UNIVERSAL HEALTH COVERAGE (UHC): A MUST DO FOR GHANA AND SUB SAHARAN AFRICA

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Abstract: In September 2000, leaders of 189 countries gathered at the United Nations (UN) headquarters and signed the historic millennium declaration in which they committed to achieving a set of eight measurable goals. The goals ranged from halving extreme poverty and hunger to promoting gender equality and reducing maternal and child mortality by the target date of 2015. The eight millennium development goals (MDG) failed to consider the root causes of poverty and overlooked gender inequality as well as the holistic nature of development. The goals made no mention of human rights and did not specifically address economic development.

Key Words: Sustainable development goals (SDG), Universal health coverage (UHC), Millennium development goals (MDGs), National health insurance (NHIS), health care, finance

1.0 INTRODUCTION:

Universal health coverage (UHC) means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

This definition of UHC embodies three related objectives:

1. Equity in access to health services - everyone who needs services should get them, not only those who can pay for them;
2. The quality of health services should be good enough to improve the health of those receiving services; and
3. People should be protected against financial- risk, ensuring that the cost of using services does not put people at risk of financial harm.

UHC is firmly based on the WHO constitution of 1948 declaring health a fundamental human right and on the Health for All agenda set by the Alma Ata declaration in 1978. UHC cuts across all of the health-related Sustainable Development Goals (SDGs) and brings hope of better health and protection for the world's poorest. Commenting on the effect of MDGS, UN Secretary General, Ban Kimoon (W.H.O 2014) said: The MDGs helped to lift more than one billion people out of extreme poverty to make inroads against hunger to enable more girls to attend school than ever before and to protect our planet. However the progress has been uneven - a problem the upcoming sustainable development Goals (SDGs) seek to address.

2. 0 METHOD:

Sample research where taken from scientific data from other works done and published in peer reviewed journals. They were analysed, criticized constructively, appraised and some which the writers deem fit was taken as a reference on this work. Stratified and probity of empirical data and cross sectional surveys done on the subject matter was also revised by the authors in bringing out the final write up.

3.0 DISCUSSION:

3.1 SUSTAINABLE DEVELOPMENT GOALS (SDGs)

The SDGs are new universal set of goals, targets and indicators that the UN member states will be expected to use to frame their agenda and political policies over the next 15 years. The SDGs follow and expand on the MDGs. Unlike the MDGs which were put together by a team of experts, the SDGs are a summation of consultations conducted in countries across the globe among different stakeholders. The 17 SDGs range from ending poverty to achieving gender equality and empowering all women and girls and ensuring healthy lives and promoting well-being for all at all ages by the target date 2030. The United Nations Sustainable Development Goals that all UN Member States have agreed to try to achieve Universal Health Coverage by 2030. This includes financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

A new global coalition of more than 500 leading health and development organizations worldwide is urging governments to accelerate reforms that ensure everyone, everywhere, can access quality health services without being forced into poverty.

The coalition emphasises the importance of universal access to health services for saving lives, ending extreme poverty, building resilience against the health effects of climate change and ending deadly epidemics such as Ebola.

3.2 How healthy is the Health Sector in Ghana to achieve UHC

Most times, the state of health in Ghana has been featured by significant inequalities over years. Although the health status of the general population may be increasing and improving, the health of the less endowed is rather treading behind. Financial and geographical access to health care delivery remains a challenge and health sector acknowledges this (ministry of health mid-term plan 2014 – 2017).

The National Health Insurance Scheme (NHIS) has a national coverage rate of only about 41 percent, leaving 59 percent resorting to cash and carry system or alternative sources of health care. The NHIS was set up to allow Ghanaian citizens to make contributions into a fund so that in the event of illness, Ghanaian contributors could be supported by the fund to receive affordable health care. According to the National Health Insurance Authority (NHIA) 2010 Annual report, the main challenge facing the scheme is late release of funds and fraud in the system.

