ALIGN CONSORTIUM

CASE STUDY

The Health Technology Assessment System in Ghana

A short study of how one country decides which health products to introduce and fund—part of a series across countries.

Health leaders in all health systems must make critical decisions about which products—including diagnostics, medical devices, medicines, and vaccines—and services to provide within the constraints of their health budget. Between the global pipeline that brings technologies to market and the national systems that must deliver them at scale lies a critical inflection point: health innovation introduction. Prioritization—which often includes health technology assessment (HTA) processes—is an essential function of innovation introduction, as are the coordinated set of national and subnational processes through which innovations are prepared for sustained, scaled access (e.g., regulatory review, procurement, supply chain planning, etc).

Every health system faces difficult choices about which innovations to fund and how to make the best use of limited resources. For Ghana, these questions became increasingly urgent as pressures on the National Health Insurance Scheme (NHIS) grew. In response, the country embarked on **a deliberate effort to institutionalize Health Technology Assessment (HTA), establishing a structured pathway for reviewing evidence on new health innovations** and ensuring that coverage decisions support both population health and the long-term sustainability of the insurance scheme.

Approach

Built HTA incrementally onto existing structures (EML,[1] Standard Treatment Guidelines, NHIS) over more than a decade—not from scratch.

Stage

Recently institutionalized (governance 2019–2020, process guidelines 2022); early implementation.

Home

Inside the Ministry of Health; the HTA Secretariat lives in the Pharmacy Directorate and advises the Minister of Health.

Takeaway

Anchoring reform to a politically prized insurance program reduced resistance—relevant for countries expanding coverage under fiscal pressure.

Figure 1: Summary of Ghana's health technology assessment system.

[1]Essential Medicines List

CURRENT SYSTEM

Health product prioritization structures and processes

Where introduction starts: the Essential Medicines List

Innovation introduction in Ghana starts with inclusion on the Essential Medicines List (EML). The EML is designed to satisfy the priority healthcare needs of the population and ensure harmony among the Standard Treatment Guidelines (STGs), procurement processes, and reimbursements. It serves as the national standard for the selection of medicines based on public relevance, efficacy, safety, and comparative cost-effectiveness. Despite its name ("medicines"), the EML also includes vaccines, diagnostics, devices, and supplies. The process of adding medicines to the Essential Medicines List (EML) is a rigorous, evidence-based procedure coordinated by the Ghana National Drugs Programme (GNDP) and led by the National Medicines Selection Committee (NMSC). The procedure relies on criteria used for the World Health Organization's (WHO) EML. **Unlike the WHO's EML, which is reviewed and updated every two years, Ghana's EML is rigorous but inconsistently updated**—the most recent update was in 2017. "Limited resources" is the most cited reason for the inconsistent updates.

From the EML to reimbursement: the NHIS Medicines List

Inclusion on the EML does not automatically mean coverage by the NHIS. The NHIS Medicines List is a subset of the EML designed to guide health providers in delivering services to insurance subscribers. The list concentrates on diseases covered under the NHIS benefits package, which importantly excludes program drugs (such as those for HIV/AIDS and TB) and anesthetics. This list is developed by evaluating evidence for managing health problems commonly seen at health facilities.

Specialist groups (doctors, pharmacists, and midwives) and a core group of clinicians perform these evaluations. **The NHIS Medicines List is updated more frequently than the EML—often annually—to account for changing market prices and healthcare needs.** However, due to the infrequency of updating the EML, the NHIS Medicines List has incorporated some products not yet included in the EML.

While these lists offer a guidepost for the health products and technologies needed to meet the health system's needs, dependence on the EML poses a key challenge for introducing new innovations. The inability to update the EML without undertaking a full review limits the effective and efficient introduction of new health products.

Adding a new evidence pathway: institutionalizing HTA

The institutionalization of Ghana's HTA process in 2020 offered a new pathway for organizing evidence for reviewing new health technologies and making recommendations for the NHIS benefits package. Ghana's HTA system is embedded within the Ministry of Health (MoH), with clearly defined roles and authorities and a sequential process for conducting HTAs and implementing them in decision-making. Yet the extent to which HTA is fully routinized and authoritative within innovation introduction decisions remains a work in progress.

