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Monitoring quality of care and accountability mechanisms at the district level:

The potential role of the National Health Insurance Scheme in Ghana

Royal Tropical Institute (KIT)
Merel Martens, Junior Advisor Health Systems
Jurrien Toonen, Senior Advisor Health Systems

SNV Ghana
Bertram van der Wal, Network Leader Health West & Central Africa

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Author contacts:
Merel Martens: m.martens@kit.nl
Jurrien Toonen: j.toonen@kit.nl

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List of acronyms

CHIC	Community Health Insurance Committee
CTC	Care Taker Committee
DMHIS	District Mutual Health Insurance Scheme
HO	Head Office (of the National Health Insurance Scheme)
KIT	Royal Tropical Institute
M&E	Monitoring & Evaluation
MOH	Ministry of Health
MOFEP	Ministry of Finance and Economic Planning
NHIC	National Health Insurance Council
NHIS	National Health Insurance Scheme
NHIA	National Health Insurance Authority
OOPE	Out of pocket expenditures
RO	Regional Office (of the National Health Insurance Scheme)

1 Introduction

In 2005 Ghana started implementing the National Health Insurance Scheme (NHIS), after passage of the National Health Insurance Act in August 2003 (National Health Insurance Act, 2003). The NHIS was introduced as a new way of health financing to enable access to basic quality health care services to all residents of Ghana (National Health Insurance Act, 2003). The NHIS was implemented as a response to the decrease in health services utilization rates resulting from the 'Cash and Carry' policy and to increase funding of the sector. The aim of the NHIS is to decrease the financial barrier to health care access by protection against out-of-pocket payment at the point of service uptake (Ministry of Health, 2004).

Several studies show that the NHIS led to a number of positive developments. The NHIC contributed to an increase of the total per capita expenditure on health from $13.5 in 2005 and $27 in 2008 – Ghana almost reached the Abuja Target for health care spending (15% of the public budget spent on health) for the last three years. Health care utilization rates increased as a result of the implementation of the NHIS (Mensah et al., 2010; Rajkotia, 2007), and has yielded significant benefits for its members. Mensah and colleagues (2010) show that the NHIS created better health outcomes and lower maternal mortality figures. Also, the NHIS is perceived as an adequate financing tool to establish risk-equalization and cross-subsidization (Mc Intyre et al., 2008).

Up to 2009 51% (12,145,526 people) of the Ghanaian population was insured through the NHIS and holds an insurance card (up from 25% in 2006). Many more are registered in the system (13,840,198 people - estimated at around 58% of the population) but not all have a valid health insurance card (Mensah, June 2009). Research indicate that the utilization of health care services tend to increase for those insured and that they are gaining positive health outcomes (Mensah et al., 2010; SEND, 2010).

However, concerns about the quality of health care have been expressed (e.g. Rajkotia, 2007; SEND, 2010). Already before the implementation of the NHIS several studies signal poor quality of care, either perceived by the patients or objectively measured using medical professional performance indicators. The Ghana Statistical Service (2002) found that patients were in general satisfied with the specific programmes and services, but unsatisfied with long waiting time, poor staff attitudes, extra illegal charges, high costs and dirty environment. A study by D'Ambruoso et al. (2005) revealed underutilization of maternal health care services due to the perception of poor quality referring to birthing position, fluid intake during delivery, caring actions and health staff attitudes. Also after the implementation of the NHIS assessments indicate that the quality of health services could be improved. Taking into account more objective measures, several studies (Ministry of Health, 2008) noted shortcomings relating to maternal health care services (inadequate treatment of obstetric complications, poor management of third stage of labour, etc.). In general it was concluded that quality of the available health care services needs to be improved; there was a continuous lack of basic supplies and equipment, shortage of human resources, and de-motivated staff due to poor working conditions. Poor (perceived and objectively measured) quality of care will probably affect enrolment and utilization of the NHIS and is a potential risk for trust of the clients and therefore for the financial sustainability of the policy. Consequently assuring good quality of care should be a matter of concern in the NHIS.

Given the concerns regarding the relevance of good quality of care, this paper aims to search solutions. It is assumed here that improving "down-stream accountability" by the different stakeholders may provide a solution by holding providers to account on qualitative good health care services. Local governments or third-party players (like a health insurer) play an increasing significant role in assuring and improving quality of care. As a 'purchaser' of health care services the NHIA, and moreover the District Mutual Health Insurance Scheme (DMHIS) could play a role here.

The operations of the NHIS, as outlined in Act 650 as well as in Legislative Instrument (LI) 1809, 2004, are reviewed and currently before parliament. The proposed revisions of the Act and LI are not known to the public, but will affect the structure, roles and responsibilities of the NHIS. District Health Insurance Schemes will most likely become District Offices of the NHIA. These and other changes will in turn affect the governance and accountability mechanisms of the Scheme. It may create new opportunities at district level to focus more on quality of care. This report assists in identifying these opportunities. Furthermore, it contributes to continued discussions on how the actual implementation of these new instruments can be most beneficial to improving quality of care in Ghana.

The Royal Tropical Institute (KIT) based in Amsterdam has recently developed a monitoring and evaluation (M&E) tool for and with the NHIA – which could serve down-stream accountability as a tool. SNV/Ghana strengthens capacities of various district health insurance teams to improve its performance and governance by making evidence-based decisions[1]. It supports community health insurance structures to demand accountability and identify indigents. Furthermore, SNV fosters a multi-stakeholder dialogue at operational level, and other initiatives to increase enrolment of the poor in the NHIS, including its support to the Health Insurance Reference Group. This appraisal aims to gain insight in the accountability mechanisms regarding the matter of quality of care on the district level of the NHIS. Involvement of different stakeholders would lead to an increase of responsiveness of the services to the society's expressed needs. Monitoring data will be used to trace challenges for improvement and lead to action in such a multi-stakeholder environment. This assessment on behalf of the NHIA, KIT and SNV/Ghana attempts to answer the following question: *What are current accountability mechanisms at the district level, with a specific focus on quality of care and what are opportunities to improve them?*

To answer this main question, the following chapters will look specifically at:

- Perspectives on quality of care and presents a framework based on the literature that can be used to monitor quality of care (chap 2)
- Current accountability mechanisms at district level related to measuring and assuring quality of care (chap 3)
- Identifying opportunities to improve these accountability mechanisms to contribute to improving quality of care (chap 4)
- Identifying questions for further discussion and study (chap 5)

This assessment should be considered as an exploratory study; through semi-structured interviews with key stakeholders at the district level it is intended to gain more insight into the accountability mechanism regarding the issue mentioned above. This appraisal does not aim for representation of all the regions in Ghana but is a first exploratory assessment. Results could feed into

[1] We thank the health advisors of SNV, Rita Tetteh-Quarshie, Nicholas Guribie, Augustus Boateng, Edem Amesu-Addor and Remy Faadiwie, for sharing their practical knowledge, cases and experience related to the operations of NHIS and for linking us to useful contacts of various district health insurance schemes.

the improvement and/or development of an accountability mechanism or tools that improve the quality of care of contracted health care providers in the NHIS. Please refer to Annex 1 and 2 for the methodology, list of interviewed stakeholders[2] and semi-structured topic list.

[2] We like to thank all the stakeholders who were willing to participate in this assessment. We appreciate your frankness concerning your insights, experiences and opinions. Without your help this appraisal would not have been possible.

2 Perspectives on quality of care

To be able to put the outcomes of this appraisal into perspective this chapter will first elaborate on the notion of quality of care and quality assurance based on international scientific literature - as this topic is often conceived as a 'complex' issue – without aiming to give a full systematic overview of (un)published literature. Towards the end a framework will be presented that was developed based on the literature and experiences gained in practice, which can be used to monitor quality care.

2.1 Quality of Care and Quality Assurance in the Literature

With the development of a health care system, quality of care is an increasingly important issue. In developing countries, the quantity rather than the quality of health care has been the focus of policy making. It is only since the last two decades that quality of care is receiving more attention (Reerink & Rainer, 1996; Peabody et al., 2006). Traditionally the national government and health care providers would initiate interventions to improve quality of care, but local governments or third-party players (like a health insurer) play an increasing significant role in assuring and improving quality of care.

To improve quality of care, it must be (1) defined, (2) measured, and adequate (3) interventions and/or measures must be taken accordingly (Silimper et al., 2002). The Institute of Medicine (IoM), known for its revealing publication 'To err is human: Crossing the quality chasm' (2000), moreover states that good quality of care must be rewarded.

2.1.1 Definition and Elements of Quality of Care

Several authors have attempted to define quality of care. The IoM defines quality as 'the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge' (IoM, 2001 pg. 244).

Within the health system quality of care is usually assessed from two different perspectives: the patient's perspective and the provider's perspective. The perspective determines how the quality of care of a certain health care provider is assessed.

To measure quality of care several authors attempted to break up quality of care in several elements or aspects of quality of care. Referring to Donabedian, Peabody and colleagues (2006) state that quality of care consist of the following three elements:

1. **Structure** *refers to stable, material characteristics (infrastructure, tools, technology) and the resources of the organizations that provide care and the financing of care (levels of funding, staffing, payment schemes, incentives);*
2. **Process** *refers to the interaction between caregivers and patients during which structural inputs from the health care systems are transformed into health outcomes;*
3. **Outcomes** *can be measured in terms of health status, deaths, or disability-adjusted life years—a measure that encompasses the morbidity and mortality of patients or groups of patients. Outcomes also include patient satisfaction or patient responsiveness to the health care system (World Health Organization, 2000).*

The rationale behind this categorization is that although structural measures are the easiest to obtain and most commonly used in developing countries (Peabody et al., 2006), there is only a weak link between structural elements and better health outcomes (Donabedian, 1980). However linking this

information with the more difficult to measure process and outcome indicators should provide a full, comprehensive picture of quality of care.

