



Healthcare System Country Notes African Region

Ghana

The purpose of the IMSA National Health Insurance (NHI) web-site is to put in the public domain material and evidence that will progress the technical work of developing a National Health Insurance system in South Africa. This series of Country Notes is a collation of material submitted by independent researchers who are willing to place their research notes in the public domain. The collated notes, together with other studies found in the public domain are presented as a service to researchers, policy-makers and stakeholders who are looking at health reforms around the world.

A. Research Notes on Ghana

Context

- Upon receiving independence, in 1957 Ghana implemented a largely free public health care system. In the 1960s economic strains led to fiscal constraints for government and a gradual phase-in of user fees. Continued economic distress finally led to the cash-and-carry system, in which users were charged the full procurement cost for drugs and a partial cost for most services. As a result of these charges in 1985, subsequent utilization of health services declined and public discontent grew.
- Fee exemptions for the poor proved difficult to implement, and partly fostered by the ruling party (the NDC) community-based health insurance (CBHI) movements began to emerge. These schemes grew from a few in the 1990s, to 168 schemes in 2003, based around districts, communities, schools, NGOs and churches. They emerged as a pre-payment mechanism for people to meet out-of-pocket shortfalls due to ill health events, but covered only 1% of the population.

Reform

- In 2000, after the NPP beat the NDC in a national election, they promised to develop a new health system policy and abolish the cash-and-carry system through a system of national insurance (NHIS).
- This reform essentially 'scooped up', re-categorised and centralised the diverse range of pre-existing mutual arrangements
- The section below describes the reform process which led to the final implementation of the NHIS

Consultation and reform process

- The new ruling party promised to abolish out of pocket payment in the health system through a NHIS.
- The policy had to result in the establishment of a national system that could quickly be scaled up to cover the majority of the population and for political reasons needed to be publicly perceived as an NPP initiative, rather than a continuation of the National Democratic Congress (NDC) efforts.
- To ensure a speedy process, government formed a change team to craft the NHI strategy..
- The **first change team** pursued a strategy of presenting the most technically sound options, based on wide consultation, with relatively little regard for the NPP's political considerations. The team recommended using an already growing civil society initiative i.e. the CBHI movement as a platform for building a NHIS, i.e. that government should offer support to this movement, but not try to control it. The team believed it was still too early to offer a nationally scaled insurance system. But the inability of the change team to incorporate

political considerations undermined the viability of its policy recommendations. Politicians lost confidence in a technical and consensus-based approach.

- A **second change team** was therefore formed to help develop more politically acceptable policy and politically trusted consultants were added to this new team. They proposed the establishment of a centrally regulated scheme in every district of Ghana. The team proposed to establish a 2.5 % health insurance levy on goods and services and divert a share of the social security contributions of formal sector workers into a central health insurance fund. This strategy leveraged existing community infrastructure but also introduced central control. Technical committee members believed that this approach was simplistic and that the premiums were too low to sustain the system. They felt that actuarial studies needed to be conducted to estimate a sustainable premium for the benefits offered. The more technical actors in the process pointed to worldwide evidence showing cost-explosion as a result of unrestrained demand in an environment where services were provided free at point of use. But political actors brushed these arguments aside believing that setting premiums any higher would be unpalatable to the general public and sustainability could be dealt with later, after the insurance system had developed some legitimacy and permanence. They also believed that even if there were financial shortfalls early on, the 2.5% insurance levy (on goods and services) would be able to sustain the system. The chair of the design process also felt that “since this is social insurance, moral hazard is not important.” He believed that gate-keeping would largely prevent overuse of health services.
- Some members of the change team disagreed with the strategy on technical and ideological grounds, so a **third change team** was formed. This team maintained a strong vertical network, and appeased the main stakeholders in the process. The core principles guiding their work were:
 - To ensure equity and solidarity through cross-subsidisation, with payment based on ability to pay, so the rich subsidise the poor and healthy subsidise the sick, with economically active adults paying for children, the indigent and aged.
 - Quality of care was emphasised, assisted by efficiencies in collecting premium and delivering services.
 - To encourage community participation and leverage community-based infrastructure to ensure maximal participation by informal sector in the NHI system. While some efficiency would be lost through this decentralization, the view was that equity would be gained through greater participation
 - To prioritize maximum enrolment during the formative years of the system
 - That sustainability and total public cost of the scheme should not be of prime concern in the short term
 - That the scheme should be financed primarily through general taxation since the majority of the country worked in the informal sector, from which premiums would be hard to collect