3.3 Why and what is Universal Health Coverage (UHC)

Universal Health Coverage championed by the world health organization (WHO) is ensuring that all people can use the preventive, curative, rehabilitative and palliative health services they need which is of significant quality to be effective while also ensuring that use of these services does not expose the user to financial hardship. The goal of UHC is to ensure that all people obtain the health care they need without suffering financially when paying for them. This requires a strong, efficient, well run health system. With good financing and access to essential medicines prescribed and technologies needed in a sufficient capacity by well trained professionals like medical doctors (physicians and surgeons), biomedical scientist, medical laboratory officers, nurses, midwifes, radiographers and sonographers, physiotherapist, Paramedics etc.

Any country that has achieved UHC has the following features:

1. The quality of health care delivery is strong and good enough to improve the health of the population
2. It has a stable, firm financial risk protection

3.4 SDGS: The tangent to a better UHC

Goal three of SDGs is specifically on health, thus to ensure a healthy lives for all ages. The target urges all countries to achieve UHC at every stage of life with particular emphasis on primary health care delivery including mental and reproductive health. This is to ensure that all people receive quality health care without suffering financial hardship. Countries are required to implement policies that will create the enabling environment to promote the health of citizens for sustainable development in their daily lives. For much of the 20th century,

universal health coverage was limited to a few high-income countries, but in the past two decades, a number of lower- and middle-income countries have successfully embraced reforms to make quality health care universally available. Countries as diverse as Brazil, Ghana, Mexico, Rwanda, Turkey and Thailand have made tremendous progress toward universal health coverage in recent years. Today, the two most populous countries, India and China, are pursuing universal health coverage, and more than 80 countries have asked the World Health Organization for implementation assistance.
The 500 and over organizations participating in the first-ever Universal Health Coverage Day coalition represent a diverse cross-section of global health and development issues, including infectious diseases, maternal and child health, non-communicable diseases and palliative care.

Across these issues, knowledge and technologies exist to save and improve lives in significant numbers, but the impact of these tools is severely hampered by lack of equitable access to quality health services.

3.5 Universal Health Coverage as an anti – dote

Universal Health Coverage (UHC) and investments in health systems can accelerate global efforts to ensure access to healthcare to anyone who needs it, leaving no one behind. UHC can help us galvanize progress towards achieving all the health - related Millennium Development Goals and ending preventable deaths, particularly among the most vulnerable populations -women, children and adolescents as well as communities beyond 2015. With universal coverage, we can foster greater equity, empower countless individuals, and contribute to a life of dignity for all. India's health reform movement coincides with this global crusade for UHC at a crucial time, when the country's population faces impoverishment due to rising healthcare costs, emerging and new disease outbreaks and a health system badly in need of integrated services, better access and more robust primary health care. UHC would provide an ideal framework to address many of these pressing issues in a comprehensive manner. Strong health systems that reach every one everywhere are crucial to fight HIV, TB and malaria.

3.6 Health financing in Universal Health Coverage

Universal health coverage (UHC) aims to ensure that everyone, everywhere, can access quality health services without facing financial hardship as a result. Every year 100 million people are pushed into poverty and 150 million people globally suffer financial catastrophe annually because of out- of- pocket expenditure on health services. Financial protection is at the core of UHC and improving financial protection is a central focus of health financing policy.

Health financing is concerned with how financial resources are generated, allocated and used in health systems. Health financing policy focuses on how to move closer to universal coverage with issues related to:

(i) how and from where to raise sufficient funds for health
(ii) how to overcome financial barriers that exclude many poor from accessing health services
(iii) how to provide an equitable and efficient mix of health services

Spending on health: A global overview (Fact sheet N°319, April 2012)

Total global expenditure for health1 US$ 6.5 trillion

Total global expenditure for health per person per year US$ 948

Country with highest total spending per person per year on health United States (US$ 8362)

Country with lowest total spending per person per year on health Eritrea (US$ 12)

Country with highest government spending per person per year on health Luxembourg (US$ 6906)

Country with lowest government spending per person per year on health Myanmar (US$ 2)

Country with highest annual out-of-pocket household spending on health Switzerland (US$ 2412)

Country with lowest annual out-of-pocket household spending on health Kiribati (US$ 0.2)

Average amount spent per person per year on health in countries belonging to the Organisation for Economic Co-operation and Development (OECD) US$ 4380

Percentage of the world's population living in OECD countries 18%

Percentage of the world's total financial resources devoted to health currently spent in OECD countries 84%

WHO estimate of minimum spending per person per year needed to provide basic, life-saving services US$ 44

Number of WHO Member States where health spending – including spending by government, households and the private sector and funds provided by external donors – is lower than US$ 50 per person per year 34

Number of WHO Member States where health spending is lower than US$ 20 per person per year 7

Percentage of funds spent on health in WHO's Africa Region that has been provided by donors 11%.