In recent years, the concept of quality of care has been shifted away from the classical framework of structure-process-outcome to specific aims in quality of care (Peabody et al., 2006). This shift was initiated by the IoM, with the publication 'Crossing the Quality Chasm' introducing six elements of quality that a health facility should aim for:

1. Patient safety. Are the risks of injury minimal for patients in the health system?
2. Effectiveness. Is the care provided scientifically sound and neither underused nor overused?
3. Patient centeredness. Is patient care being provided in a way that is respectful and responsive to a patient's preferences, needs, and values? Are patient values guiding clinical decisions?
4. Timeliness. Are delays and waiting times minimized?
5. Efficiency. Is waste of equipment, supplies, ideas, and energy minimized?
6. Equity. Is care consistent across gender, ethnic, geographic, and socioeconomic lines?

This framework gives clear guidelines for a health facility to work towards; however both the continuity of care as well as a detailed patient's perspective (like waiting time and status of the building), which are apparent in Donabedian's framework are not reflected in this framework. Conversely, equity is not considered in Donabedian's concept specifically. In the last decade several quality assurance programmes have been based on the IoM framework, like the Regional Office for Europe of the World Health Organization (WHO, 2009) framework for assessing hospital performance for mothers and newborn babies: (1) clinical effectiveness, (2) safety, (3) patient centeredness, (4) production efficiency,(5) staff orientation, and (6) responsive governance (Veillard et al., 2005). Yet, the Donabedian concept has been applied too, for example in the Taiwanese health care quality indicators system (Wen-Ta et al., 2007). In the Netherlands too sets of indicators for quality of care are being developed and categorized as structure, process or outcome indicator (Beersen et al., 2007).

2.2 Accountability and quality of care

In conclusion, it can be noted that all the frameworks combine objective indicators (medical professional outcome data and organizational structure and process outcome data) with subjective measures (perceived quality of care data). With regard to the scope of this study (accountability) "outcomes" are not suitable to hold providers accountable upon. Outcomes are only partially attributable to health workers, other determinants of health (women's literacy, macro-economic situation, water and sanitation, etc) may even be more important in attributing health outcomes. In this study we will explore the place of "outputs" in quality care, as it informs on outcomes; together with "process" it may mean the "missing link" between "structure" and "outcomes". In terms of outcomes we propose to use not the classical indicators, such as mortality rates, DALY's and QALY's. In stead we propose tracer indicators (for quality of care) such as utilization and coverage rates.

For the sake of this assessment we propose the framework below that integrates different elements from the frameworks above, which can be used to measure quality of care and therefore hold health providers accountable.

1. **Structure** refers to stable characteristics for the organizations that provide care *to provide the conditions to provide quality care*:
   - available (human, physical and financial) resources and their functionality;
   - *governance and management of health services (internal processes)*

These aspects are usually considered in accreditation processes – monitoring would be called "*ex ante*" control of Q/C

2. **Process** refers to the interaction between caregivers and patients during which structural inputs from the health care systems are transformed into health outputs, and how this is organised, such as:
   - *from the providers perspective of quality care (specified below)*
   - *from the patients perspective of quality care (specified below)*

Monitoring of some of these aspects may be called "*ex post*" control of Q/C and used to hold providers to account

3. **Outputs** in quality of care: results of immediate responsibility of providers, on which they can be held to account – unlike for outcomes. To be mentioned are waiting time, drugs out of stock, hygiene and sanitation of the facility;
   - *from the providers perspective of quality care (specified below)*
   - *from the patients perspective of quality care (specified below)*

Monitoring these aspects may be called "*ex post*" control of Q/C

4. **Outcomes** *can be measured in terms of health status, deaths, or disability-adjusted life years—a measure that encompasses the morbidity and mortality of patients or groups of patients. Outcomes also include patient satisfaction or patient responsiveness to the health care system.*
   - *from the providers perspective of quality care (specified below)*
   - *from the patients perspective of quality care (specified below)*

Using this framework, the following elements and types of information may be appreciated when studying or monitoring Quality of Care:

1. For appreciating the Structure, the following types of information may be taken into consideration:
   - *the material resources*:
     - availability and the physical status of the facility's infrastructure,
     - instruments, medical technology
   - *the human resources:*
     - availability of right skills-mix and right size of staffing,
     - job descriptions,
     - payment schemes, incentives, tools,
     - financing of care:
     - organization and use of funding
     - levels of funding
   - *Governance and managing quality of care of health services*
     - Leadership in the facility
     - Vision and strategy development for quality care
     - human resource management and development
     - Introduction of audits focusing on (diminishing) fraud
     - Availability of protocols focusing on assuring quality of care
     - introduction of consequences for "good" and for "bad" performance – like (non-) financial incentives to foster quality of care

- structures available for handling of complaints
- processes for safety and quality management
- organization of internal meetings to monitor quality of care and to establish priorities in improving quality of care
- organization of multi-stakeholder meetings to monitor quality of care and to establish priorities in improving quality of care

2. For appreciating the **Process**, the following types of information may be taken into consideration:
   - *The providers perspective of quality care:*
     - continuity of care – e.g. openings hours, absenteeism, etc;
     - continuity of care – e.g. follow-up visits
     - appropriate testing, not prescribing extra tests
   - *The patients perspective of quality care:*
     - Availability of skilled, trained, qualified/experienced personnel, gender provider
     - (financial) accessibility of the health care facility, affordable costs, affordability of drugs
     - different treatment facilities such as, specialist care,

     Some elements that may be used to hold providers to account would be:

     - Patient centeredness: care being provided is responsive to a patient's preferences, needs, and values; time spent per patient
     - communication is respectful, empathetic, friendly, not stigmatizing, listening/ exploring problems, explanation of treatment and prescription
     - Patient values guide clinical decisions - e.g. birthing position during delivery,
     - appropriate testing, not prescribing extra tests
     - hygienic environment
     - Equity. Care is consistent across gender, ethnic, geographic, and socioeconomic lines?

3. For appreciating the **Outputs**, the following types of information may be taken into consideration, and that may be used to hold providers to account:
   - *From the providers perspective of quality care:*
     - continuity of care – e.g. how the third stage of labour was managed
     - continuity of care – e.g. if referral was adequate and timely
     - Patient safety – e.g. if injuries of patients in health services took place;
     - Effectiveness – was care provided scientifically sound – tracer indicators may be made se of and be taken from the HIS, such as: tuberculosis treatment rate, infection rates, ANC-4/ ANC-1, etc.
     - Was prescription of drugs appropriate (e.g. INRUD indicators)
     - Efficiency: e.g. was waste of equipment, supplies, ideas, and energy minimal?
     - Were services neither underused nor overused
     - pharmacy stock (drugs out of stock)
   - *From the patients perspective of quality care:*
     - Timeliness: delays and waiting times, differences by type of patients
     - Availability of drugs
     - illegal charges
     - Availability of diagnostic and testing facilities
     - Status of the facility: neat and cleanliness, Seating arrangements, patient flow in the facility, private conditions

4. For appreciating the **Outcomes**, the following types of information may be taken into consideration:
   - *From the providers perspective of quality care:*
     - utilization of health care services: coverage of different services
     - Effectiveness of care provided – tracer indicators could be taken from the HIS, such as tuberculosis cure rate, in hospital mortality rate, etc.
   - *From the patients perspective of quality care:*
     - Appropriateness of treatment – good result
     - Patient's satisfaction – overall and by type of services
     - Health seeking behaviour – utilization of one facility to another "competing" facility or self-medication

The above is quite an extensive list of topics, issues and criteria for appreciating quality of care – a selection could (should) be made, based on "what the provider should be held to account" in terms of SMART indicators for quality of care. SMART here means: Specific, Measurable, Accurate, Relevant and Time-bound. Priorities should be decided upon: priorities both at "up-stream level" (according to national policies) as well as upon local priorities "down-stream": what is at local level most important to be improved in quality of care. Both clients and patients should be represented in priority setting.

2.3 Measurement and interventions

Classical methods to assess quality of care from the patient's perspective include: patient exit interviews, household interviews, standardized (simulation) patients, and from the provider's perspective: analysis of facility records, score-board analysis, provider interviews, manager interviews, direct observation, clinical vignettes (case studies) and collection of medical professional outcome indicators (Franco et al., 2002). Interviews may be structured (e.g. by questionnaire) or semi-structured (e.g. by topic-lists). Data may be collected in a routine way (processes and outputs) for monitoring and through surveys for studies or evaluations on outcomes. How data are organized and analysed depends on the underlying framework ('Donabedian' or 'IoM' or the combination of both as presented) that one chooses.

Interventions to assure or improve quality of care so to improve health outputs and outcomes are interlinked with measuring quality of care. Broadly there are three types of interventions to improve quality of care: (1) those that influence provider behavior by changing the structural conditions of the organization, or that involves the (re)design of the health care system, (2) those that directly target provider behavior at the individual or the group level e.g during supervision (Peabody et al., 2006) and (3) those that include different stakeholders in health , in holding providers to account on quality of care after being provided, and link the results to incentives and sanctions. These interventions may take place at different levels: firstly the level of the provider of services in the facility, their management (e.g. leadership) and organization of services. With the intermediate level (for training and supervision) this level would address internal factors. Governance would bring in external factors of other stakeholders at the operational level, The central level would influence quality of care through policies, norms and standards.

