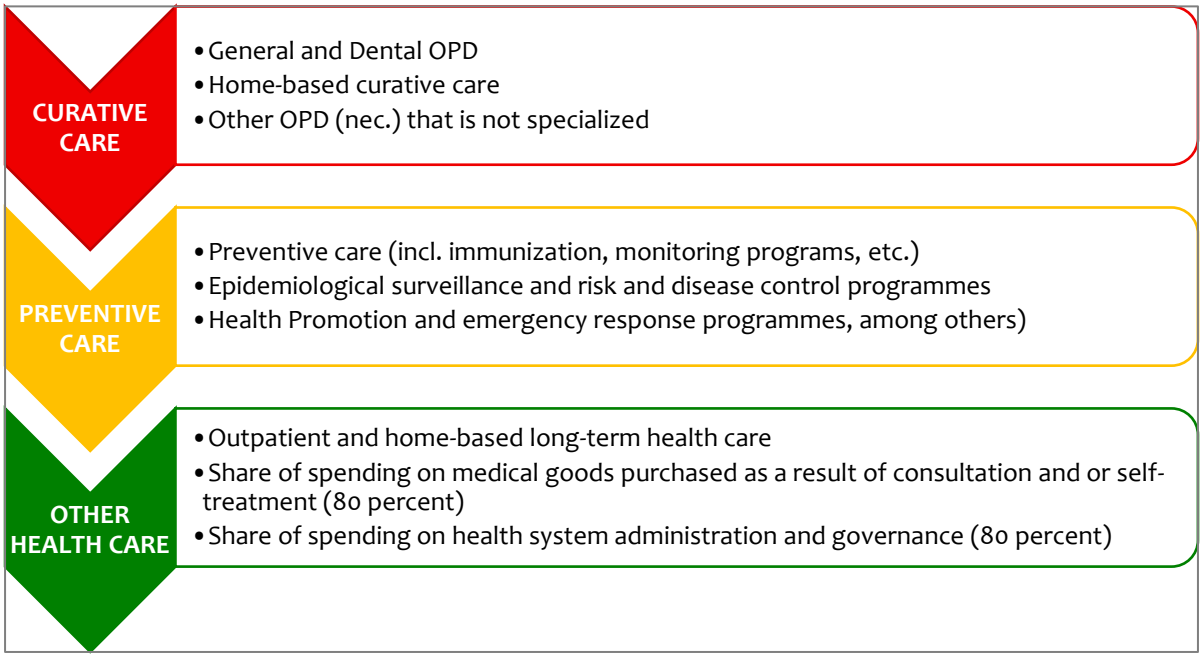
1.3 Purpose and Scope of the Policy Brief

This policy brief offers a comprehensive analysis of Primary Health Care (PHC) financing in Ghana covering the period from 2021 to 2023. It utilizes the System of Health Accounts (SHA-2011) framework, which employs a three-dimensional

approach to examine healthcare financing, service provision, and consumption within a country over a specified period. The brief synthesizes the most recent National Health Accounts (NHA) data available for Ghana.

This brief will follow the methodological framework developed by WHO as guidance for PHC [10], which is premised on the recognition that measuring PHC expenditure is complex and goes beyond simply identifying spending by "primary care facilities". Thus, it follows a functional approach which recognizes that PHC activities, such as preventive care or outpatient medical goods, can be financed or delivered by various entities beyond traditional health centres, thereby capturing these expenditures more comprehensively. And since this methodology is internationally accepted, this brief ensures methodological consistency and enhanced international comparability of the findings for Ghana. The key services considered as PHC are shown in the Figure 1 below.

Figure 1: Framework for assessing PHC financing



Source: Adapted from WHO (2021)

Using the above approach, the brief will provide information that can assist health care management in the country to effectively monitor and optimize PHC financing in Ghana. This approach further underscores the need to fully institutionalize the National Health Accounts reporting framework in the country. The enhanced level of data detail provided through the National Health Accounts extends beyond administrative purposes and constitutes a critical foundation for the formulation of targeted policies. It will also promote more efficient allocation of resources within the health sector and enable more accurate international comparison of Ghana's investment in primary health care. Collectively, these measures will contribute to the development of a stronger and more resilient health system that serves all citizens.