NHIS structure

- As a result the structure passed into law in August 2003 and implemented in December of the following year had the vision “to assure equitable universal access for all residents in Ghana to an acceptable quality of essential health services” and was made up as described below:
- Institutional form
 - Broadly, the system contains a mixture of structures and approaches to health financing, incorporating social health insurance and mutual health insurance features.
 - A central, National Health Insurance Fund (NHIF) would be set up to bridge funding gaps experienced by schemes (described below) in financial distress.
 - The National Health Insurance Act 2003 (Act 650) sets out three types of scheme that may be established in Ghana:
 - District Mutual Health Insurance Scheme (DMHIS) – making up most of the enrolment, they are not-for-profit entities organised by district, which can receive central subsidies. They perform most member enrolment and administration of claims.
 - Private Mutual Health Insurance Schemes – non-for-profit, but which are not entitled to central subsidies

- Private Commercial Health Insurance Schemes– for profit and also not entitled to central funding
 - A National Health Insurance Authority (NHIA) would have an overall role of “securing the implementation of a national health insurance policy that ensures access to basic healthcare services to all residents.” More specifically, this includes registering and regulating schemes, accrediting providers and monitoring performance, educating the public, resolving complaints, and managing the NHIF. The NHIA also provides logistical, capacity and financial support to DMHIS’s.
- Registration and use
 - People need to register with the scheme of their choice and pay the required premiums if applicable. Exempt enrolees have their premiums paid on their behalf by a central level transfer into the scheme they choose.
 - They receive a card which allows access to healthcare at the accredited providers.
- The funding structure was largely composed of:
 - A 2.5% additional VAT on selected goods and services, which accounts for over two thirds of the revenue of the system
 - A 2.5% automatic contribution from the income of the formally employed paying into the Social Security and National Insurance Trust (SSNIT), which makes up about a quarter of system revenue
 - Premiums payable by the informally employed were set initially at \$4 per person per year, with exemptions for those under 18 and over 70, indigents, pensioners and pregnant women. But this was raised to \$8 as it was clear that there were more exempt individuals than originally expected. Even still, this accounts for only 5% of total system revenues.
 - Contribution from general government tax revenue, investments and other contributions
 - Fund allocation would be on a risk-equalised basis, guided by the disease burden and mortality pattern of the different districts.
- The benefit package offered in return consisted of:
 - Full out and inpatient treatment (medical and surgical), including basic oral and eye care, from accredited providers
 - Full payment for medicines on the NHIS approved list
 - Payment for referrals (through the gatekeeper system) to teaching hospitals
 - It excluded appliances, prostheses, rehabilitation, cosmetic surgery, HIV retroviral drugs, treatment abroad, dialysis for chronic renal failure, expensive heart and brain surgery, etc.
 - Co-payments and deductibles were ruled out
 - It was publicly announced that the NHIS would cover 95 percent of all illnesses in Ghana.
- Provider accreditation and reimbursement
 - Public and private providers could apply for accreditation to receive reimbursement for goods and services from the NHIS.
 - A fee-for-service was the only mechanism suggested according to the NHI council.
 - The highest service delivery and pharmaceutical prices from around the country were adopted for reimbursement to ensure buy-in from pharmaceutical manufacturers and providers. Partly, this was a political decision to stave off dissent and ensure smooth passage of the legislative instrument.

Results

- Registration
 - By end of 2006, 38% of the population had enrolled into the program. By the end of 2008, about 61% of the population had registered
 - About 60% of those enrolled were exempt
 - This was mainly because:
 - those who were exempt had a greater financial incentive to enrol