In comparison, the first category includes changing structural elements like materials and staff but also interventions like administrative regulations, legal mandates and accreditation. It appeared that the former (so replacing materials or hiring more staff) are not necessary linked to better health outcomes, but interventions touching upon other components of structure—

such as the organization or the financial structure—can influence processes by changing the socioeconomic, legal and administrative, cultural, and information context of the health care system. Administrative regulations, legal mandates and accreditation change the process by excluding unqualified health staff, however a direct link with improving health outcomes has not been detected so far (Salmon et al., 2003). A further often seen intervention in this category is the introduction of clinical guidelines (protocols, standard operational procedures) to ensure a minimum of quality care. Another intervention that is gaining ground and that is based on organizational change - the idea that simply adding resources or a process does not improve quality of care – is the Total Quality Management concept or related interventions like the Plan-Do-Check-Act cycle (Deming cycle). These interventions aim to create an environment of continued feedback, evaluation and adaptation of processes. Several cases are known where these interventions resulted in improved quality of care (Peabody et al., 2006).

Under the second category 'interventions that directly target provider behavior at the individual or the group level' are considered interventions that directly give feedback on the performance of the provider. Some examples are training with peer review feedback and performance based financing, where payment is related to performance outputs. The latter is received a potentially powerful tool to accelerate improvements in quality care (Eichler et al., 2001; Jack, 2003; McBride et al., 2000). However, a precondition for performance based payments is the split of functions between the provider, purchaser, regulator and verifier – and for that reason an appropriate institutional framework and autonomy at facility level, Also specific process or output measures are a requirement (Broomberg et al., 1997, Toonen et al., 2009). Nevertheless, nonmonetary incentives are considered to improve quality of care too; performance based professional recognition through certificates and awards are highly appreciated among health care workers (Peabody et al., 2006). This needs further exploration, and this assessment aims at identifying opportunities.

3 Accountability structure in the NHIS

3.1 Governance structure

At the central level a new institution, the National Health Insurance Authority (NHIA) is set up as a legislative central coordination mechanism and responsible for registration, licensing and regulation of the DMHISs, and supervision of their operations. It is also responsible for granting accreditation to health care providers and monitoring their performance (please refer to Annex 3 for an overview of the objective and specific tasks of the NHIA as described in Act 650). In practice the Regional Offices (RO) carry out many of these tasks. The NHIA is led by a presidentially-appointed Chief Executive Officer (CEO) and a seven-division executive management team (Asenso-Boadi, 2008), and is governed by the National Health Insurance Council (NHIC). The NHIC is a board consisting of fifteen members, including the CEO and representatives of the stakeholders such as the Ministry of Health, Ghana Health Services, regulators, and consumers (Witter & Garshong, 2009). Annex 4 lists the legislative make up of the NHIC.

The Council is required to set up a Health Complaint Committee which will hear and resolve complaints that may be submitted to the Council by members of health insurance schemes, the schemes themselves and providers of health care. The complaint committee is to be decentralized and established in the districts (Ghana Ministry of Health, n.d.).

The 145 DMHISs are registered and licensed by the Council, and organize and deliver NHIS benefits at the local level. A license expires after two years and is renewable. Originally, tasks and responsibilities were decentralized in the NHIS. The DMHISs were autonomous corporate bodies governed by a locally-designated board (elected by a General Assembly comprised of Community Health Insurance Committee (CHIC) representatives) which would hire and supervise local managers of each scheme (National Health Insurance Regulations, 2004). The District Health Insurance Assembly (DHIA), formed by the chairman and secretary of every CHIC within a district, was the highest decision making body on health insurance in the district and ought to prepare a constitution to provide general guidelines for the operation of health insurance in the district. However, all boards in the country have been dissolved by the new government, so also the District Health Insurance Board and Assembly. Each DMHIS is appointed a temporary Care Taker Committee (CTC) instead, until further decisions regarding the governance structure of the NHIS are taken. The CTC is comprised of the District Director, the District Accountant and the Scheme Manager, and is supposed to hold the scheme accountable on operations in the first place.

In conclusion, the DMHIS is hold responsible and accountable for implementation of the health insurance scheme on the district level; to enroll clients, collect premiums, to manage claims, and for administration. The DMHIS is supervised by the CTC. The DMHISs report to the ROs and the ROs are hold responsible for functioning of the DMHISs in its region by the HO.

3.1.1 Accountability concerning Quality of Care

Ghana does not have a single institute or manner for assuring the quality of care, instead several associations and organizations (i.e. medical professional councils, Ghana Health Services (GHS), Christian Health Association of Ghana (CHAG), and the NHIS) are involved with quality assurance applying a number of methods (standards for practice, accreditation, quality assurance programmes).

The medical professional councils like the Ghana Medical & Dental Council, the Pharmacy Council, the Ghana Registered Nurses and Midwifes Council and the Traditional & Alternative Medicine Council play a role in assuring quality of care, as a Statutory Governmental Agency that regulates standards of training and practice of the different professions. Also, they keep a register of duly qualified medical practitioners.

Both CHAG and GHS have been or are working on guidelines and protocols for delivering quality care. Licensing and de-licensing of health care providers is executed by the GHS (of GHS providers), CHAG (of CHAG providers) and the Private Hospitals and Maternity Homes Board (of other private providers) based on a set of structure and process indicators for quality of care. Besides providing guidelines and protocols for quality assurance programmes, strategies or tools have been developed by GHS and CHAG. Within GHS the Quality Assurance Department of the Institutional Care Division aims to mainstream quality assurance into planning and delivery of health care. Therefore it provides four strategic objectives (based on the IoM model): (1) improve client-focused services, (2) improve patient safety, (3) improve clinical practice, and (4) improve management systems and accountability. In order to facilitate achievement of these objectives, intermediate objectives with activities and 'objectively verifiable indicators' are given (Bannerman, 2007). A quality assurance team is set up in every facility responsible for the implementation of the quality assurance strategy. The Regional and District Health Administration monitor compliance with the strategy. The strategy, objectives and activities are mostly on the structure and process aspect of quality of care. However besides this programme medical professional outcome indicators are measured too: these are partly included in the sector-wide indicators established in The Ghana Health Sector Programme of Work (MoH, 2009b). Quality assurance teams in GHS health facilities are ought to send monthly reports to the District Health Administration, so to monitor the sector wide indicators.
CHAG is responsible for quality assurance of mission hospitals within the non-for-profit private sector. A Peer and Participatory Rapid Hospital Appraisal (PPRHAA) tool has been developed and once a year every CHAG member institution will be undergone such an appraisal (CHAG, 2007). The appraisal covers patient care management, internal hospital management, external linkages and relations of the hospitals, finance and accounting, equipment and infrastructure, service output, and client and community views. Results of the appraisal can be used to identify areas for improving the quality of care. The tool can be used to gain insight into the structure and process aspect, and the patient perspective regarding the outcome aspect of quality of care. This tool is merely used for evaluation rather than monitoring. The CHAG Secretariat is planning to set up a monitoring and evaluation system that would enable it to undertake routine monitoring and evaluation (CHAG, 2007).

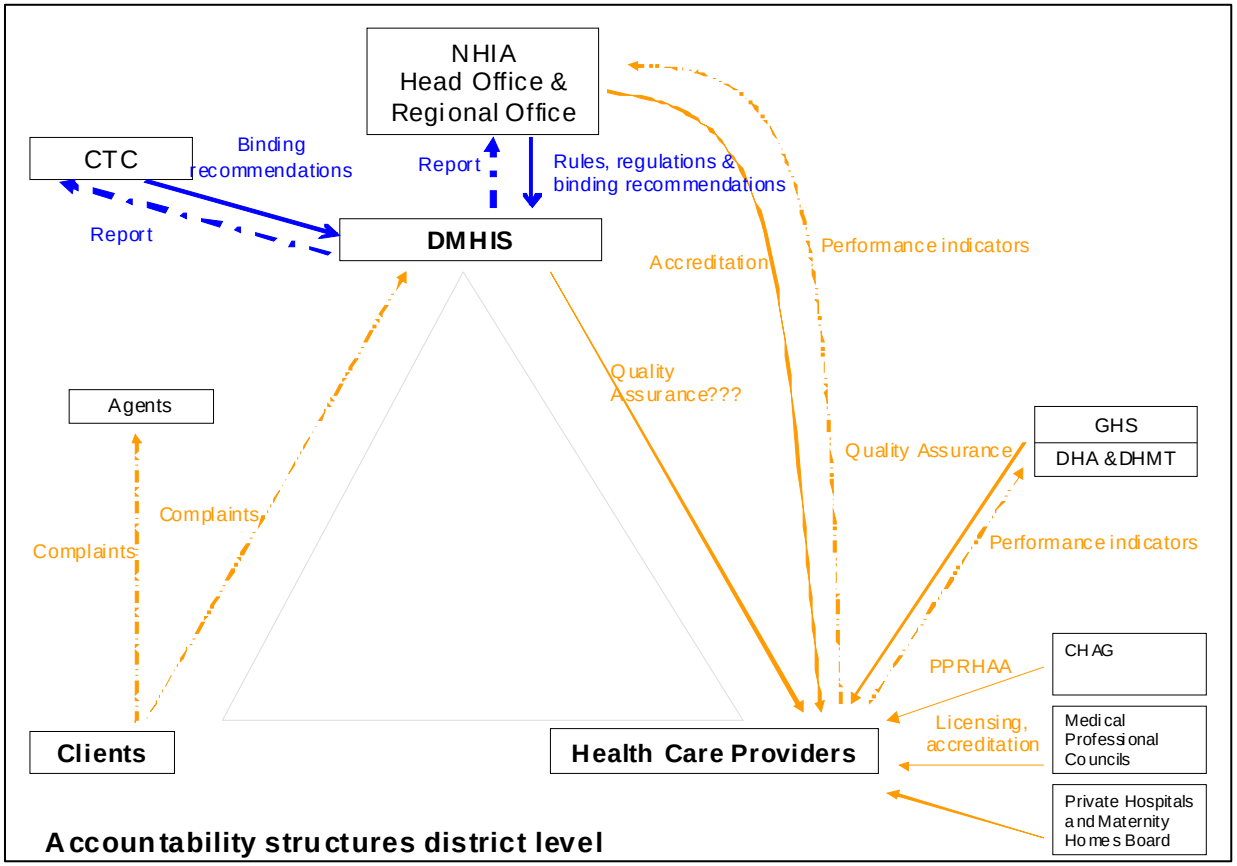
The introduction of the NHIS has consequences for the accountability structure regarding quality of care. As the DMHISes become purchasers of health care services they should ensure a certain standard of the quality of contracted health care services. For that purpose they are ought to monitor the performance of health care providers and to have established a structure to deal with complaints from both members and health providers. If the complaint is not handled properly within two months the complaint can be taken up by the Health Complaint Committee.
As of 2009, the NHIA has initiated a process of **accreditation** of health care providers that are enrolled in the NHIS or wish to be enrolled. Core areas considered within the accreditation are: (1) range of services, (2) staffing levels relevant to the service, (3) organization and management, (4) safety