What is HTA?

Health technology assessment (HTA) is a multidisciplinary process that uses explicit methods to determine the value of a health technology at different points in its lifecycle. The purpose is to inform decision-making to promote an equitable, efficient, and high-quality health system (HTAi).

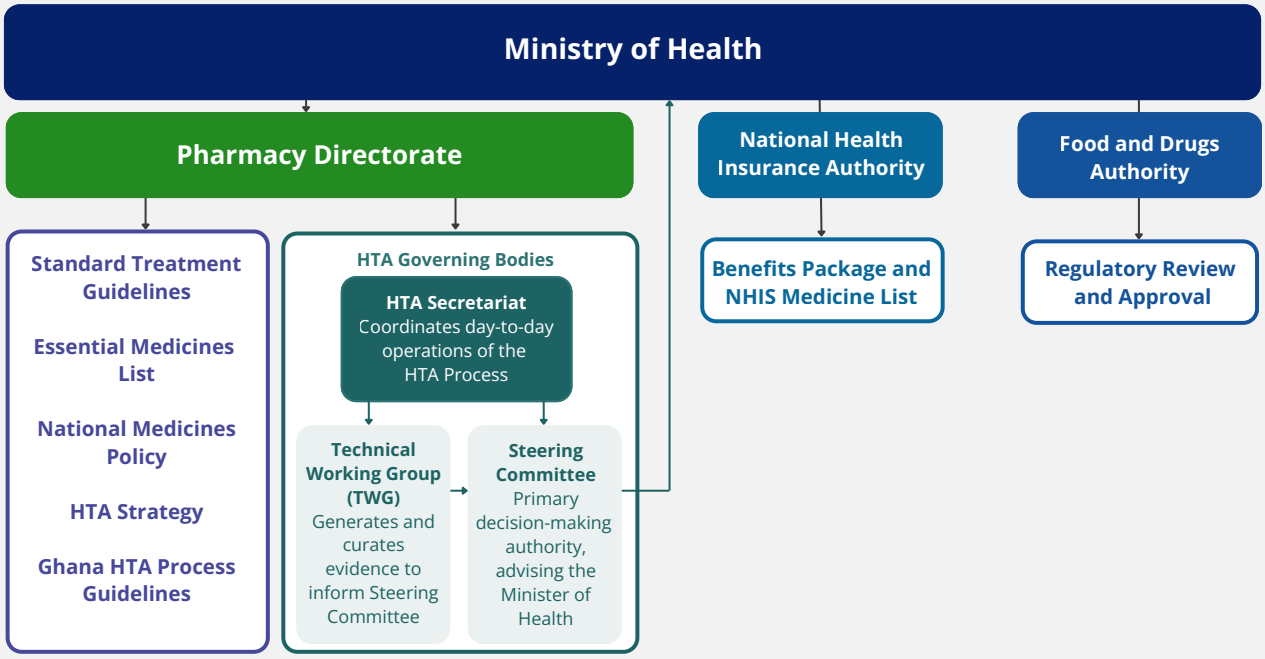

Figure 2: Structures and roles for decision-making on innovation introduction in Ghana's health system.

The establishment of an HTA governance structure and official guidelines on the HTA process in 2022 is a promising step toward using HTA in decision-making for the NHIS. **Ghana's HTA governance structure consists of three core bodies** (Figure 2):

- The *HTA Secretariat*—housed within the Pharmacy Directorate of the MoH—coordinates topic nomination, manages the assessment process, and supports the work of the Technical Working Group (TWG) and the Steering Committee.
- The *Technical Working Group (TWG)* is responsible for generating and synthesizing the evidence that underpins HTA deliberations. This group brings together multidisciplinary government and academic actors, including technical representatives from the Ministry of Health, clinical and academic institutions, and the National Health Insurance Authority (NHIA).
- The *Steering Committee* serves as the principal deliberative and decision-making body within Ghana's HTA architecture, developing formal recommendations for the Minister of Health.

Together, these bodies are intended to generate evidence, deliberate on findings, and issue recommendations regarding prioritization and potential reimbursement of nominated health technologies.