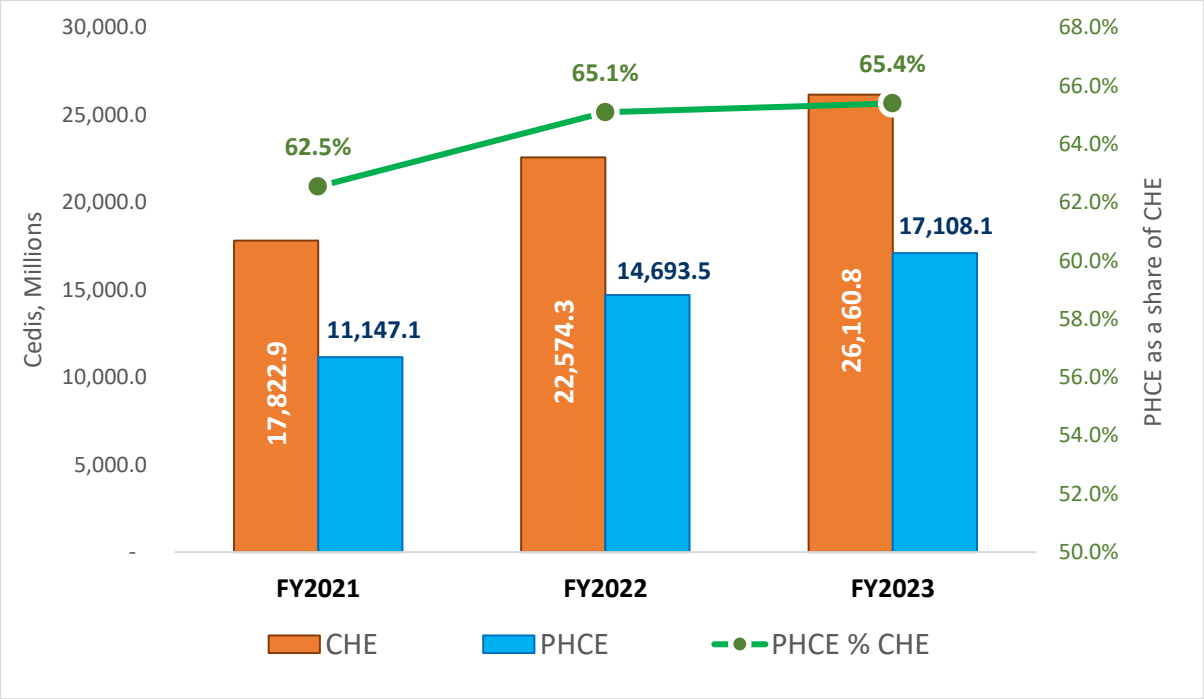
2 FINANCING

2.1 General Current Health Financing for PHC

The NHA findings (Figure 2) show that Ghana's Current Health Expenditure (CHE) has demonstrated a consistent upward trajectory over the observed period, which started at GHS17.8 billion in 2021, increasing to GHS 22.6billion in 2022 and culminating in GHS26.16billion in 2023. At the same time, Primary Health Care Expenditure (PHCE) has also shown growth, although with a slight dip in the final year of analysis (2023).

PHCE rose from GHS11.1billion in 2021 to GHS 14.7billion in 2022. However, it experienced a marginal decrease to GHS 17.1billion in 2023, despite the continued rise in overall CHE. This is represented by the PHCE as a share of CHE (PHCE % CHE) metric (green line), which indicates health spending dedicated to primary healthcare. PHCE % CHE was 62.5% in 2021, which increased to 65.1% in 2022 and further to 65.4% in 2023 as shown in Figure 2.

Figure 2 PHC expenditure trends in Ghana



While the continued growth in CHE indicates an overall increase in health sector spending, the rate of growth of PHCE suggests a growing commitment to financing primary healthcare over the three-year period at a reduced pace.

A deeper analysis, regarding PHCE per capita, when measured in Ghana Cedis (GHC), showeda notable increase from GHC361.9 in 2021 to GHC465.0 in 2022, and further to GHC 529.7 in 2023 (Table 1). This suggests a growing nominal per-person investment in PHC. However, when PHCE per capita is converted to US Dollars (USD), a contrasting trend emerges. It decreased from USD 60.3 in 2021 to USD 54.2 in 2022,

and significantly dropped to USD 44.6 in 2023. This decline in USD terms, despite the increase in GHC, points towards the impact of exchange rate fluctuations and potential depreciation of the local currency, which can diminish the real value of health spending, particularly concerning imported goods and services that are necessary for PHC interventions.

Table 1 Trends of expenditure in NCDs in Ghana

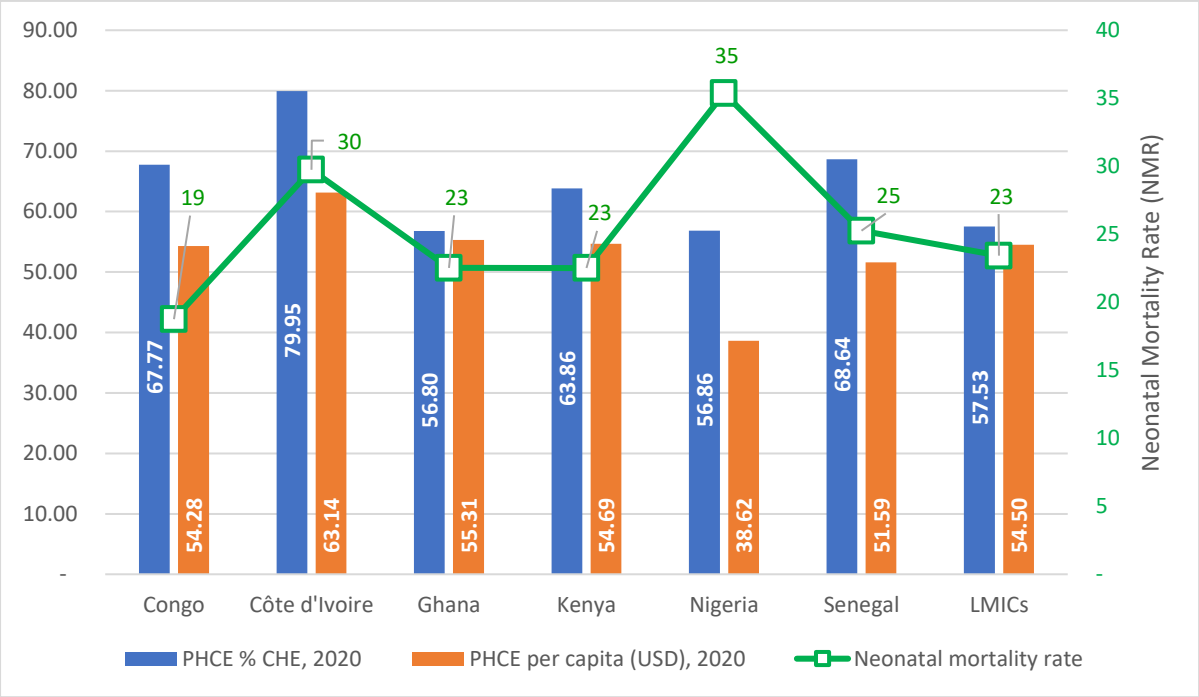
Key Indicator	Units	2021	2022	2023
CHE	GHC, Million	17,822.9	22,574.3	26,160.8
PHCE	GHC, Million	11,147.1	14,693.5	17,108.1
PHCE % CHE	Percent	62.5%	65.1%	65.4%
Population	Millions	30.8	31.6	32.3
PHCE per capita	GHC	361.9	465.0	529.7
PHCE per capita	USD	60.3	54.2	44.6