and quality management, (5) care delivery. Other areas considered are environment and infrastructure, basic equipment, specialized care, diagnostic services and pharmaceutical services (NHIS, 2009). The accreditation team of the Operations Division within the NHIA independently accredits health care providers. Health facilities are graded based on the facilities and personnel available. Grading is linked to the tariffs reimbursed for a service provided. The DMHIS is not directly involved or responsible for accreditation. Having gone through the accreditation process a health facility is graded from A+ to D, 'excellent quality' level to 'just sufficient' respectively, depending on the quality level reached. The fee structure within the NHIS is based on the grading. If a provider does not meet the accreditation standard it has 6 months time to improve before requesting another survey. Several trainings and programmes are offered to upgrade the facility.

Every DMHIS has recruited a number of agents that are responsibility for registering clients and providing membership cards. Agents are also assigned to provide the population with information on NHIS and clients can direct complaints about quality of care issues to their agent or directly to the DMHIS.

3.2 Conclusion

Formally there are quite a number of accountability structures in the NHIS at the district level. The health facilities especially have several authorities to hold them accountable on the quality of their health care services. How these structures function in reality, and what elements of quality of care are considered, is subject to this assessment. The formal governance structure and accountability mechanism regarding quality of care at the district level of the NHIS are depicted in figure 1 below.



Accountability on:
- Daily management
- Quality of Care

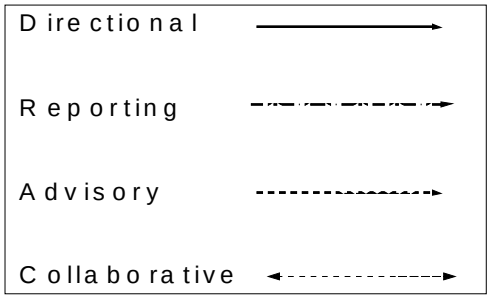


Figure 1: Formal accountability structures at the district level

4 Results

The following chapter will present the findings on the functioning of the accountability structures on the district level of the NHIS as gathered through twenty-three semi-structured interviews with relevant stakeholders (Annex 1). First of all findings concerning the overall governance accountability will be presented, followed by the results specifically on accountability of quality of care.

4.1 Governance structure and accountability overall

First of all, participants were asked to identify their stakeholders so to gain insight in their understanding of the governance structure. Several players were identified by the interviewed as stakeholders of the NHIS at the district level. Most obvious the DMHISs, the health care providers and the clients (the Ghanaian population). Some mentioned the District Health Administrations (DHA) and the District Assembly (DA) spontaneously; the majority recognized them as stakeholders when prompted only. The CHICs and the CTC were not mentioned spontaneously at all.

4.1.1 DMHIS

The DMHIS describe their task as day-to-day running of the scheme which involves registering people, issuing ID cards, purchasing services from health care providers, vetting claims, and reimbursing providers. Other stakeholders refer to them as '*the ones that pay the health care providers*'. Assuring the quality of delivered care was never mentioned as one of the DMHIS's responsibility, however when prompted four out of the seven interviewed DMHISs did feel that they naturally should play a role there. The DMHISs regard the maximization of registering clients as their number one priority. While the majority regarded this a logical priority, one DMHIS felt it was enforced on them by the NHIA – they preferred to focus their activities more on assuring quality of care of the health care providers.

The DMHISs reported that they are requested to send monthly, quarterly, half yearly and year reports to the HO, via the ROs, which are usually first reviewed by the CTCs. These reports are composed of details regarding income and costs of the DMHIS, categorized registration and renewal numbers, claims and reimbursement per provider details, number of complaints, number of meetings with stakeholders. Apart from the number of complaints, which are ought to be filed adequately in the ORACLE information management system (see below), more detailed information on the (perceived) quality of care is not provided within these reports. However, a one-time official client satisfaction survey assessing the satisfaction with the DMHIS and the health care providers has been performed on the request of the NHIA and summaries were drafted and send to the Regional Office and the Head Office. The monthly, quarterly and half yearly reports are not being sent to other stakeholders like the clients, health care providers, the DA, the DHA, or the community representatives. However, the DMHIS is invited at several meetings, where these stakeholders are present, to update on the situation of the DMHIS.

First the RO and than the HO examine these reports and hold the DMHIS accountable on registration numbers, claim reimbursements, and fraud. The CTC meets with the DMHIS quarterly and orally reflects during these meetings on the performance. Agreements are being made to improve certain issues. The RO reflects on the reports and meets with the DMHIS in case of a particular situation (financial problems, signs of fraud). The HO does not meet on a regular basis with the DMHISs, they only act in particular situations.

4.1.2 Health Care Providers

The DMHIS has a contractual relation with the health care providers. The contracted health care providers claim services and drugs (if included in the benefit package) at the DMHIS, after which the DMHIS vets the claims and reimburses the approved amount. The DMHIS aims for contracting qualitative good health care providers that assures geographical access to health. Interviewed participants state that in order to assure physical access most existing health care providers are contracted, impeding the possibility for the scheme not to contract a health care provider based on the quality of care status. Also most health care providers prefer to have a contract with the DMHIS so to assure a minimal number of patients and thus income.

Throughout the interviews it appears that claims management is a priority. Although the interview did not focus on the matter of claims management, both the DMHIS and the health care provider brought up the challenges concerning this issue often. While the DMHIS is investing much effort in minimizing errors (misspelling, missing dates, etc.) and fraud (claiming more drugs than prescribed, mismatch diagnosis and treatment/drugs, etc.), the health care providers are dissatisfied with deductions and delays in claims reimbursement.

To avoid fraud, medical audits of the claims are performed. The audit aims to unmask claimed drugs that were never prescribed, mismatches between diagnosis and treatment, and over utilization of health care services. The audit is first of all performed by the Claims Manager of the DMHIS. Occasionally the DMHIS contracts individual health professionals to perform the medical audit. In addition the HO has a medical audit team that performs audits at random.

The quality of care plays a minor role in the relationship between the DMHIS and the health care provider. GHS and CHAG health care providers are hold accountable for the delivered quality of care by the DHA, which will be elaborated on below.

4.1.3 Clients/patients

Regarding the clients, the DMHIS feels responsible for purchasing quality care and replacing their former out-of-pocket (catastrophic) expenditures (OOPE). Clients are used by the DMHIS as a verification of the (perceived) quality of care. Moreover, clients would submit complaints about the functioning of the scheme (i.e. delay in receiving ID-card) and the quality of care in relation to the NHIS at contracted health care providers (extra OOPE demanded, longer waiting times than non-insured patients, etc.). Within the interviewed districts there was not such a thing as a ‘Health Complaint Committee’, the Public Relations Officer (PRO) of the scheme was usually responsible for handling complaints. The PRO is ought to lodge all received complaints into the ORACLE information management system of all the schemes, but PRO officers acknowledged not to do that routinely.

Interviewed health care providers reported that treating insured patients well is important as they bring in money.

In the current composition of the NHIS, the clients/patients are not formally represented. When the boards of the DMHISs were still existing, they were somewhat represented through community representatives. Interviewees felt that the clients could also be represented through the CHICs, yet many of those are non functional at the moment. Also, if a CHIC is still in place, they are never invited for formal meetings with the DMHIS. Many DMHISs felt that they themselves are representing the patients as they are clients of the

DMHIS. However each of the interviewed felt that there is need for an independent body representing the patients/clients rights.

4.1.4 District Assembly (DA)

The District Chief Executive and the District Accountant, working for the DA, are the respective chairman and member of the CTC that replaced the former boards of the DMHIS. The composition of the CTC varies per district. Permanent members of the CTC are the scheme manager, the District Chief Executive and the District Accountant – however in some cases a RO representative is member of the committee too. From the interviews it appeared that not all CTCs are active. Also, interviewees reported that the roles, responsibilities and decision taking varied between the several 'active' CTCs. While in one district the CTC never met and only passively read the monthly reports as drafted by the DMHIS, the CTC in another region actively hold the DMHIS accountable on hiring staff, purchasing goods (i.e. a computer), reimbursed claims, and number of registrations and renewals. None of the CTCs reported to discuss the delivered quality of care.

Apart from the role of the District Chief Executive and the District Accountant in the CTC the DA does not have a role in the NHIS.