4.0 ANALYSIS:

4.1 SUMMARY OF SUSTAINABLE DVELOPMENT GOALS (SDGs)

On 25 September 2015, the UN General Assembly adopted the new development agenda "Transforming our world: the 2030 agenda for sustainable development". The agenda builds upon the outcome document of the UN Conference on Sustainable Development (Rio + 20 conference), which took place in June 2012 and led to the establishment of the Open Working Group on SDGs, a group of Member States tasked with preparing a proposal on the SDGs. The Open Working Group proposal was welcomed by the UN General Assembly in September 2014 and became the principal guideline for integrating SDGs into the post- 2015 development agenda. Further intergovernmental negotiation processes resulted in the final document for the Sixty-ninth UN General Assembly in 2014, which also included the outcomes of major global meetings such as the Sendai Framework for Disaster Risk Reduction 2015 – 2030 and the Addis Ababa Action Agenda, as well as inputs such as the synthesis report of the Secretary - General on the post-2015 agenda, "The road to dignity: ending poverty, transforming all lives and protecting the planet", published in December 2014. The 17 goals of the new development agenda integrate all three dimensions of sustainable development (economic, social and environmental) around the themes of people, planet, prosperity, peace and partnership.

The SDGs seek to continue to prioritize the fight against poverty and hunger, while also focusing on human rights for all, and the empowerment of women and girls as part of the push to achieve gender equality. They also build upon, and extend, the MDGs in order to tackle the "unfinished business" of the MDG era. The SDGs recognize that eradicating poverty and inequality, creating inclusive economic growth and preserving the planet are inextricably linked, not only to each other, but also to population health; and that the relationships between each of these elements are dynamic and reciprocal. For example, with regard to health, a fundamental assumption of the SDGs is that health is a major contributor and beneficiary of sustainable development policies.

4.2 THE 17 SUSTAINABLE DEVELOPMENT GOALS

1 End poverty in all its forms everywhere

2 End hunger, achieve food security and improved nutrition and promote sustainable agriculture

3 Ensure healthy lives and promote well-being for all at all ages

4 Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

5 Achieve gender equality and empower all women and girls

6 Ensure availability and sustainable management of water and sanitation for all

7 Ensure access to affordable, reliable, sustainable and modern energy for all

8 Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all

9 Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation

10 Reduce inequalities within and among countries

11 Make cities and human settlements inclusive, safe, resilient and sustainable

12 Ensure sustainable consumption and production patterns

13 Take urgent action to combat climate change and its impacts

14 Conserve and sustainably use the oceans, seas and marine resources for sustainable development

15 Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss

16 Promote peaceful and inclusive societies for sustainable development provide access to justice for all and build effective, accountable and inclusive institutions at all levels

17 Strengthen the means of implementation and revitalize the global partnership for sustainable development.

4.3 What W.H.O is doing in the area of health systems financing

WHO works with countries to devise ways of raising more funds for health equitably, to use the available funds efficiently, and to monitor the use of funds. It works with the international community to try to raise more, and more predictable funds for health.

Many countries need to use available funds more efficiently and raise more funds from domestic sources, but these measures would be insufficient to fill the current gap in the poorest countries. Only an increased and predictable flow of donor funding will allow them to meet basic health needs in the short to medium term.

In its 2010 world health report:

1. The World Health Organization noted that there is no single, best path for reforming health financing arrangements to move systems closer to universal health coverage, i.e. to improve access to needed, effective services while protecting users from financial ruin. However, this lack of a blueprint for health financing reforms was not meant to convey the message that “anything goes” on the path to universal health coverage. Indeed, concerns have been raised that some reforms, often implemented in the name of expanding coverage, may actually compromise equity.