Ghana's consistent increase in PHCE as a percentage of CHE, reaching 65.4% in 2023, aligns positively with the recommendation of the WHO [11] that a significant portion of health expenditure be directed towards primary healthcare. Primary healthcare is recognized as the most equitable, efficient, and cost-effective approach to achieving health for all. This trend demonstrates a strategic prioritization of foundational health services, which is vital for strengthening health systems and achieving SDG 3 with associated targets on UHC, financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all [12].

In comparison with other peer-countries (Figure 3), Ghana allocated 56.80% of its CHE to PHCE in 2020, placing it within the mid-range among the selected countries. While this figure is in the range as that of Kenya (63.86%) and Senegal (68.64%), it is remarkably lower than Côte d'Ivoire (79.95%) and Congo (67.77%), as well as Nigeria (56.86%). The average PHCE as a share of CHE for the depicted LMICs stands at 57.53%, suggesting Ghana is marginally below the average for this specific cohort.

In terms of PHCE per capita (USD), Ghana recorded $55.31 in 2020 which positions Ghana favorably compared to Congo ($54.28), Kenya ($54.69), Nigeria ($38.62), and Senegal ($51.59). Côte d'Ivoire, however, stands out with a significantly higher PHCE per capita of $63.14. The average PHCE per capita for the LMICs presented is $54.50, indicating Ghana's per capita investment in PHC is slightly above this average.

Figure 3 PHCE as a share of CHE and PHCE per Capita for selected countries



Source: Global Health Expenditure Database

Examining both expenditure metrics and outcome indicators provides a clear perspective on Ghana's health financing prioritization and performance relative to other LMICs. This approach offers valuable insight into the country's progress and highlights areas for potential improvement in primary healthcare investment and impact. For instance, a country like Côte d'Ivoire which spends more than Ghana in terms of PHCE per capita and PHCE % CHE but has a higher NMR (30) compared to Ghana's NMR of 23 indicates that Ghana has a better system in utilizing available PHC resources efficiently. However, the LMICs picture, where in general the average NMR is 23 (similar to that of Ghana) yet Ghana spends more in terms of PHCE per capita shows that there is still room for improvement as far as efficient utilization of PHC resources is concerned.

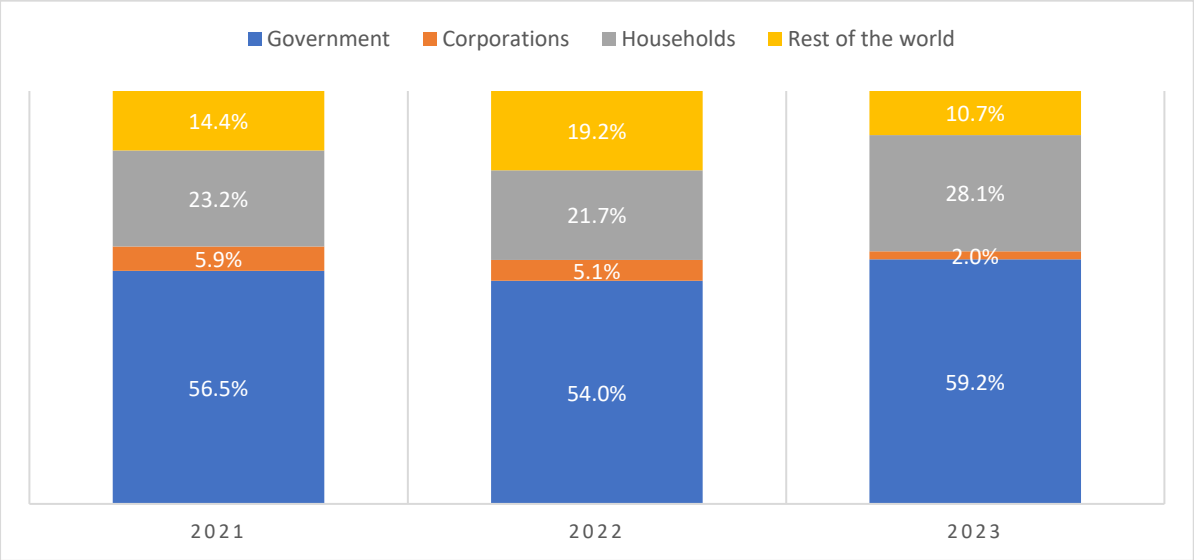
In summary, the PHCE per capita of $55.31 places Ghana above the average for the selected LMICs, suggesting a commendable per-person investment. This is vital for translating financial commitment into tangible services, such as access to essential medicines, routine immunizations, and skilled health workers, all crucial components of UHC. However, the varying neonatal mortality rates across countries, despite similar PHC financing levels in some cases, underscore that financial input alone does not guarantee optimal health outcomes. Factors such as the efficiency in spending, governance, equity of access, quality of care, and broader social determinants of health play equally critical roles [5, 9].