4.1.5 DHA and DHMT

The DHA and the DMHT are responsible for regulation, management and planning of health services delivery - public and private – at the district and sub-district level in each region and for supervision and management of curative health care delivery at the district and sub-district level, by GHS or CHAG providers.

They are not directly involved in management of the scheme and also do not have a formal role in supervision of the DMHIS, unlike the DA. The DMHISs mainly use the DHA/DHMT for channeling information to the health care provider, for the reason that they are well respected by the health care providers. The other way around, the DHA/DHMT discusses bottlenecks experienced by the health care providers on their behalf with the DMHIS. Formally the DMHIS is not required to share monthly reports with the DHA/DHMT, however this is being done occasionally.

The DHA/DHMT meets quarterly with providers to discuss, amongst others, the submitted quality assurance reports with performance indicators by GHS providers. At those meetings the DMHIS is usually invited to give a presentation on the performance of the scheme and to discuss mutual concerns and issues. These mainly concern registration and renewal issues and claims management and related problems, according to all the stakeholders interviewed. Both the DMHISs, DHA/DHMT, as well as the health care providers assert that the DMHIS does not involve themselves in specific quality of care matters discussed during those meetings.

4.1.6 Agents and CHICs

Clients may register to obtain a national health insurance card at the office of the DMHIS or through an agent. Agents are hired by the DMHIS, paid by commission, and are a tool to increase registration as they are able to register people that are unlikely to travel to the DMHIS office to register. Also, as the agent is usually a resident of a village in the district he/she is able to educate the people on the concept of health insurance.

Formally the agent is a member of a CHIC, a committee that was ought to be composed of 5 members from the community: a chair, a public relations

officer, a secretary, a premium collector (the agent) and a general member. However, in the majority of the visited districts the CHICs were 'dormant' or not functioning, according to the interviewees. Only in the Western and Eastern Region some districts assured that some CHICs were still in place. The bottleneck is the lack of the financial contribution of the members, except for the agent. Moreover, if members of the CHIC move away, this person is usually not replaced. The DMHISs regretted the fact that the CHICs were not in place as they would be in the perfect position to educate the population and increase the registration and renewal rate. Interviewed participants believed that some CHICs are however still functioning because of personal interest of the members – for example to strengthen their political career perspective.

4.2 Accountability regarding quality of care

4.2.1 Views on quality of care

In order to be able to discuss accountability mechanism for quality of care, interviewees were first of all asked about their perception of quality of care. They were asked how they perceive quality of care at the moment and what kind of elements encompasses quality of care.

Views on the concept of quality of care varied among the interviewed participants considerably. Non medical professionals, such as personnel at the DMHIS and some personnel at the DHA would refer to quality of care in terms of (financial) accessibility of the health care facility, the physical status of the facilities (e.g. condition of the building, cleanliness), availability of type of services and patient satisfaction elements (e.g. attitude of the medical personnel, waiting times). Only personnel of one DMHIS and several health care providers also referred to quality of care in terms of medical professional indicators such as mortality rates, tuberculosis treatment rate, and infection rates. In addition, most interviewees stated that the notion of quality of care is 'difficult and complex' as it consists of so many elements.

All of the participants regarded the delivered quality of care 'ok', however stated that it could be improved, mostly in terms of being more friendly to patients, bringing back waiting times, spending more time per patient, and describing appropriate drugs.

Most interviewees (both non medical and medical professionals) felt that the introduction of the NHIS positively influenced the quality of care as *'people are now able to go to the doctor without paying out-of-pocket'* and *'[the doctors] can now follow up patients'*. However, it was also recognized that the increase of utilization of health care services, with an increase of work load for the health care workers must impede the quality of care.

4.2.2 Accountability structure regarding quality of care

As reported above formally within the NHIS several actors play a role regarding assuring the quality of care. Here follow the views of the stakeholders given there role within the accountability structure.

The DMHISs state that they play a role in assuring quality of delivered care as they employ patient satisfaction surveys (exit interviews at health facilities). These surveys are ought to capture the satisfaction of the clients of the scheme with the health care provider in terms of attitude of the medical professional, waiting times, drugs availability, drugs prescribed and extra out-of-pocket payments. No DMHIS was able to show such a survey when requested, however the RO could provide some. The RO declared however that these

patient satisfaction surveys were not carried out routinely but only once within the last years at the request of the HO. The indicators actually do not generate insight into the delivered quality of care in terms of medical professional outputs and outcomes, but more how structural and process aspects of health care delivery are influenced by the introduction of the NHIS. Apart from the incidental patient satisfaction survey, the PRO of the DMHIS is responsible for collecting and handling complaints concerning health care providers and the health insurance (charging extra out-of-pocket payments, longer waiting times for insured patients). Several interviewed PROs claimed to be indeed responsible for this matter and collected complaints. If possible the PRO would handle the complaint by counseling between the health provider and the client or would otherwise park the complaint with the RO or the HO of the NHIA. As mentioned above, medical audits of the claims are performed. Interviewees stated that these audits are rather focused on diminishing fraud instead of assuring quality of care. If a facility frequently commits fraud, or if many complaints regarding the attitude of the medical professional are received, the DMHIS might take action. Reported consequences for bad performance are termination of the contract for a short period and de-accreditation. However, only one of the interviewed DMHISs had done so, so far. Two interviewed DMHISs indicated to use positive incentives to praise and stimulate the health care providers to perform well. Well one of them would pay a financial incentive to the director of a health facility; the other awarded the health facilities with certificates of appreciation. Performance was measured in terms of patient satisfaction, based on patient exit interviews and proper claims management (regarding flaws or fraud).

Further, interviewees referred to the accreditation system within the NHIS often. A special team within the HO of the NHIA is responsible for accrediting health care providers. Structural elements of quality of care and processes within the facility are assessed and the facility is graded accordingly (ranging from community based health provider service (CHPS) to tertiary care hospital). Facilities are thus graded according to the *potential* to offer certain health care services. Grading is linked to tariffs in the NHIS. Participants automatically referred to the accreditation as an adequate tool to assure quality of care and to hold the providers accountable for quality of care. However, after a more thorough discussion they stated that accreditation assesses and assures certain conditions for delivering quality care only and does not directly influence the medical professional aspect of quality of care. Also, some participants admitted that certain facilities should not have been accredited, but were accredited only to assure geographical access to health care. The system is set up in such a way that a facility can be both up- and downgraded. Interviewees stated that some facilities were upgraded (e.g. because of the arrival of an extra medical doctor, or the purchase of certain equipment), no health facility was downgraded yet. Most interviewees, including most health care providers, were very content with the accreditation team. However, still a number of health care providers did not feel this way: they thought the NHIA was intervening in the role of the Councils.

Another player in the accountability structure regarding quality of care is the DHA/ DHMT. Interviewees stated that both the GHS as well as mission based health care facilities are hold accountable for the medical professional aspect of quality of care by the DHA/DHMT. Other private providers are not included in this quality assurance program. All health care facilities are requested to report on quality of care issues including medical professional quality of care indicators to the DHA/DHMT monthly. None of the interviewed DHA/DHMTs or providers were willing to give insight in these reports/formats as approval from GHS head office was needed. During formal quarterly reporting meetings, all

providers of care in the various districts meet for a review. In end of year review meetings a number of issues, including quality assurance, are discussed and interventions (e.g. feedback sessions, facility wide trainings, district wide trainings) are taken to improve on any short-comings in this area. With respect to incentives – in certain districts the DHA/DHMT rewards good performing health facilities with in-kind investments (equipment), a certificate or extra food for the employers. No district reported giving positive financial incentives. Nonetheless, the DHA/DHMTs reported not to have the financial capacity anymore to award health providers with such appraisals. There were no negative consequences reported if a provider is not performing well. The Regional Health Administration (RHA) is ought to verify the quality of care as stated in the monthly reports, however it was reported during the interviews that lack of resources (car, personnel, finances) are a barrier to doing so.

Nearly all interviewees were of the opinion that the DMHISs do not hold the health care providers accountable for quality of care in terms of (medical professional) outputs and outcomes. When informing about the opportunity or possibility of the DMHIS to play a role in holding the providers accountable for quality of care outcomes, giving the contractual relationship with the providers, the opinions were mixed. The majority of the DMHISs agreed that they should play a role there, because they felt responsible for the quality of services that they purchase on behalf of their clients. However, they felt the need for some preconditions; claims should be reimbursed without delays and DMHIS personnel would need a basic medical training, as they feel they will otherwise be 'blown away by the medical professionals'. The providers felt that first of all the DMHIS should guarantee timely paying of the claims, before they could 'demand' a certain level of quality, in terms of medical professional outcomes. A minority (mainly DMHISs) on the other hand feel that there is no role and place for the DMHIS in assuring quality of care or holding the providers accountable for quality of care. They argue that it is not within their 'job description', their personnel is not (technically) qualified to do the job, and in general they find 'quality of care' a too complex notion to handle.

4.3 Accountability on other issues

Although it was not the subject of this assessment, the accountability regarding claims management was raised by the participants often. Apart from safeguarding a high number of clients, proper claim management was one of the priorities within every DMHIS. Proper claim management encompasses the following elements: filling out adequate data on the claims form by the health care provider, no fraud by the health care provider, timely and flawless entering of claims forms into the information system by the DMHIS, timely reimbursement of claims by the DMHIS. All interviewed schemes reported to be hold accountable on these elements by the Care Taker Committee, the RO, the HO, the DA, the DHA/DMHT, and the providers – however they would all focus on a particular issue within claims management. The provider and the DHA/DHMT are very much concerned about the time between claiming and receiving their reimbursement, and discounts on reimbursements. Conversely, the participants stated that the Caretaker Committee and the regional and head offices of the NHIA hold the DMHISs accountable for fraud and misuse of the system.