The HTA process: eight steps from nomination to decision

The HTA process involves an eight-step decision-making framework (Figure 3), which can be executed as a full or rapid HTA (with compressed timelines). Full HTAs include economic evaluation and, where feasible, modeling of costs and outcomes under different policy scenarios. Rapid HTAs compress timelines by relying more heavily on existing evidence syntheses and contextual adaptation. Rapid HTAs apply the same core criteria but streamline analytic depth, limiting new economic modeling and extensive consultation, to enable more time-sensitive decisions.

The first step, topic nomination, is primarily guided by government policy direction, Ministry of Health priorities, or specific health system challenges. Topics may also emerge through consultations with key stakeholders. The HTA TWG leads the way on the assessment and development of recommendations. Assessments may include evaluations of clinical effectiveness, safety, cost-effectiveness, budget impact, and broader health system implications.

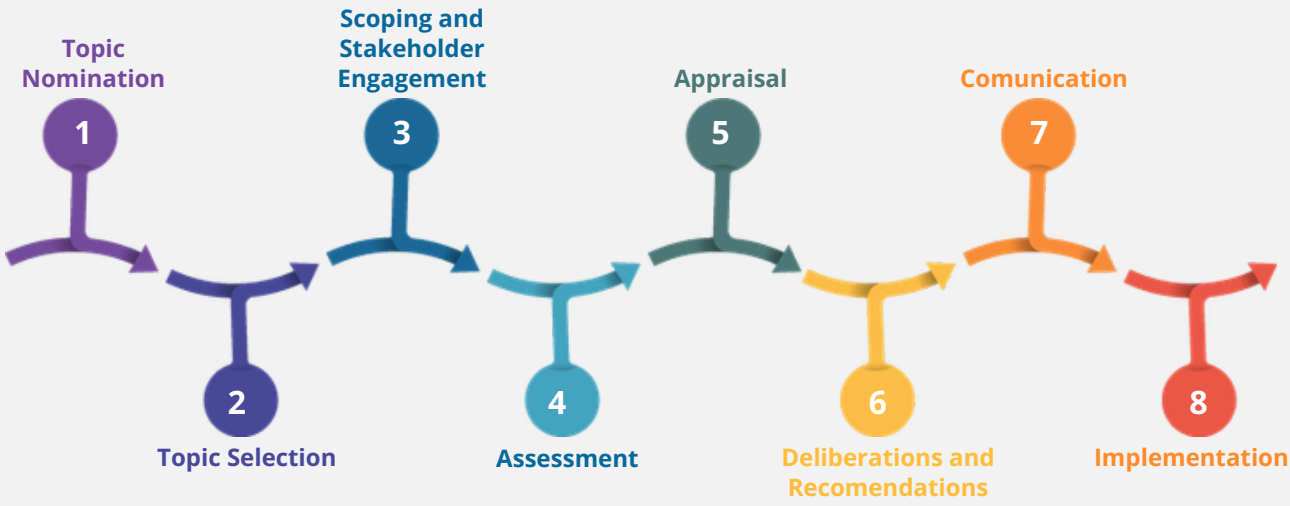

Figure 3: Ghana's eight-step HTA process.

The TWG then passes its recommendations on to the Steering Committee, the primary decision-making authority. The Steering Committee deliberates and issues a final recommendation to the Minister of Health. **The Steering Committee's decisions are published on the Ministry of Health's official website for public comments for two weeks, and any appeals must be submitted within 10 days of publication.** This publication-and-appeals mechanism introduces a formal transparency and accountability layer into the HTA process.

HTA implementation in Ghana is still ongoing and faces hurdles such as limited capacity to conduct HTA. However, the steps taken to date that build upon existing structures have positioned Ghana's HTA to be an important decision-making tool for the NHIS moving forward.

HOW DID THIS SYSTEM COME ABOUT?

Ghana's experience with institutionalizing HTA demonstrates how reforms to innovation prioritization and introduction can be accomplished in a way that is politically feasible, fiscally responsible, and aligned with broader universal health coverage (UHC) goals. **The National Health Insurance Scheme (NHIS) has long been a politically salient program, regularly featured in election campaigns and shaped by political influence over appointments and policy direction.**

Because of this political centrality, reforms to strengthen NHIS required solutions that addressed both technical and political pressures. HTA gained traction precisely because it offered a structured way to manage rising costs, sustain UHC commitments, and reinforce public trust.