2.2 Financing Sources for PHC

Government funding consistently remained the largest contributor to PHC financing throughout the period. In 2021, government spending accounted for 56.5% of PHC funding which slightly decreased to 54.0% in 2022, before notably increasing to 59.2% in 2023 (Figure 4). This indicates a reinforced commitment to public financing of PHC in the most recent year. Households represented the second largest source of PHC financing even when this was characterised by fluctuation. The contribution of households was 23.2% in 2021, decreasing to 21.7% in 2022, and then rising significantly to 28.1% in 2023, which might suggest that there is a growing reliance on out-of-pocket payments or private household expenditures for PHC services in the most recent year.

The Rest of the World (representing external funding/aid) played a substantial, though varying, role. The NHA findings show that the external aid contributed 14.4% in 2021, which increased to 19.2% in 2022, and then experienced a considerable reduction to 10.7% in 2023. This fluctuation highlights the variable nature of external support. Lastly, private corporations consistently contributed the smallest share to PHC financing in Ghana. Their contributions amounted to 5.9% of all PHCE in 2021, declining to 5.1% in 2022, and further to a minimal 2.0% in 2023. This might indicate a possible diminishing role for corporate funding in Ghana's PHC landscape over these three years or its inability to share health expenditure information to enable granular analysis.

Figure 4 Financing Sources for PHC in Ghana



Overall, Ghana's predominant reliance on Government funding for PHC, particularly its strong rebound to 59.2% in 2023, is a positive development. This is because it aligns with WHO recommendations which emphasize the country's responsibility in ensuring health equity and financial protection [11]. However, the concurrent increase in Household contributions to 28.1% in 2023 is a matter of concern. If a significant portion of household contribution comprises out-of-pocket (OOP) expenditures, it could pose

be a major barrier to UHC by pushing vulnerable populations into poverty and deterring access to necessary care [13].

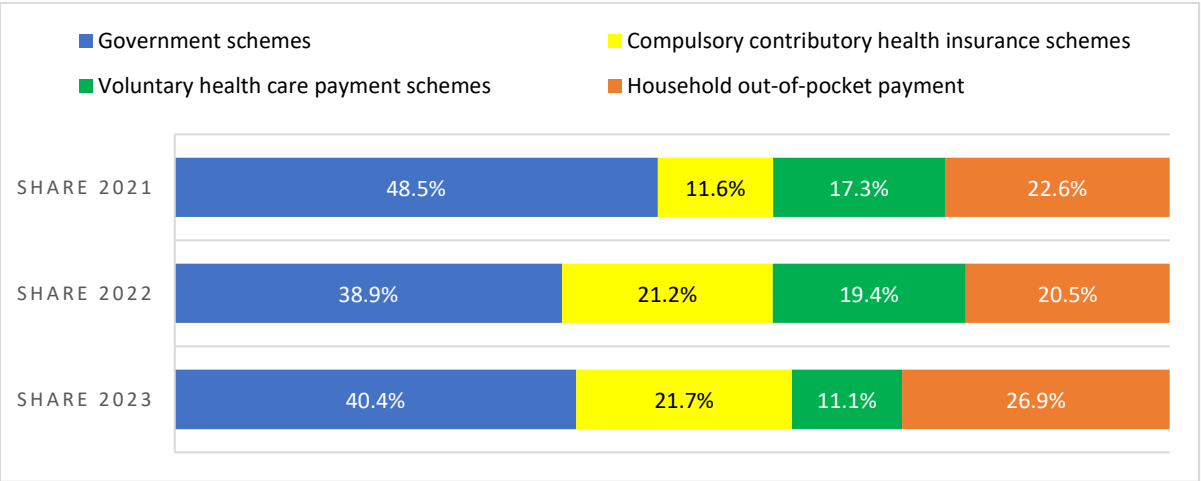
The fluctuating and ultimately declining contribution from the Rest of the World underscores the need for Ghana to build more resilient and domestically driven financing mechanisms. This is because, while external aid can play a crucial supplementary role, over-reliance can create instability in funding streams. Similarly, the marginal and diminishing role of Corporations suggests an untapped potential for private sector engagement and contributions to PHC financing, which could be explored through innovative partnerships or targeted levies.

2.3 Financing Schemes for PHC

Financing schemes refer to the mechanisms through which health resources are collected and pooled to pay for health services. Findings show that the Government schemes constituted the largest share of PHC financing in 2021, accounting for 48.5%, which decreased to 38.9% in 2022, before slightly recovering to 40.4% in 2023 (Figure 4). Compulsory contributory health insurance schemes demonstrated a consistent upward trend in its contribution to PHC financing. Starting at 11.6% in 2021, the contribution of compulsory contributory health insurance schemes nearly doubled to 21.2% in 2022 and further increased to 21.7% in 2023.

Household out-of-pocket payment remained substantial, and in the most recent year, growing source of PHC financing. After contributing 22.6% in 2021, household OOP share slightly decreased to 20.5% in 2022, but significantly increased to 26.9% in 2023. This surge in 2023 highlights an elevated financial burden directly borne by households for PHC services. Conversely, the voluntary health care payment schemes showed a declining trend with contribution at 17.3% in 2021, which increased to 19.4% in 2022, but experienced a sharp drop to 11.1% in 2023.

Figure 4 Financing Schemes for PHC in Ghana



These findings highlight predominance of government-led resource pooling mechanisms throughout the period under review. This aligns with the WHO recommendation which emphasizes that increased domestic public financing for health is generally considered the most equitable and sustainable pathway to achieving UHC by reducing reliance on regressive financing mechanisms like out-of-pocket payments [11, 14]. The increasing share of Compulsory contributory health insurance schemes (rising from 11.6% to 21.7%) is a positive development, as it represents a move towards risk-pooling and potentially greater financial protection for beneficiaries.