Interviewees declared that mismanagement could lead to consequences like loosing your job. Apparently, in the past scheme managers and even a regional manager have been removed from their position because of fraud of one of the stakeholders in the system (e.g. an agent or a health care provider). Positive incentives for adequate management of fraud and misuse within the NHIS are not in place.

5 Discussion

This study is an exploratory assessment of the governance structure and accountability system regarding quality of care on the operational/ district level within the NHIS. An analysis of literature and semi-structured in-depth interviews with key stakeholders provided insight into the current situation as well as what determines 'quality of care' in the perceptions of the different actors and opportunities for development and improvement. The following chapter will give the strengths, weaknesses and opportunities for an accountability structure at the district level.

5.1 Strengths and weaknesses

From the interviews it follows that actually there are a number of stakeholders involved with the NHIS at the district level of the health sector in Ghana. Indeed, as described in literature, local governments and other stakeholders seem to have an increasing important role in quality assurance. Besides the DMHIS, CTC and CHIC, also the DA, DHA/DHMT, the health providers, opinion leaders and the community play a role. Clients are not represented by one body but are merely presented through the opinion leaders in the community. This assessment revealed that the stakeholders do not recognize each other as stakeholders at all times. The only platform where all involved stakeholders meet is the Health Committee of the DA. It seems that existing multi stakeholder organizations are not yet functioning adequate. No clear accountability structure to monitor a pivotal issue such as the quality of delivered care has been set up or management of the stakeholders is in place.

The NHIS was implemented to '*ensure access to basic quality health care services to all residents of Ghana'*. However the quality of care is not yet received as a priority by all stakeholders and monitoring is not introduced in a structural systematic way, which probably results in the current situation where players do not hold each other to account. Stakeholders are currently primarily concerned with sustaining the day-to-day operations of running the scheme; the players hold each other above all to account on adequate use of claims forms, timely reimbursement of claims, timely issuing of ID cards, and overall financial management of the DMHIS. This is probably due to the fact that the NHIS and the health care providers are facing financial difficulties and that the NHIS has been implemented only four years ago. Mutual accountability on these issues is strong and consequences are in place: misuse or fraud of claims forms, as well as mismanagement of claims management is faced with penalties such as losing accreditation or a job. There are however no consequences in case quality of care is not according to standards.

Participants did not identify weaknesses of the accountability structure regarding quality of care. From the assessment it appears however that the quality assurance interventions in Ghana are at the moment very patchy; in reality but also formally 'on paper' as illustrated in chapter three. Accreditation is now fragmented over a number of institutes, namely the Councils, the GHS, CHAG and the NHIS, with each a different specific focus. Furthermore, quality assurance of delivered health care services is executed by a number of organizations as well.
The DMHIS reported to occasionally carry out patient exit interviews (on patient satisfaction) and ongoing measuring of quality of care of the provider. These interventions by the DMHIS are however all focused on the structure and process aspects of quality of care with a specific focus on health insurance related issues (i.e. extra out of pocket payments charged, insured/not insured waiting time rate, etc.). Only for the latter issues an accountability system with incentives and consequences is in place.

The DHA/DHMT and health providers state that they do have a quality assurance program – and thus did not recognize a lack of comprehensive quality assurance. A consequence for underperformance of a health facility is having health personnel taken certain training as indicated by the DHA/DHMT. There used to be incentives, however due to financial constraint these are abolished. While on the one hand it is positive that several methods and interventions are used to measure and assure quality of care, on the other hand there is no clear structure and coordination between the players which seems to weaken accountability between the stakeholders. Moreover quality assurance measurements and interventions focus very much on the structure and process indicators and less on the medical professional output and outcome indicators.

5.2 Opportunities

Indeed, a number of constraints in the mechanisms to carry out accountability activities can be mentioned. There are however different (potential) platforms to hold providers to account on results, which can be strengthened:

a. the District Assembly (DA, Local Government) has a health committee in which all stakeholders discuss health in the specific district;
b. District Health Administration (DHA), the District Health Management Team (DHMT)
c. The Community Health Insurance Committee (CHIC) with the Care Taker Committee (CTC);
d. The Regional Office (RO) of the NHIA
e. A new, to be installed, autonomous inter-agency body for quality assurance

The DMHIS will report quarterly on the new M&E system that was recently developed by the NHIA (supported by KIT). These reports may serve as a base for discussions in these platforms – besides patient satisfaction studies, medical audits, complaint counseling*, etc.*

Potentially, the CHIC would be the designated body to hold the DMHIS accountable, nevertheless the formation of a CHIC was not mandated by the NHIA and therefore neither the DMHISs nor the RO invested time or resources into the establishment and training of the CHICs. This is unfortunate as the CHICs could play an important role in enhancing accountability and impact of the scheme.

The responsibility for **quality assurance** in Ghana is at the moment distributed among a number of stakeholders without proper coordination. In the long term it might be wise to aim for integration of the several quality assurance interventions; accreditation could be performed by one independent institute instead of the Councils, GHS, CHAG, and the NHIS. Also the measurement of quality of delivered care, which is at the moment performed by the DMHIS and the DA, DHA/DHMT, could be combined and all aspects [structure, process, (patient and medical professional) outputs and outcome] could be taken into account. There are however opportunities to improve the current structure.
Before all, quality of care should be correctly measured on all its aspects and it is advised to introduce consequences and incentives, as literature demonstrates that these may be very effective. The DMHIS could, as purchaser of health care services, implement a system of (financially or non financially) awarding providers that are performing well in terms of quality of care based on certain performance indicators (also referred to as performance based financing – in case of a financial incentive). In such accountability structure the GHS, CHAG, DHA/DHMT could use their current quality assurance efforts to support the health facilities to meet the performance indicators.

It is advised that the performance indicators are set between all the stakeholders (health care providers, DMHIS, clients/patients, DHA/DHMT, DA, NGOs). Verification of performance and allocation of incentives takes place at a similar platform were all stakeholders are represented. In the case of Ghana, from this assessment it appeared that this platform could be hosted at the DMHIS as they may be considered as 'neutral' by (at least) between the health care providers and clients.

It should be noted though that the DMHISs attribute their current small role in quality assurance to the fact that this is not within their 'tasks' as amended by HO. Their lack of skills to 'demand' better quality of care from the medical professionals, the current concerns around claim management need to be addressed before considering increasing the role of the DMHIS in this field.

Important in such a structure is the development and agreement upon the performance indicators for quality of care, in other words 'what are the health care providers' hold accountable on? In this background paper, in chapter two, we provide a conceptual framework based on Donabedian's –and on IoMs work providing a number of elements that health providers should aim for. Structuring the indicators by the results chain can give an even more profound overview of the performance of a health care provider and can expose weak points in the structure and processes of a provider. As several institutions in Ghana use different sets of indicators for measuring performance of the health provider including quality of care (either the sector-wide indicators, the objectively verifiable measures of the GHS, or the PPRHAA indicators by CHAG) a process should be facilitated to reach consensus and develop a set of performance indicators.

When developing such a set of indicators important considerations that have to be taken into account are described by Vergeer and colleagues (2010), Eichler and De (2008) and Beersen et al. (2007). They stress that the outcome of each of the selected indicators should be relevant, the outcome of each indicator should be within the influence of the implementing organization, indicators must be feasible to measure and verifiable, the number of indicators must be well balanced, one must focus on both quantity and quality indicators, and indicators must address both structures and processes as well as actual quality of care outcomes (Eichler & De, 2008). In Liberia Vergeer and her colleagues (2010) came up with 12 performance indicators and 15 monitoring indicators that are not directly linked to incentives. From the process it was learned that it is 'vital to begin with a limited number of indicators feasible to collect and relevant to the objectives while building the capacity in data collection to allow for evolution of performance indicators over time', 'that one of the key challenges was to juggle the different, and sometimes competing, interests of the different stakeholders when identifying suitable performance indicators', and 'sufficient time must be allocated for selecting indicators'.

Important in these discussions is that classical 'quality of care frameworks' focuse primarily on being in the right conditions to provide quality of care (resources, processes) – which is often linked to accreditation and what we calle here "*ex ante*" control. Monitoring quality of care needs to be adapted to "new" health systems approaches such as health insurance schemes and performance based financing (PBF). These health system interventions are basically provider-payment mechanisms and payment is based on results – in which quality of care should be considered as a result, so should make part of "ex post" control, besides indicators on productivity, In chapter two, we did an attempt to develop a quality of care framework of information issues for both "ex ante" as well as "ex post" control.

Actually, most methods for assessing quality of care are about research and studies – we propose here to focus in case of health insurance and performance based financing on routine information which may include small scale studies to include qualitative information next to quantitative information. We propose here to include different methods:

1. those that influence provider behavior by changing the structural conditions of the organization,
2. those that directly target provider behavior at the individual or the group level during supportive supervision;
3. include different stakeholders in health, in holding providers to account on quality of care that has been provided and link the results to incentives and sanctions.

6 Conclusion and Recommendations

The study has been undertaken after discussions with the NHIA staff, while developing their new M&E system. Questions that rose were: how to use the results deriving from monitoring the performance of the DMHISes and of health care providers for accountability purposes in a multi-stakeholder environment? And, what are the existing platforms for multi-stakeholder gatherings, and what is their actual functionality? A focal point in these discussions was the operational level, where results of the DMHISes and the providers of services need informed discussions and follow up to attain better health results. Another focus was on quality of care; while developing the M&E system for the NHIA, this aspect was difficult to define in terms of quality of services after being delivered.