The push toward HTA emerged gradually over more than a decade (Figure 4). Different actors saw HTA as a response to distinct challenges:

- For the *Ministry of Health (MoH)*, the central challenge was how to sustain universal health coverage (UHC) commitments under increasing fiscal pressure while maintaining legitimacy and public trust.

- *For the National Health Insurance Authority (NHIA)*, the problem was how to secure greater efficiency and value for money in reimbursement decisions, particularly given the high share of claims attributable to medicines.
- For *development partners*, HTA represented a mechanism to institutionalize evidence-informed decision-making and strengthen domestic governance systems.
- For *academics and technical experts*, it offered an opportunity to build local analytic capacity in economic evaluation and priority-setting.

Persistent NHIS deficits and high spending on medicines sharpened these incentives. The scheme's expansive benefits package had not been developed through systematic prioritization or explicit budget analysis, creating a misalignment between benefits and available resources. This environment created both fiscal and political pressure for more transparent and structured decision-making.

Importantly, Ghana did not build HTA from scratch. **The country already had strong foundations in the form of the Essential Medicines List, Standard Treatment Guidelines, and the National Medicines Selection Committee, which provided institutional infrastructure and norms around evidence appraisal.** Early training activities between 2009 and 2012, supported by WHO and partners, raised awareness of economic evaluation and highlighted capacity gaps. A readiness assessment under the Access and Delivery Partnership in 2014–2015 further outlined options for institutionalizing HTA, supported by partners including the Government of Japan, PATH, UNDP, WHO, the Norwegian Public Health Institute, LSHTM, and iDSI.

A turning point came with the 2016 HTA on hypertension treatment, which demonstrated how economic evaluation could inform policy and reduce costs. The findings influenced the 2017 Standard Treatment Guidelines and highlighted opportunities for price negotiation and therapeutic substitution. This shifted HTA from an abstract concept to a practical tool with visible benefits.

The 2017 National Medicines Policy formally recognized HTA as a priority-setting mechanism and emphasized alignment with existing statutory bodies such as the Food and Drugs Authority and NHIA. Embedding HTA within established structures minimizes institutional disruption and reduces perceived threats to existing mandates. High-level policy fora also played a critical role in advancing HTA institutionalization.

Advocates secured space for HTA at the 2017 and 2018 National Health Sector Summits, an annual planning forum, where agenda influencers could align HTA with national strategic goals. In 2018, the Health Sector Aide-Mémoire following the Health Sector Summit included HTA, and subsequently, implementation efforts began to take shape.

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In 2019, the Minister of Health inaugurated the HTA Technical Working Group and Steering Committee, formalizing governance arrangements. The decision was made to house the HTA Secretariat within the Pharmacy Directorate—a pragmatic choice that aligned with existing responsibilities for the EML and STGs, despite some initial internal debate.[2]

The Ghana Strategy for HTA (2020) and subsequent HTA process guidelines (2022) introduced standardized procedures for evaluation methods, perspectives, uncertainty analysis, and budget impact. These instruments helped routinize HTA and ensure consistency across analyses. **By embedding HTA within statutory structures, engaging multisector stakeholders, and retaining ministerial oversight, Ghana transformed HTA into both a technical tool and a governance mechanism for navigating UHC's core tension:** expanding entitlements amid finite resources and growing technological possibilities.

Underpinning these reforms was the support and advancement of key champions within the Ministry

[2] Some argue the arrangement introduces a potential risk to the Secretariat's independence, as HTA decisions could be perceived as more vulnerable to Ministry of Health influence.

of Health and the Pharmacy Directorate. These champions used their existing influence and authority to steer introduction decisions, navigate bureaucratic systems, and align HTA with national priorities. They mobilized coalitions and used formal policy instruments, such as the health sector aide-mémoire, to secure commitment and maintain momentum.

The reformers and champions were careful to frame HTA as a mechanism not only to enhance fairness, efficiency, and sustainability within UHC, but also to organize evidence needed during the review of guidelines. This framing helped secure political buy-in. By leveraging their institutional positions, coordinating technical working groups, and drawing on external expertise, these champions helped embed HTA into routine decision-making despite resource and capacity constraints.