The diminishing role of Voluntary health care payment schemes further consolidates the need for robust mandatory or publicly funded mechanisms. To advance towards UHC goals and effectively meet the health-related SDGs, Ghana must intensify efforts to strengthen and expand compulsory contributory health insurance scheme, ensuring broader population coverage and more comprehensive benefit packages for PHC.

2.4 Financing Agents for PHC

General Government (mainly central government) consistently remained the dominant financing agent, accounting for over 60% of total PHCE in all three years (60.1% in 2021 and 2022, increasing to 62.0% in 2023). The Social Security Agency's share of management increased, more than doubling its share from 10.0% in 2021 to 19.7% in 2023, indicating a growing role for social health insurance in PHC financing.

Households, on the other hand, represented the second largest financing agent, with its share increasing from 22.6% in 2021 to 26.9% in 2023. The share of Non-profit Institutions Serving Households (NPISH) increased from 12.1% in 2021 to 15.1% in 2022, before decreasing to 9.3% in 2023 (Table 2). Insurance Corporations and Corporations (Other than insurance corporations) consistently contributed smaller proportions to PHC financing, with shares generally declining over the period.

Table 2 PHCE by financing agents in Ghana

	2021		2022		2023	
Financing Agents	Amount (GHC, Millions)	Share (%)	Amount (GHC, Millions)	Share (%)	Amount (GHC, Millions)	Share (%)
General government	6,702.7	60.1%	8,829.3	60.1%	10,611.1	62.0%
- Central government	*5,593.1*	*50.2%*	*6,576.7*	*44.8%*	*7,249.3*	*42.4%*
- Social security agency	*1,109.5*	*10.0%*	*2,252.6*	*15.3%*	*3,361.8*	*19.7%*
Insurance corporations	344.8	3.1%	359.3	2.4%	219.9	1.3%
Corporations (Other than insurance corporations)	229.7	2.1%	271.1	1.8%	80.6	0.5%
Non-profit institutions serving households (NPISH)	1,351.3	12.1%	2,220.2	15.1%	1,594.7	9.3%

	2021		2022		2023	
Financing Agents	Amount (GHC, Millions)	Share (%)	Amount (GHC, Millions)	Share (%)	Amount (GHC, Millions)	Share (%)
Households	2,518.6	22.6%	3,013.5	20.5%	4,601.8	26.9%
TOTAL PHCE	**11,147.1**	**100.0 %**	**14,693.5**	**100.0%**	**17,108.1**	**100.0%**

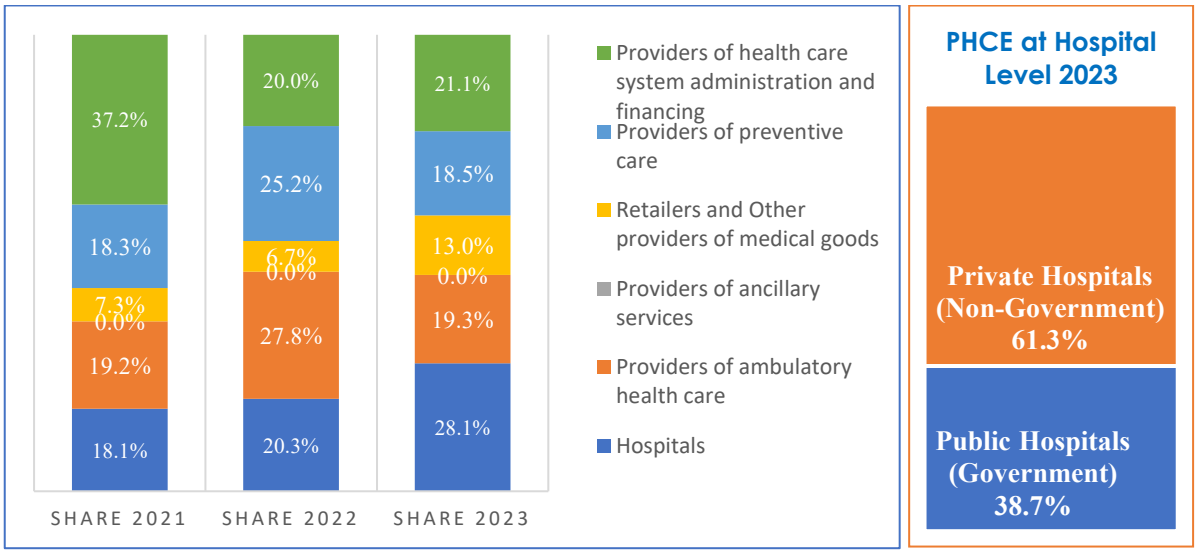
In summary, Ghana's predominant reliance on the General Government as the leading financing agent is generally positive, as government management of PHC resources is key in ensuring that available financing is aligned to government priorities without duplication of effort. The substantial increase in the Social Security Agency's share (from 10.0% to 19.7%) within the general government contribution is particularly encouraging. This reflects a commendable strengthening of social health insurance mechanisms, which are crucial for risk pooling and reducing financial barriers to access, directly contributing to SDG 3, Target 3.8 on financial risk protection.

2.5 Providers of PHC services

The NHA findings show that, from 2021 to 2023, the distribution of PHC service providers in Ghana underwent notable shifts. In 2021, administration and financing providers held the largest share (37.2%), with hospitals and ambulatory care providers each accounting for around 19%, and preventive care at 18.3%. By 2022, ambulatory care significantly increased to 27.8%, becoming the largest category, while preventive care also grew to 25.2%, and administration's share dropped to 20.0%. Hospitals saw a slight rise to 20.3% (Figure 5).