For this study the concept of quality, and different frameworks to assess and assure quality of care was described. This exercise fed into the development of a conceptual framework tailored to the information needs of the NHIS/NHIA as a purchaser of *quality* care. The NHIA is invited to develop its indicators for monitoring quality of care based on this framework.

Also, the current status of accountability of quality of care was assessed through a number of semi-structured in-depth interviews with relevant stakeholders. It can be concluded that at the district level there are a number of stakeholders involved with the NHIS/A, some of them within the official institutional framework of the NHIS and some outside.

At the moment stakeholders hold each other to some extent to account on processing of claims and ID cards, and on overall financial management of the DMHIS. Accountability concerning quality of care is fragmented with several players intervening with each other. Both accreditation and quality assurance over delivered care are spread over a number of organizations, while none of the involved organizations, except for the Councils, are truly independent. A number of opportunities were identified in the interviews how this structure of accountability could be strengthened.

Recommendations:

- The DMHIS should not only be hold accountable on the total number of services but also on the quality of care that has been delivered, through:
    - Strengthening the purchaser role of the DMHIS by implementing a system in which good performance in terms of quality of care is rewarded (i.e. financial bonus, certificate of appreciation, naming & shaming, etc.) and bad performance is sanctioned;
    - develop a comprehensive quality model for the health sector;
    - develop a set of relevant and SMART quality of care performance indicators based on the framework that was developed in this report;
    - train DMHIS staff in using this set of indicators for monitoring quality of care;
    - Civil Society Organizations (CSO) may be hired for verification of the results.

  These activities are even more relevant now the DMHIS will have these responsibilities in the Results Based Financing program
- The DMHIS and RO of the NHIA should present the results of monitoring providers on quality of care to discuss with other stakeholders in health at the district level in the appropriate platform – probably this is the health committee of the DA.

References

Arhinful, D.K. (2003). The solidarity of self-interest: Social and cultural feasibility
of rural health insurance in Ghana. African Studies centre, ASC Research Report No. 71. The Netherlands: University of Amsterdam

Asenso-Boadi, F. (2008). Using National Health Insurance to Finance Health Care: Ghana's Experience. PowerPoint presentation accessed at: http://www.healthfinance.org/files/pages/events_webinars/Session%20I%20Ghana%20Overview.pdf.

Bannerman, C., Akufo, C., Enyimayew, N. and Killian, R. (2006). *Health Care Quality Assurance Manual.* Accra: Ghana Health Services, Institutional Care Division

Basaza R, Criel B, Van der Stuyft P. (2008). Community health insurance in Uganda: why does enrolment remain low? A view from beneath. *Health Policy*, 87(2):172–84

Basaza R, Criel B, Van der Stuyft P. (2007) Low enrolment in Ugandan community
health insurance schemes: underlying causes and policy implications. *BMC Health Services Research*, 7:105.

Beersen, N., Kallewaard, M., van Croonenborg, J.J., van Everdingen, J.J.E. and van Barneveld, T.A. (2007) *Handleiding Indicatorontwikkeling*, Kwaliteitsinstituut voor de Gezondheidszorg CBO

Broomberg, J., P. Masobe, and Mills, A.. (1997). To Purchase or to Provide? The Relative Efficiency of Contracting-Out versus Direct Public Provision of Hospital Services in South Africa. In *Private Health Providers in Developing Countries: Serving the Public Interest?*, ed. S. Bennett, B. McPake, and A. Mills. London: Zed Press.

Christian Health Association of Ghana, CHAG (2007) Programme of Work 2008-2012

D'Ambruoso, L., Abbey, M., and Hussein, J. (2005). Please understand when I cry out in pain: women's accounts of maternity services during labour and delivery in Ghana*. BMC Public Health*, 5, 140.

De Allegri, M., Sauerborn, R., Kouyaté, B. and Flessa, S. (2009). Community health
insurance in sub-Saharan Africa: what operational difficulties hamper its successful development? *Tropical Medicine and International Health*, 15(5), in press.

Donabedian, A. (1980). *The Definition of Quality and Approaches to Its Assessment.* Ann Arbor, MI: Health Administration Press.

Eichler, R., Auxila, P., and Pollock, J. (2001). Performance-Based Payment to Improve the Impact of Health Services: Evidence from Haiti. *World Bank Institute Online Journal.*

Eichler, R. and De, S. (2008). *Paying for Performance in Health: A Guide to developing the Blueprint*. Health Systems 2020 for USAID

Franco, L.M., Franco, C., Kumwenda, N. and Nkhoma, W. (2002). Methods for assessing quality of provider performance in developing countries. *International Journal for Quality in Health Care*, 14 (S1):17-24

Ghana Ministry of Health (2004) National health insurance policy framework for Ghana (revised version), Accra.
Ghana Ministry of Health (2006). Human resource policies & strategies for the health sector 2007-2011 (draft)

Ghana Ministry of Health (2008). *Independent Review: Health Sector Programme of*
Work for 2007. Accra: Ministry of Health

Ghana Ministry of Health (2009a). *Ghana annual independent health sector review for 2008.* Accra: Ministry of Health

Ghana Ministry of Health (2009b). The Ghana Health Sector 2009 Programme of Work. Change for Better Results: Improving Maternal and Neonatal Health

McIntyre, D., Garshong, B., Mtei, G., Meheus, F., Thiede, M., Akazili, J., Ally, M., et al. (2008). Beyond Fragmentation and towards universal coverage: insights from Ghana, South Africa and the United Republic of Tanzania. *Bulletin of the World Health Organization*. 86(11):871-876

Ghana Statistical Service, Health Research Unit, ORC Macro (2003). *Ghana Service Provision Assessment Survey 2002*

Institute of Medicine (2000). *To Err is Human: Building a Safer Health System*. Washington, D.C.: National Academy Press

Institute of Medicine (2001). *Crossing the Quality Chasm*. Washington, DC: National Academy Press.

Jack, W. (2003). Contracting for Health Services: An Evaluation of Recent Reforms in Nicaragua. *Health Policy and Planning*, 18(2):195 - 204

McBride, A.B., Neiman, S. and Johnson, J. (2000). Responsibility-Centered Management: A 10-Year Nursing Assessment. *Journal of Professional Nursing,* 16(4): 201 - 9

Mensah, S. A. (2009). Status of NHIS and New Strategic Direction. PowerPoint presentation to the Ghana Bi-Annual Health Summit, November 2009. Accra. Accessed at: http://moh-ghana.org/health_summit_N09/present.html.

Mensah, J., Oppong, J.R., Bobi-Barimah, K., Frempong, G. and Sabi, W. (2010). *An Evaluation of the Ghana National Health Insurance Scheme in the Context of the Health MDGs.* Global Development Network Working Paper Series, Working Paper No. 40.

National Health Insurance Scheme, NHIS. (2009). *Accreditation Tool for Health Facilities.* Accra, Ghana. Downloaded from: http://chagghana.org/chag/assets/files/NHISACCREDITATION_TOOL180109_FINAL2.11[1].pdf

Peabody, J.W., Taguiwalo, M.M., Robalino, D.A. and Frenk, J. (2006) Improving the Quality of Care in Developing Countries. In *Disease Control Priorities in*

Developing Countries (2nd Edition) 1,293-1,308. New York: Oxford University Press.

Oxfam and SNV (2010) Indigents are falling through the cracks. The unsupported need support! Policy Brief

Rajkotia, Yogesh (2007). *The Political Development of the Ghanaian National Health Insurance System: Lessons in Health Governance.* Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.

Reerink, I.H. and Rainer, S. (1996). Quality of Primary Health Care in Developing Countries: Recent Experiences and Future Directions. *International Journal for Quality in Health Care*, 8(2):131-139

Republic of Ghana. (2003). *National Health Insurance Act, 2003.* Act 650. Accra, Ghana. Accessed at: http://www.nhis.gov.gh/_Uploads/dbsAttachedFiles/Act650original2.pdf
Republic of Ghana. (2004). *National Health Insurance Regulations, 2004.* L.I.1809. Accra, Ghana.

Salmon, J., J. Heavens, C. Lombard, and P. Tavrow. (2003). The Impact of Accreditation on the Quality of Hospital Care: KwaZulu-Natal Province, Republic of South Africa. *Operations Research Results*, 2(17). Published for the U.S. Agency for International Development (USAID) by the Quality Assurance Project, University Research Co., Bethesda, MD.

SEND-Ghana. (2010). *Balancing Access with Quality Healthcare: An Assessment of the NHIS IN GHANA (2004-2008).* Accra, Ghana

SNV (2010) Bringing Health Insurance to Communities. Increasing enrolment through Community Health Insurance Committees (CHICs).

Silimper, D. R., Franco, L.M., Veldhuyzen van Zanten, T., and MacAulay, C. (2002). A Framework for Institutionalizing Quality Assurance. *International Journal for Quality in Health Care,* 14 (Suppl. 1): 67–73.

Toonen, J., Canavan, A., Vergeer, P. and Elovainio, R. (2009). *Performance-based financing for health*. Amsterdam: KIT Publishers

Toonen, J., Matinga, P., Chebere, M. and Blanchett, N. (2009) The Political Economy of HR Policy-Making in Ghana. Final draft

Veillard, J., Champagne, F., Klazinga, N., Kazandjian, V., Arah, O.A. and Guisset A.L. (2005). A performance assessment framework for hospitals: the HWO regional office for Europe PATH project. *International Journal* for *Quality* in *Health Care*, 17:487-496

Vergeer, P., Rogers, D., Brennan, R.J. and Sarcar, S. (2010) Results-Based Financing for Health (RBF). Identifying Indicators for Performance-Based Contracting (PBC) is Key: The Case of Liberia.