> *Champions mobilized coalitions and used formal policy instruments, such as the health sector aide-mémoire, to secure commitment and maintain momentum.*

The HTA process in Ghana is still in the early stages of implementation and hasn't yet had a chance to be put to the test on how it can improve effectiveness. Since the implementation of governance structures and guidance, HTA has only been conducted for one politically salient priority: cancer treatment. HTA-related analyses provided evidence to include four childhood cancers in the NHIS.

However, one important lesson emerged from the initial use case of economic evaluation for hypertension. **Despite cost-saving gains from the evaluation process, persistent delivery constraints continue to impede effective hypertension management.** This underscores a central lesson: *prioritization reform must work within delivery system constraints and/or be paired with delivery and system strengthening to translate efficiency gains into improved health outcomes*.

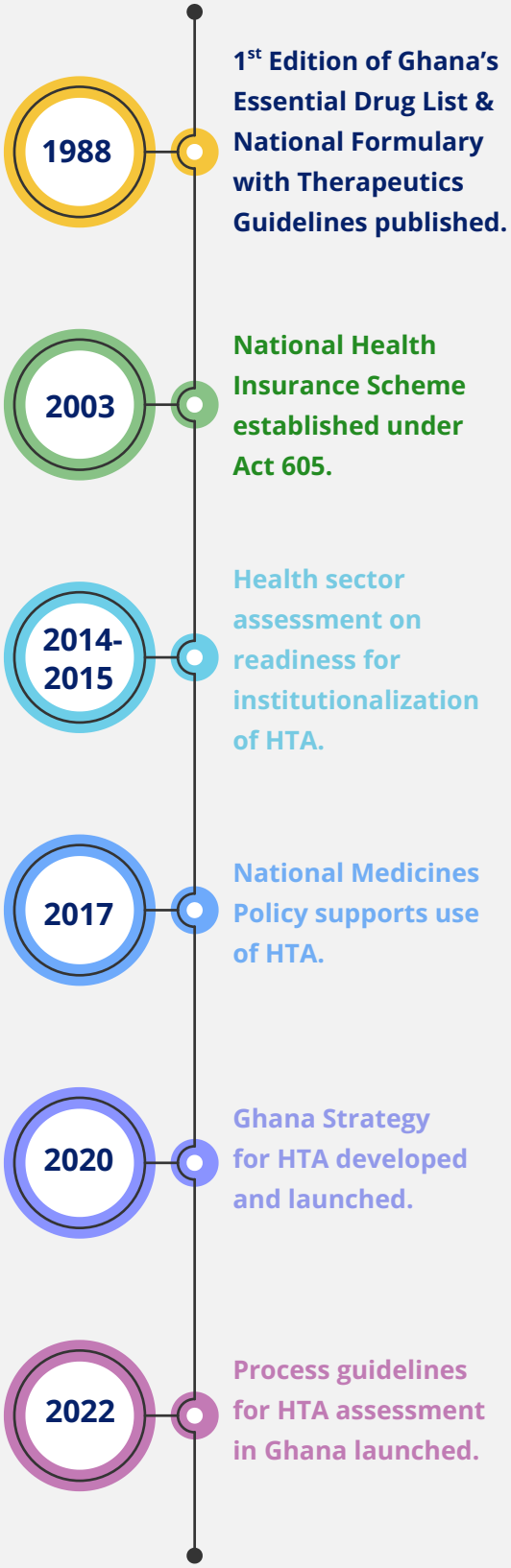

Figure 4: History of key reforms in health innovation prioritization and institutionalizing HTA in Ghana.