2. Theory and country experience yield important lessons on both promising directions and pitfalls to avoid. Interpretation of health financing reform experience requires getting beneath commonly used labels such as “tax-funded systems” or “social health insurance”, or simply even “health insurance”, which was used as the basis for a systematic review published in the September issue of the WHO report on finance 2014. Such labels hide more than they illuminate, as shown by emerging evidence on reforms that increase access and financial protection but are funded predominantly from general tax revenues (e.g. Kyrgyzstan, Mexico, Rwanda, and Thailand).

Deriving meaningful lessons from innovative reform experiences requires a deeper understanding of how countries have altered their funding sources, pooling arrangements, purchasing methods, and policies on benefits and patient cost- sharing. All systems, regardless of what they are called, have to address these functions and policy choices.

4.4 Revenue sources

Predominant reliance on compulsory or public financing is essential for universal coverage. No country has attained universal population coverage by relying mainly on voluntary contributions to insurance schemes, whether they are run by nongovernmental organizations, commercial companies, "communities", or governments. Compulsion, with subsidization for the poor, is a necessary condition for universality. So while it is unfortunately the case that low- and middle-income countries with poor fiscal capacity may need to explore voluntary prepayment mechanisms as an alternative to out - of - pocket payments, this is not a long - term solution. And certainly, misplaced faith in voluntary prepayment should not provide an excuse for governments to direct public resources away from the health sector.

While public funding can come from general government revenues or compulsory "social health insurance" contributions (payroll taxes), general government revenues are essential for universal health coverage. Even the German government injects general revenues into the system to ensure coverage for those unable to contribute. For poorer countries, the structure of the economy, with a large share of the population outside salaried employment, makes it difficult to enforce either income taxes or payroll taxes on most citizens. Thus, increasing the size of the compulsory prepaid pool of funds requires transfers from general revenues (sourced predominantly from consumption taxes (e.g. value added tax) in most low - and middle - income contexts), and the relative need for this grows in proportion to the size of the so - called "informal sector" of the population. This further implies that moving towards universal health coverage in such contexts means moving away from the idea of a purely or even a predominantly contributory basis for entitlement and coverage.

4.5 Larger pools with more diverse populations

Universal health coverage goals of equitable access with financial protection require pooling arrangements that redistribute prepaid resources to individuals with the greatest health service needs. Fragmentation exists when there are barriers to this redistribution, with perhaps a worst-case scenario where there are different schemes for different social groups. For example, in most low- and middle-income countries that have initiated financing reforms with a health insurance scheme solely for the formal workforce, attention and resources are focused on already advantaged and well organized groups, which tends to exacerbate rather than redress inequalities and leads to locking into a two - tier system.

For countries that have not yet implemented a formal sector scheme, alternatives exist. Rwanda initiated its "community- based health insurance" system by first fully subsidizing the identified indigent from general revenues, then bringing contributions from the rest of the population into the same pools and continuing to subsidize the entire system via budget allocations for salaries and infrastructure. Kyrgyzstan and the Republic of Moldova designed a universal system from the beginning of their reforms by having a single pool for both the formal sector (from contributions) and the rest of the population (from general revenues). In a recently published review, common themes among nine African and Asian countries that had made sustained progress towards universal health coverage were both the use of tax revenues to extend coverage and the consolidation of risk pools. These examples highlight what, on reflection, should be an obvious aim for low - and middle-income countries: to use existing scarce funding sources in an explicitly complementary way.

4.6 Strategic purchasing to sustain progress

Countries cannot simply spend their way to universal health coverage. To sustain progress, efficiency and accountability must be ensured. The main health financing instrument for promoting efficiency in the use of funds is purchasing, and more specifically, strategic purchasing. Developing the skills and systems needed for this is at the heart of strengthening national health financing systems, as it requires ongoing use and analysis of data generated by the system, which enables countries to adapt their systems to changing circumstances. As with the term "insurance", much attention is given to initiatives described as schemes: "performance-based funding", "results-based financing" or "pay - for - performance", etc. The important question is not the "success" of a given scheme or project; undue attention has probably been given to trying to prove whether or not these schemes work. This is not the central issue. We know that passive purchasing methods, whether in the form of unmanaged fee - for - service reimbursement or rigid line - item budgets, harm efficiency. Thus, the point is that these initiatives should be more appropriately conceived (and evaluated) as entry points to move away from passive methods and

strengthen purchasing arrangements within a national health financing system, not as stand-alone projects or time - limited interventions.