Wen-Ta, Ch., Che-Ming, Y., Hui-Wen, L. and Tu-Bin, C. (2005). Development and implementation of a nationwide health care quality indicator system in Taiwan.
International Journal for Quality in Health Care, 19(1):21-28

World Health Organization, WHO (2009) Assessment tool for the quality of hospital care for mothers and newborn babies. Geneva: WHO Regional Office for Europe

World Health Organization, WHO. (2000). *World Health Report 2000 Health Systems: Improving Performance.* Geneva: WHO

Witter, S. and Garshong, B. (2009). Something old or something new? Social health insurance in Ghana. *BMC International Health and Human Rights*, 9:20

Annex 1: Methodology and overview interviewed organizations

A qualitative method has been applied to gain insight in the accountability mechanisms regarding registration and quality of care at the district level within the context of the NHIS. Relevant stakeholders at the district level have been interviewed using a semi structured interview topic list. Furthermore a study of national and international literature has been carried out on aspects that could be used to hold providers accountable on the quality of care after being provided. Results of the latter were partly presented in the previous chapter and further presented in the 'Discussion' section

This study does not aim for representation of all the regions in Ghana, but is a first exploratory assessment. Therefore, through established contacts districts were invited to participate in the assessment. A number of districts were known for a reasonable involvement of the community, in terms of enrolling the poor. For the purpose of this assessment of number of those districts where invited to participate too. The table below gives an overview of the districts that participated in this exercise.

In total 23 interviews were conducted. They worked for either a DMHIS (7), a private provider (3), a public provider (2), District Health Administration (3), District Assembly (3), Regional Office (4), Regional Health Administration (1). Moreover, a Caretaker Committee meeting and a meeting between a DMHIS and a number of providers was attended. Below you find an overview of the organizations and corresponding district and regions, participating in the assessment. Interviews were conducted using a semi-structured interview topic list, enclosed as Annex 2.

Region	Districts	Organization interviewed
Greater Accra Region	-	Regional Office
	Ayawasso	DMHIS Private provider GHS provider
	Kpeshie	DMHIS CHAG provider Meeting with several providers
Central Region	Assin South	DMHIS CHAG provider
	Komenda-Edina-Eguafo-Abrem	DMHIS District Health Administration District Assembly
	Awutu Senya	District Health Administration
Western Region	Mpohor Wassa East	DMHIS District Health Administration District Assembly
Eastern Region	-	Regional Office
	-	Regional Health Administration
	Akuapem North	DMHIS GHS
	New Juaben	DMHIS District Assembly Caretaker Committee

Annex 2: Semi-structured topic list

Topic	Stakeholder	Question
General governance structure / Multi-stakeholder environment	**DMHIS** **DMHT** **CHIC** **Patient Groups** **Professional Association** **Provider**	What is your role, task and responsibility within, or related to, the NHIS, in theory and in practice? (How is that translated into work, what are your objectives) What is the role, task and distribution of responsibility of the other players in the NHIS Can you describe collaboration/partnership with the other players – how it works in real life What are shared goals/objectives (or expected results) (in health sector but also other sectors) between you and partners. Are there conflicts in objectives? How do you deal with them? Do you feel the shared objective is 'natural' or are there incentives needed for all the players to stick to the shared objective (expected result) Is this collaboration/partnership formal or informal? Do you have documents/regulations concerning this partnership? What is the nature of the relationship (directive, advising, reporting, ..). How is your communication, info sharing etc. What are the 'partnership attributes' (regulations, checks, meetings) used? Are these formal or informal? How is relationship with your partners (trust, respect, atmosphere, commitment)? Can you describe a meeting How important/powerful are the other stakeholders? Is that good/not good? Do you feel you can influence them, do you feel you have any 'power'/influence. Do you feel like the patients should be represented? Why yes/no? And who represents the patients What are your priorities? Can you attain those priorities? Why yes, no, what would you need for that. Are you confident with your role? Do you feel you can do what is expected? Do you have all the attributes to execute your role? What could be changed? Accountability on what, how is that organized, what are consequences
Quality of Care	**DMHIS** **DMHT** **CHIC** **Patient Groups** **Professional Association** **Provider**	How is the quality of care at the moment? Did NHIS change the quality of care? What are elements of quality of care? What is/are the most important element(s) of quality of care for you? How is quality of care measured at the moment? How should quality if care be measured (method, structure, indicators, stakeholders, info flow) → use list Are claims used in measuring/assuring quality of care? Do you think they could be used I measuring quality of care? How is quality of care assured in the system at the moment? (what players, who has a role in it, who carriers final responsibility, who is accountable?) How should quality of care be assured in the system

		How are the health care provider and assurer of quality of care hold accountable? Should quality of care have a place in a contract? How should that look like, what should be in contract specifically? Who should all be on the contract? Do you feel that you have a role in assuring quality of care? What should your role be? How would you do that, what do you need for that? (Internally, externally, incentives) How could you be hold accountable in that role? Who can influence quality of care (internal/external factors)? What is done to improve quality of care? What is the consequence of good/bad quality of care?
	Specific: **DMHIS** **DMHT**	Do you ever receive complaints on quality of care and how many from clients/somebody else. What do you do with this? Do you use incentives to influence/improve quality of care? What kind of incentives, positive/negative? What would you need to do that? Do you ever visit health care providers to check quality of care? Do you give feedback?
	Specific: **Patient Groups** **Professional Association** **Provider**	What do you do when you receive complaints? How are you stimulated to improve the quality of care? Incentives? Positive or negative
Enrolment (of the poor)	**DMHIS** **DMHT** **CHIC** **Patient Groups** **Professional Association** **Provider**	What is the current policy/strategy of enrolling the poor. From NHIA, in your district. Are these documented? What is the system of enrolment? Who are involved, who is responsible, how is this 'player' hold accountable/responsible? How many indigents are enrolled? Why so many/little? What are your implementation policies to try to enrol the poor? Is it important for you to enrol the poor? How do you stimulate enrolment of the poor? Is there a special 'outreach' program? CHIC agents: how are they paid? Do you think this should be improved How could this be improved? What could be your role? What do you need for this? How are you hold accountable/responsible? What are consequences for high/low enrolment?
	Stick to how this is now, how it works and how it is measured	What do you think is a good mechanism to identify the poor – how is it done now. Do you think there should be other ways to pay premium (i.e. in kind) Is the population/the poor sensitized? Educated about the NHIS? How?

Management	**DMHIS**	How do you manage your daily operations?
		What would you need to manage daily operations?
		What kind of information would you need to manage daily operations? Do you collect this? Why yes/no? Have you received a M&E system from the NHIA? (or SNV)
		How do you use this? How do you interpret the numbers/information?
		Who does that? When, how often? How do you collect data, how do you analyse etc.. How do you fund these activities?
		Do you think that is good? What should be changed?
		What do you with information? Can you give an example how you used collected information?
		Who do you share information with? Do you share mandatory or voluntarily.
		Do you discuss results internally/externally? Do you get feedback? (From NHIA/C,RO, anyone else)?
	DMHT **CHIC** **Patient Groups** **Professional Association**	Do you ever receive information on management/daily operations NHIS (district schemes)? Why yes/no Would you like to receive that information? What kind of information exactly?
		What would you use this information for?
		Do you think this would improve: Quality of care, enrollment of the poor, overall management and governance?

Annex 3: Object and Functions of the National Health Insurance Authority

(1) The object of the Authority is to secure the implementation of a national health insurance policy that ensures access to basic healthcare services to all residents.

(2) For the purposes of achieving its object, the Authority may

(a) register, licence and regulate health insurance schemes;

(b) supervise the operations of health insurance schemes;

(c) grant accreditation to healthcare providers and monitor their performance;

(d) ensure that healthcare services rendered to beneficiaries of schemes by accredited healthcare providers are of good quality;

(e) determine in consultation with licensed district mutual health insurance schemes, contributions that should be made by their members;

(f) approve health identity cards for members of schemes;

(g) provide a mechanism for resolving complaints by schemes, members of schemes and healthcare providers;

(h) make proposals to the Minister for the formulation of policies on health insurance;

(i) undertake on its own or in collaboration with other relevant bodies a sustained public education on health insurance;

(j) devise a mechanism for ensuring that the basic healthcare needs of indigents are adequately provided for;

(k) maintain a register of licensed health insurance schemes and accredited healthcare providers;

(l) manage the National Health Insurance Fund;

(m) monitor compliance with this Act and the Regulations and pursue action to secure compliance; and

(n) perform any other function conferred on it under this Act or that are ancillary to the object of the Council.

Annex 4: Governing body of the National Health Insurance Authority

(1) The governing body of the Authority is a Council consisting of

(a) the chairperson,

(b) one representative of

(i) the Ministry of Health not below the rank of a Director,

(ii) the Ghana Health Service not below the rank of a Director,

(iii) the Society of Private Medical and Dental Practitioners nominated by the Ghana Medical Association,

(iv) the Pharmaceutical Society of Ghana,

(c) one representative each of licensed

(i) mutual health insurance, and

(ii) private health insurance schemes,

(g) one representative of the Minister responsible for Finance not below the rank of a Director,

(h) one legal practitioner with experience in health insurance nominated by the Ghana Bar Associations,

(i) one representative of the National Insurance Commission,

(j) one person representing organised labour,

(k) two persons representing consumers one of whom is a woman,

(l) one representative each from

(i) the Ministry of Local Government, and

(ii) Social Security and National Insurance Trust, and

(m) the Executive Secretary appointed under section 92.

(2) The chairperson and the other members of the Council shall be appointed by the President in accordance with article 70 of the constitution.