CRITICAL CONTEXT

- **Coverage and financing.**
  - **Who's covered.** The National Health Insurance Scheme (NHIS) covers about 20 million people—roughly 60% of Ghana's ~35 million population. The 2012 National Health Insurance Act mandates enrollment for all residents, though coverage remains well below universal.
  - **What's covered.** NHIS covers about 95% of diagnosed conditions, including outpatient, inpatient, and emergency care (with some exceptions), plus medicines—recently extended through HTA to high-cost care such as treatment for four childhood cancers. Program drugs (e.g., HIV/AIDS, TB) sit outside the scheme, funded through other public channels.
  - **Who pays.** Ghana spends about 4% of GDP on health (~$83 per capita in 2022), with government domestic revenue funding 53–60% of health resources (including NHIS), donors about 12%, and out-of-pocket spending around 26%. NHIS itself is financed mainly through a dedicated consumption tax—the National Health Insurance Levy (a share of VAT)—plus earmarked payroll deductions from formal-sector workers and member premiums.
- **Ghana's National Health Insurance Authority also regulates Private Health Insurance Schemes (PHIS).** In addition to the NHIS, there is a robust private health system in Ghana with 12 licensed PHIS offering complementary services to the NHIS. It covers services not fully covered by the NHIS, such as specialized care, and also provides access to private health facilities.
- **Government-purchased products for vertical programs** are procured through the Ministry of Health's Procurement and Supply Chain Directorate. Program drugs, such as those for HIV, TB, and childhood immunizations, are not included in the NHIS medicine list since they are funded through other public sources. Donor-procured products use partner-supported channels such as the GHSC-PSM (a global supply-chain mechanism), though there are plans to interface procurement from all sources into a common platform to promote visibility.
- **Ghana's health system is decentralized—but not for the decisions most relevant for innovation prioritization and introduction.** Prioritization and introduction decisions for health products are largely centralized within the Ministry of Health and the Pharmacy Directorate. District health management teams, responsible for delivery, rarely participate in the policy formulation process. District Assemblies serve as the political decision-making bodies at the local level, but policy-making remains largely top-down.

INSIGHTS & IMPLICATIONS FOR OTHER COUNTRIES

Ghana's experience offers four transferable lessons for other countries seeking to institutionalize evidence-based decision-making for health innovation introduction (also summarized in Figure 5):

1. **Align product prioritization and introduction reforms with politically salient UHC agendas.** Reforms gain traction when aligned with visible, politically salient commitments like UHC and embedded within existing policy and institutional structures. In Ghana, HTA advanced because it was framed as essential to sustaining the NHIS and anchored to the National Medicines Policy and existing medicine selection structures (EML, STGs), allowing stakeholders to view HTA as an additive, reinforcing process that supported existing systems. The Minister of Health further institutionalized HTA by embedding it within the Pharmacy Directorate and establishing governance arrangements. By embedding reforms within existing structures, Ghana reduced resistance, strengthened legitimacy, and accelerated adoption.

2. **Leverage well-embedded, high-level technical and political champions to use their authority, networks, and system knowledge to drive and sustain policy reforms.** Ghana's champions within the Ministry of Health, the Pharmacy Directorate, and development partners were already influential actors in medicine selection and benefit-package decision-making. Their positional authority enabled them to secure agenda space at national health summits and align HTA with national priorities such as sustaining the NHIS, translating political will into institutionalized structures. For countries pursuing similar reforms, identifying and enabling champions already embedded in core decision-making spaces is essential. Champions need clear mandates, access to decision forums, and technical and political support to strengthen their ability to shepherd reforms through bureaucratic and political hurdles.

3. **Recognize that effective prioritization reforms require time to get on the policy agenda, secure political adoption, and translate into routine implementation.** Ghana's experience shows that institutionalizing HTA was not a single decision but a decade-long trajectory reflecting that even when political will exists, reforms must navigate bureaucratic politics, capacity gaps, and changing priorities. Despite these realities, countries can begin where they are. Strengthened prioritization decisions can be introduced and tested, providing countries with tangible proof-of-concept that evidence-based, efficient decision-making is feasible, while using early wins to build long-term institutional momentum (such as the case of the hypertension HTA in Ghana).

4. **Push beyond institutional reforms and integrate prioritization structures into actual decision-making processes.** This move safeguards prioritization from being sidelined by political and bureaucratic forces. Ghana has made substantial progress on institutionalizing reforms and establishing processes and governance structures. However, there are still opportunities to strengthen decision-making by embedding HTA directly into regular review cycles for budgets and the benefits packages, price negotiations, and procurement pathways with clear decision points. When prioritization systems are woven into the core machinery of health sector decision-making, they become resilient, credible, and capable of improving health innovation introduction more effective and efficient over time.