In 2023, hospitals emerged as the leading provider at 28.1%, suggesting a possible re-centralization of care. Providers of ambulatory care maintained a substantial presence at 19.3%, administration remained stable at 21.1%, and preventive care providers decreased to 18.5%, while the contribution from retailers of medical goods increased to 13.0% in 2023. For 2023, majority of services were provided through non-government hospitals (61.3%) as compared to government hospitals at 38.7%).

Figure 5 Providers of PHC Services in Ghana



The fluctuations in the shares of different providers highlight areas of both progress and concern. For instance, the initial high share of "Providers of health care system administration and financing" in 2021 might suggest a significant portion of PHC expenditure was directed towards administrative overhead (during COVID-19 period) rather than direct service delivery, which, if high, could be an inefficiency.

The increase in ambulatory healthcare providers in 2022 signified promoted decentralized, community-level care but the subsequent rise of hospitals as the primary provider in 2023 suggests a potential re-hospitalization of PHC services. This trend may contradict the ideal model of community-based PHC, which aims to reduce reliance on expensive hospital care and improve care continuity [11]. Therefore, stakeholders should design policies to optimize the PHC service provider-mix, ensuring equitable access, affordability, and quality across the PHC continuum [15], while reducing unnecessary reliance on higher-cost hospital settings for services deliverable at the primary level.

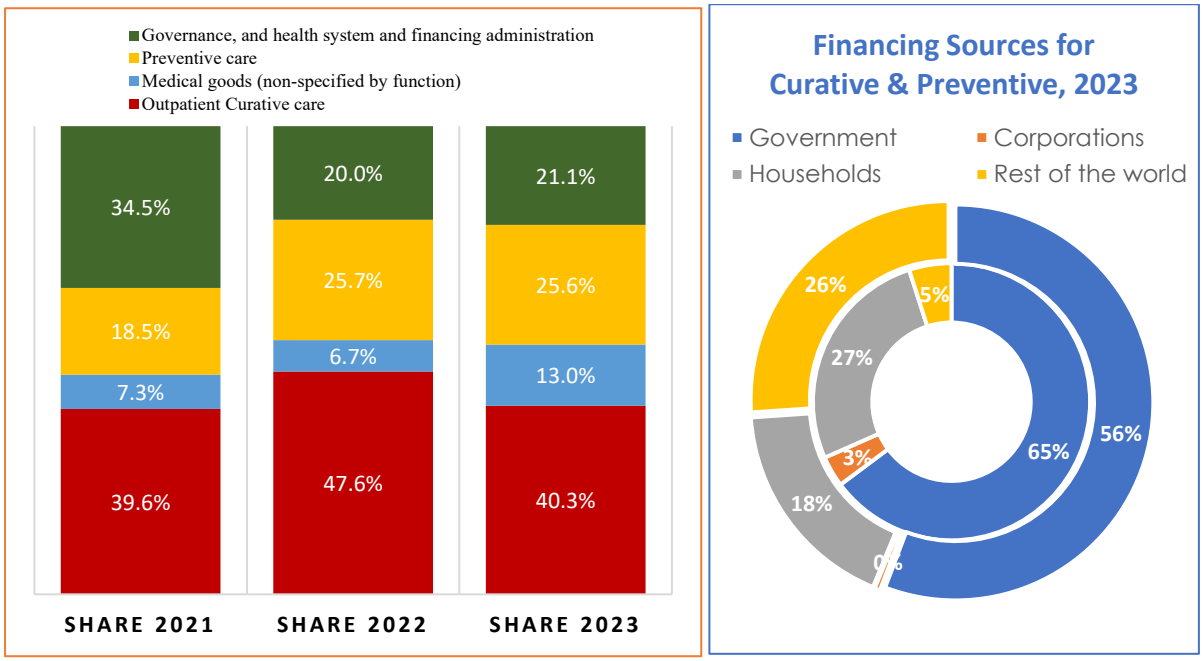
2.6 Services Provided for PHC

Analysis of the NHA data from a PHC service provision perspective shows that in 2021, outpatient curative care constituted the largest share at 39.6%, closely followed by Governance, health system, and financing administration at 34.5%. Preventive care accounted for 18.5%, and medical goods for 7.3% (Figure 6). In 2022, outpatient curative care increased significantly to 47.6%, maintaining its dominance as the largest share. Preventive care expenditure also increased to 25.7%, while Governance/administration decreased to 20.0%, and the share of medical goods dropped to 6.7%.

In 2023, outpatient curative care slightly decreased to 40.3%, but remained the largest component. The share of preventive care services remained substantial at 25.6%

whereas governance and administration saw a slight increase to 21.1%, and medical goods notably increasing to 13.0%.

Figure 6 Services provided for PHC in Ghana



The consistent dominance of curative care as the largest component of services delivered from 2021-2023, coupled with a notable share for preventive care, indicates Ghana is dedicating significant resources to direct treatment and disease prevention, both foundational aspects of PHC [11]. However, the considerable proportion allocated to governance/administration suggests a need to ensure administrative efficiency and that these expenditures directly support service delivery.

On financing these PHC services, the Government's leading contribution (inner ring/ curative) is commendable and aligns with WHO's call for increased domestic public financing to achieve sustainable UHC and reduce reliance on OOP payments. However, the substantial contribution from Households (27% in the inner ring) raises concerns about financial hardship. High out-of-pocket payments can create significant barriers to accessing necessary curative and preventive services, pushing vulnerable populations into poverty and undermining the principle of UHC.