4.7 From scheme to system

In a systematic review published in September by Spaan et al, most health insurance schemes were found to improve health service utilization and financial protection for their members. This is hardly news and certainly no basis for a policy recommendation because a scheme can benefit its members at the expense of the rest of the population if, for example, it excludes high - risk or poor people. The real question, posed long ago, is what effects a given scheme might have on universal health coverage objectives in terms of the health system and the population as a whole. Schemes can contribute to these objectives, or they may detract from them. This is truly a case in which "the devil is in the detail". But with the correct unit of analysis the entire population and a clear conceptual framework, appropriate lessons can be derived from country experiences on some "dos" and "don'ts" in health financing reform. Policy can best be informed when we get the questions right. There will never be a simple recipe or blueprint, but approaches that compromise equity are not desirable pathways to universal health coverage.

5.0 FINDINGS:

The 2030 Sustainable Development Agenda is of unprecedented scope and ambition, applicable to all countries, and goes well beyond the MDGs. While poverty eradication, health, education, and food security and nutrition remain priorities, the Sustainable Development Goals (SDGs) comprise a broad range of economic, social and environmental objectives, and offer the prospect of more peaceful and inclusive societies.

Progress towards the MDGs, on the whole, has been remarkable, including, for instance, poverty reduction, education improvements and increased access to safe drinking-water. Progress on the three health goals and targets has also been considerable. Globally, the HIV, tuberculosis (TB) and malaria epidemics were "turned around", child mortality and maternal mortality decreased greatly (53% and 44%, respectively, since 1990), despite falling short of the MDG targets.

During the MDG era, many global progress records were set. The MDGs have gone a long way to changing the way we think and talk about the world, shaping the international discourse and debate on development, and have also contributed to major increases in development assistance. However, several limitations of the MDGs have also become apparent, including a limited focus, resulting in verticalization of health and disease programmes in countries, a lack of attention to strengthening health systems, the emphasis on a "one - size - fits - all" development planning approach, and a focus on aggregate targets rather than equity.

The 17 goals and 169 targets, including one specific goal for health with 13 targets, of the new development agenda integrate the three dimensions of sustainable development around people, planet, prosperity, peace and partnership.

The health goal is broad: "Ensure healthy lives and promote well-being for all at all ages". Health has a central place as a major contributor to and beneficiary of sustainable development policies. There are many linkages between the health goal and other goals and a target, reflecting the integrated approach that is underpinning the SDGs. Universal health coverage (UHC), one of the 13 health goal targets, provides an overall framework for the implementation of a broad and ambitious health agenda in all countries.

The SDGs aim to be universal, integrated and interrelated in nature. In order to take on such a wide range of crosscutting issues, it will be necessary to achieve far greater inter - sectoral coherence, integration and coordination of efforts than has hitherto been in evidence. A revitalized global partnership for sustainable development, based on a spirit of strengthened global solidarity, informed by a readiness to reach across sectors and guided by clear and measurable objectives will be critical for the mobilization of the means required to implement the SDG agenda, focused particularly on the needs of the poorest and most vulnerable.

6.0 RESULTS

SUMMARY ON MILLENIUM DEVELOPMENT GOALS (MDGs)

In September 2000, the UN General Assembly adopted the Millennium Declaration, establishing a global partnership of countries and development partners committed to eight voluntary development goals, to be achieved by 2015.

Representing ambitious moral and practical commitments, the MDGs 2 called for action to:

(1) Eradicate extreme poverty and hunger;

(2) achieve universal primary education;

(3) promote gender equality and empower women;

(4) Reduce child mortality;

(5) Improve maternal health;

(6) combat HIV/AIDS, malaria and other diseases;

(7) Ensure environmental sustainability;

(8) Develop a global partnership for development.

Three of the eight MDGs are focused on health, while health is also a component of several other MDGs (nutrition, water and sanitation).

There has been unprecedented mobilization of resources around MDG-related activities across a wide spectrum of global and national initiatives and the development community has convened on a regular basis to assess progress. Major global events related to the MDGs include: the 2001 and 2011 UN special sessions on HIV/AIDS, convened to intensify international activity to fight the epidemic.