Ghana presents a timely and relevant model for other countries exploring reforms to how they prioritize and decide on which health products to introduce and reimburse in their public health systems. The lesson is not to copy Ghana's institutions, but to adapt the functions beneath them. As Ghana is still in the early phases of institutionalization, there is more to explore on how the HTA process will operate in practice and benefit the Ghanaian health system and public.

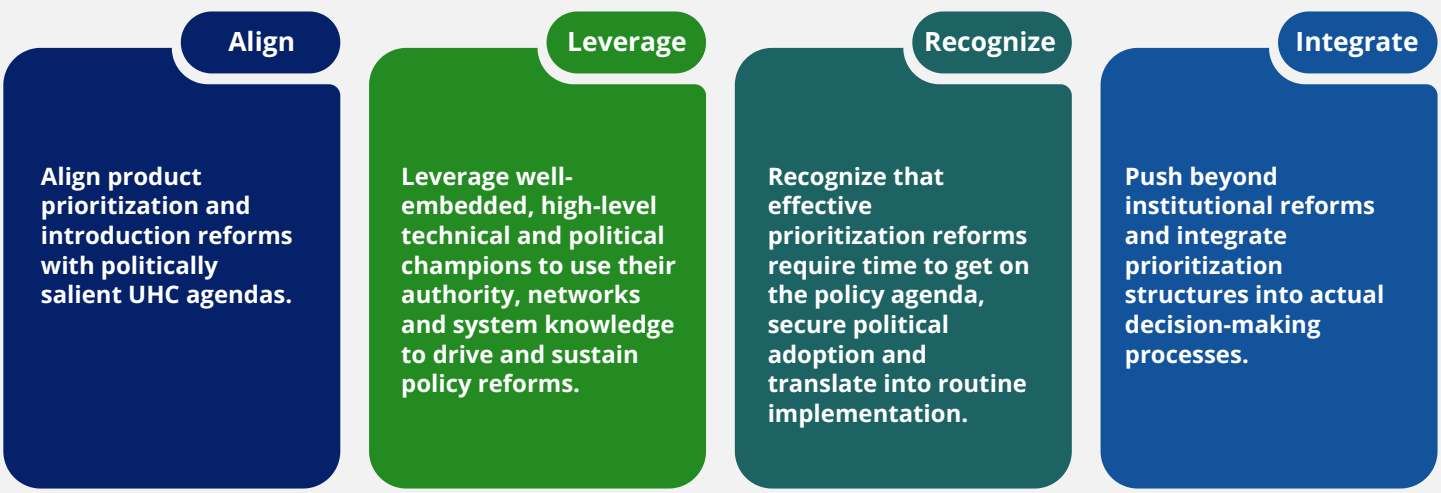

Figure 5: Summary of insights and implications for other countries about Ghana's experience with HTA.

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ABOUT THIS SERIES

This case study is one in a series of decision-making deep dives produced by the ALIGN Consortium as part of our shared learning agenda. Each examines how a particular country has navigated the persistent challenge of introducing new health innovations—how it evaluates, prioritizes, finances, and sustains them within real fiscal and political constraints. Our aim is not to rank systems or prescribe a single model, but to understand how reform actually unfolds: what enables it, what constrains it, and what does and does not transfer across contexts. These cases inform ALIGN's work alongside national partners and are offered in the spirit of mutual learning. We welcome reactions, corrections, and counter-examples from colleagues who know these systems first-hand.

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ABOUT THE ALIGN CONSORTIUM

The ALIGN Consortium aims to improve health outcomes by strengthening the critical decision-making systems that determine how health product innovations are prioritized and introduced in countries, to make those systems more effective and efficient. Comprised of the Duke Global Health Innovation Center, the South African Medical Research Council (SAMRC), the Kenya Paediatric Research Consortium (Keprecon), and ENDA Santé, the ALIGN Consortium supports national governments in Kenya, Senegal, and South Africa to enhance innovation introduction, looking at four focus areas: whole-of-government coordination and capacity, data-driven decision-making, whole-of-market engagement (including national, regional, and global engagement), and portfolio-based planning. The goal is to create more accountable, resilient health systems that deliver better health outcomes faster for all, and to generate insights, tools, and resources that can be used by stakeholders around the world.

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