The outer circle (preventive care) shows that external aid has more influence on this than on curative care (inner circle). The implication is that if these external aid resources are off-budget, then, there is a likelihood of misalignment of preventive care interventions (crucial to PHC Agenda) to government priorities and this is a possible stumbling block to sustainability effort in PHC financing for Ghana.

2.7 Service Consumption under PHC

Infectious and parasitic diseases consistently commanded the largest share of PHC expenditure, though its proportion steadily decreased from 54.3% in 2021 to 52.1% in 2022, and further to 48.1% in 2023 (Table 3). Despite this decline in share, the nominal expenditure on these diseases increased annually.

Noncommunicable diseases (NCDs) represented the second largest category, showing a continuous increase in both nominal expenditure and percentage share, rising from 20.0% in 2021 to 22.9% in 2022 and reaching 23.1% in 2023. This trend indicates a growing focus or burden of NCDs within PHC.

The reproductive health conditions maintained a stable share, fluctuating between 13.9% and 15.6% across the period, with a consistent increase in nominal spending. Expenditure on nutritional deficiencies on the other hand, saw a significant proportional increase, rising from 5.8% in 2021 to 9.5% in 2023, nearly doubling its share, alongside a substantial increase in nominal terms. The injuries consistently received the smallest allocation, and its share of PHC expenditure steadily declined from 5.2% in 2021 to 3.7% in 2023, with nominal spending also decreasing in 2023.

Table 3 PHCE by disease conditions in Ghana

	2021		2022		2023	
Disease Conditions	Amount (GHC, Millions)	Share (%)	Amount (GHC, Millions)	Share (%)	Amount (GHC, Millions)	Share (%)
Infectious and parasitic diseases	6,054.0	54.3%	7,658.7	52.1%	8,225.8	48.1%
Reproductive health	1,637.2	14.7%	2,044.1	13.9%	2,667.5	15.6%
Nutritional deficiencies	651.7	5.8%	950.4	6.5%	1,630.7	9.5%
Noncommunicable diseases	2,228.5	20.0%	3,371.6	22.9%	3,959.2	23.1%
Injuries	575.8	5.2%	668.5	4.5%	624.8	3.7%
PHC TOTAL	**11,147.1**	**100.0%**	**14,693.5**	**100.0%**	**17,108.1**	**100.0%**

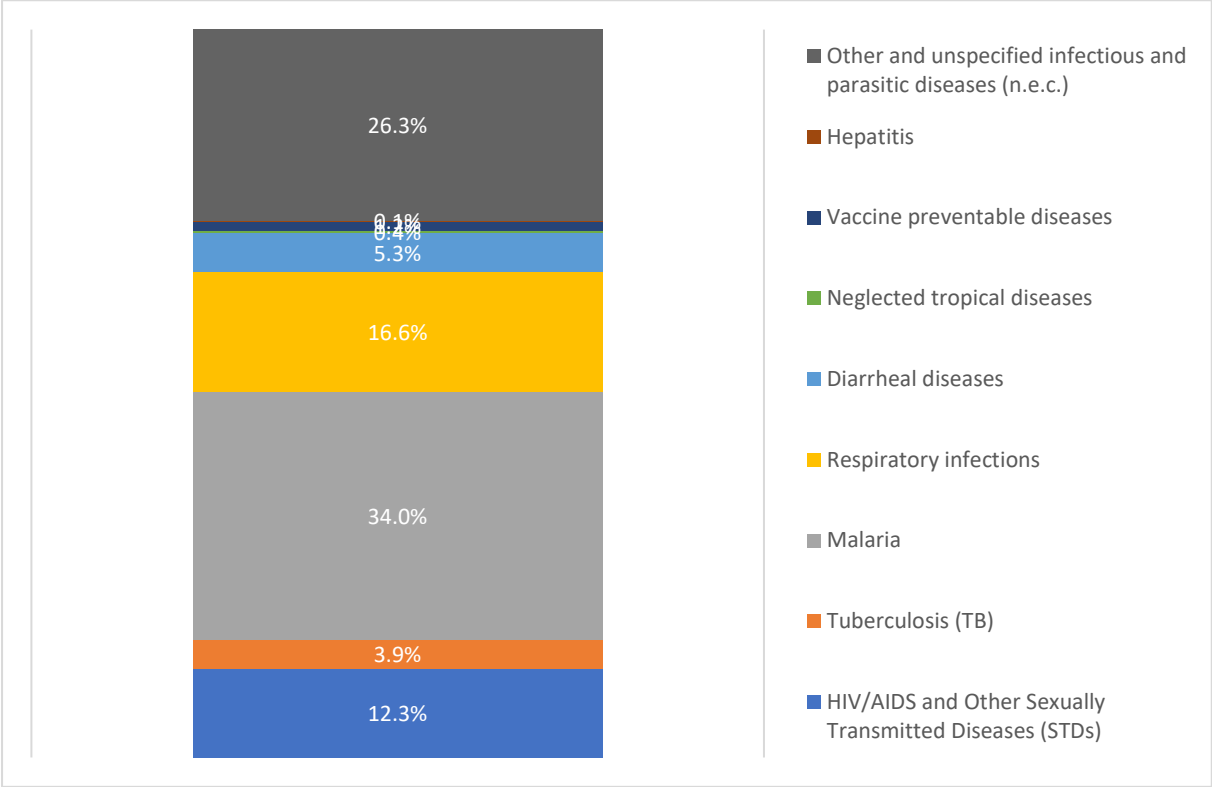
The continued dominance of Infectious and parasitic diseases (IPDs) in PHC expenditure, even with a declining share, underscores the persistent of IPDs burden in Ghana. However, the rising share of Noncommunicable diseases (NCDs) is a significant and important trend. This is in line with reflections of WHO report [16] that as LMICs undergo epidemiological transitions, NCDs are increasingly contributing to the disease burden, and effective PHC is crucial for early detection, management, and prevention.