The 2005 World Summit, which reaffirmed the commitments to the Millennium Declaration; the 2008 high-level event at the UN in New York,6 at which there was a call to accelerate progress towards the MDGs; the 2010 Millennium Development Goals Summit, which concluded with the adoption of a Global Action Plan and the announcement of multiple initiatives against poverty, hunger and disease, as well as initiatives designed to accelerate progress on women's and children's health, and at which specific MDG-related commitments were made by countries and others; and, most recently, the 2013 UN special event to follow up on MDG - related efforts.

Many regional and country events have also been held to review progress and make new commitments. The MDGs have gone a long way to changing the way we think and talk about the world, shaping the international discourse and debate on development, and stimulating popular awareness of moral imperatives such as achieving gender equality and ending poverty and starvation. The MDGs have also contributed to major increases in development assistance 8,9,10 as evidenced by the 66% jump in official development assistance (ODA, in real terms) between 2000 and 2014 when it reached an unprecedented US$ 135 billion.

6.1 Strengths and limitations of the MDGs

The MDGs have been more influential than any other attempt at international target setting in the field of development. The rapid acceleration of global progress towards the poverty reduction, gender, and health and education goals since 2000, and particularly since 2005, is just one example of their beneficial impact. The adoption of a simple, clear and time-bound framework that is compelling, easy to communicate and measurable has been one of the MDGs' great strengths, encouraging donor governments, international agencies and country decision-makers to focus attention on areas of need, and to measure the results of initiatives undertaken. And

while it is hard to isolate specific causal effects, it seems reasonable to suppose that the intensity of focus (and investment) has been a key driver of innovation, enabling the scale-up of new interventions, such as antiretroviral therapy (ART), long-lasting insecticidal nets (LLINs), artemisinin - based combination therapies (ACTs), vaccines against pneumonia and diarrhoeal disease, and new and better diagnostic tests for multiple diseases.

The emphasis on measuring results has also had a positive impact on country data systems. A good example is the improvement in country data availability for a subset of 22 official MDG indicators between 2003 and 2014. While in 2003, only 2% of developing countries had at least two data points for 16 or more of the 22 indicators, by 2014 this figure had reached 79%, reflecting the increased capacity of national statistical systems to address monitoring requirements. Development partners played an important role in boosting monitoring capacity, most successfully by providing long-term support to national health surveys, especially the United Nations Children's Fund (UNICEF) and the United States Agency for International Development (USAID). These surveys, mostly conducted by national statistical offices in collaboration with ministries of health, also generated data on inequalities in health, especially for reproductive, maternal and child health indicators.

One important benefit of increased monitoring was highlighting the importance of accountability involving a cyclical process of monitoring, review and remedial action. The importance of accountability has been underlined at all levels through, for instance, the recommendations of the Commission on Information and Accountability for Women's and Children's Health, and has not only improved monitoring, but is also gradually leading to more inclusive and transparent reviews of progress involving civil society, politicians and the media.

7.0 RECOMMENDATION:

Universal health protection is the key to fighting poverty, reducing inequity and nurturing economic growth. Sustainable development with decent jobs for all requires investment in health protection. These linkages cannot be ignored in any health related policy development.

Ghana will need to resource her national health insurance scheme (NHIS) to make it a stronger, stable and faster vehicle to achieving UHC. It is welcome news that the government has put up a seven member committee to review the operations of NHIS.

It is the hope of the society that this process will propose and bring on board the needed structural and financial sustainability to make the NHIS more robust vehicle for efficient health care delivery in achieving the universal health coverage.

We should equally accelerate the pace of progress made in fighting malaria, HIV/AIDS, tuberculosis, hepatitis, and other communicable diseases and epidemics, including by addressing growing antimicrobial resistance and the problem of unattended diseases affecting Ghana and other developing countries.

8.0 CONCLUSION:

Though the targets set for the health MDGs (4, 5, and 6) were all not achieved, the SDGs present Ghana with yet another opportunity to work towards improving the health system through UHC. There is the need for a strong political commitment in the form of domestic resources to help achieve the objectives set in the ministry of health mid – term development plan (2014 - 2017), the SDGs and Ghana's 40 year development plan.

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