Looking at the details of infectious and parasitic diseases category (seen in Table 3) findings show that Malaria accounts for the largest proportion of expenditure within this category, representing a substantial 34.0% of the total PHC spending on infectious and parasitic diseases (Figure 7). This highlights its significant burden on the health system and its continued prioritization in PHC interventions. Other and unspecified

infectious and parasitic diseases (n.e.c.) constitute the second largest share at 26.3%, suggesting that a considerable portion of resources is allocated to a diverse group of infections not individually specified, or to general infectious disease control efforts.

Respiratory infections account for 16.6% of the expenditure, indicating another major area of focus for PHC resources in Ghana. HIV/AIDS and Other Sexually Transmitted Diseases (STDs) represent 12.3% of the spending on infectious diseases, underscoring ongoing efforts in managing and preventing these conditions. Diarrheal diseases account for 5.3%, while Hepatitis and Vaccine-preventable diseases each receiving minimal shares of 0.1% and 0.4% respectively. Neglected tropical diseases are allocated 3.9% of the expenditure (Figure 7).

Figure 7 PHCE on Infectious and parasitic diseases, 2023



The highest expenditure on Malaria (34.0%) is understandable, given its endemic nature and high morbidity/mortality in Ghana and many sub-Saharan African countries. Continued investment in malaria prevention, diagnosis, and treatment at the PHC level is vital for achieving SDG 3, Target 3.3, which aims to end the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases [12].

Similarly, significant spending on Respiratory infections (16.6%) and HIV/AIDS and Other STDs (12.3%) reflects appropriate prioritization, as these conditions are major public health concerns requiring sustained PHC interventions. The allocation to "Other and unspecified infectious and parasitic diseases" (26.3%) suggests a need for more granular data to ensure efficient targeting of these diverse conditions.

3 CONCLUSION AND RECOMMENDATIONS

3.1 Conclusion

Ghana has demonstrated a commendable commitment to Primary Health Care (PHC) through consistent increases in Current Health Expenditure (CHE) and a significant allocation to PHC expenditure (PHCE). The rebound in government funding for PHC in 2023 aligns positively with international recommendations emphasizing state responsibility for health equity. However, critical challenges persist, notably the concerning rise in household out-of-pocket expenditures (OOPs) for PHC services, which poses a substantial barrier to achieving Universal Health Coverage (UHC) and addressing Sustainable Development Goal (SDG) 3 targets related to financial protection.

Furthermore, the vulnerability introduced by fluctuating external aid and the untapped potential of corporate contributions highlight the urgent need for Ghana to diversify and strengthen its domestic PHC financing mechanisms. While nominal PHCE per capita has increased, its decline in US dollar terms due to exchange rate depreciation signals a diminishing real value of health spending, impacting the accessibility and quality of essential PHC interventions. To truly leverage its PHC investments for improved health outcomes and progress towards UHC and the SDGs, health sector managers in Ghana must find ways to strategically address these financing gaps, enhance efficiency, and ensure equitable access to care.

3.2 Policy Recommendations

Develop and implement targeted policies to reduce out-of-pocket expenditures for essential PHC services, particularly for vulnerable populations.

- Expand the benefits package of the NHIS to cover a wider range of PHC services (specifically promotive and preventive services) and strengthen its financial sustainability through innovative revenue generation mechanisms.
- Explore mechanisms for direct subsidies or waivers for specific PHC interventions for the poorest households.
- Conduct a comprehensive study to disaggregate household contributions and identify the proportion of OOPs to inform precise policy interventions.

Develop and implement strategies to mitigate the impact of exchange rate volatility on health sector financing, especially for PHC.

- Establish a dedicated foreign exchange reserve for critical health imports, exploring hedging mechanisms for major health

procurement, or diversifying the sources of essential medical supplies to reduce over-reliance on single currency imports.

- Strengthen local manufacturing capacities for pharmaceuticals and medical consumables to reduce import dependency.

Develop a comprehensive national strategy for sustainable PHC financing that diversifies funding sources beyond government and external aid.

- actively engaging the private sector through innovative partnerships, corporate social responsibility initiatives, and potentially targeted levies or taxes on specific industries (e.g., unhealthy commodities) that contribute to the burden of disease.
- Advocate for more predictable and long-term commitments from development partners while simultaneously strengthening its own domestic resource mobilization for health.

Strengthen, significantly, the PHC's capacity for NCD prevention, early diagnosis, and management while maintaining robust investment in infectious disease control.

- Train PHC workers in NCD screening and counselling, integrating NCD services into routine PHC visits, ensuring the availability of essential NCD medications and diagnostics at the primary level, and implementing public health campaigns on NCD risk factors.
- Develop and implement (or review an existing) a national NCD strategy that explicitly outlines the role and financing of PHC in addressing the growing NCD burden.

Reaffirm and strengthen the gatekeeping role of community-based primary healthcare facilities.

- Make strategic investments in upgrading community health planning and services (CHPS) compounds and health centres, ensuring adequate staffing, equipment, and drug supplies at these frontline facilities.
- Prioritize and increase funding for preventive and health promotion services at the PHC level, including immunizations, maternal and child health, health education, and disease surveillance, to shift the focus from curative to preventive care and reduce the overall disease burden.
- Establish clear referral pathways to ensure appropriate utilization of hospital services, reserving them for more complex cases.

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