- collecting premiums individually from the high numbers of non-exempt but informally employed had high administrative and financial burden (premiums for exempt enrollees are paid through central-level transfers and require comparatively little administrative effort to collect).
 - Many schemes reported that they were unable to issue ID cards to all their members. (According to NHIS statistics, only 8% of the enrolled population received their ID cards during the first year, and 51% received their ID cards during the second year)
 - Insurance fund managers claimed that one of the biggest constraints in their enrolment was the perception that enrolling in insurance means siding with the ruling party (NPP)
 - Some evidence shows that the NHIS may not in fact be pro-poor, with lower rates of registration for the poor. This is partly due a restrictive definition of 'indigent' in the regulations; lack of physical access to health facilities by many of the rural poor; and also due to the registration fee payable which may deter those on low incomes.
 - Weak portability between schemes
- Governance and operational issues
 - There has been weak supervision and oversight by the NHIA of the DHMIS's
 - Weak claims management and general management capacity at district level, which permits over-servicing and fraud.
 - Poor information management and forecasting has resulted in drug stock outs. Drug availability dropped to 38% in mid-2006.
- Utilisation and costs
 - Increased enrolment into insurance and removal of copayments has led to an increased utilization of services nationwide, particularly in respect of outpatient services.
 - This has been beneficial, with insured ill people more likely than before to seek formal care rather than self-treat. Overall, there has been a drop in direct household expenditures on healthcare.
 - Increase in utilization increased the workload of nurses. They demanded wage increases, which eventually the government paid.
 - There has been concern about ineffective gate-keeping to access higher level services, supplier-induced demand, and fraudulent claims (e.g. members feign diseases to collect medicines for relatives)
 - Current payment systems encourage over-servicing and 'tariff creep'.
- Scheme solvency
 - Due to the low ratio of contributors to claimers, and growing utilisation, many schemes became financially distressed. In a 2006 study, the International Labour Organization (ILO) projected that in 2010 an additional \$49 million to \$96 million in subsidies for financially distressed schemes would be required for them to remain solvent under the current NHIS structure.
 - Most schemes increased their premiums, and some begun to charge 'administrative' fees (these fees go beyond the premium structure outlined in the legislation)
 - As a result the NHIA increased its payment per exempt enrollee to \$10.90.
 - It also established an "SOS" program, in which schemes must inform the NHIC if they become high-risk for financial insolvency, and will receive financial support to bail them out.
 - The further financing for these two corrections is made available through the central fund for health insurance (financed by the VAT and payroll deductions)
 - Mismatch between system outgo (driven largely by membership numbers) and system income (driven largely by GDP growth through VAT receipts) mean that sustainability is likely to remain a concern, with deficits projected from 2012 under the current structures.
- Provider responses
 - Relatively few private providers are accredited for the NHIS, and there have been problems identifying accredited NHIS providers.

- Many report slow settlement of claims by the DHMIS's (of 2-6 months), and by 2008 substantial amounts, equivalent to 3-4 month's revenue, were owed to health facilities
- There is anecdotal evidence, for instance, of a pharmacy accredited with the NHIS not having stock of prescribed drugs. But the same owner may have a private pharmacy accepting cash payment which does stock the drug. Similarly, nurses may give preference to uninsured patients (who pay cash) to maintain an informal fee structure.
- Also non-conformity to standard treatment protocols and drugs list
- NHIS reform has failed to address underlying problems of maldistribution or short supply of health providers in the country

Lessons for SA

- Reform process
 - Mechanisms for ensuring transparency are essential during the policy development process
 - Technical actors in a reform process also need to be aware of political imperatives
 - Political "windows of opportunity" can be vulnerable to opportunism
 - Need sufficient and credible statistics to conduct accurate costings
 - Collaboration is required between political, technical and incumbent stakeholders in the reform process, rather than each ignoring the other
 - A politically neutral, technical intermediary organisation could guide policy debate and disseminate objective information
 - Media education is essential to ensure they have the technical capacity to separate arguments from rhetoric
- Provider reimbursement
 - Incentive implications of selected tariff structures need to be carefully thought through

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B. Medi-Clinic Research Notes: The Health System in Ghana

At independence in 1957, Ghana provided free health care services to its population through public health facilities. There were no out-of-pocket payments and these facilities and care was financed solely from tax revenues. However, this system was not sustainable and the “Cash and Carry” system introduced in the 1980’s, made it compulsory for everybody to pay user fees immediately before and after treatment in hospitals and clinics. These user fees were usually not within the means of most Ghanaians and restricted access to health care. In order to cushion the burden of out-of-pocket payment the government introduced the exemptions policy, which exempted certain risk groups (children under 5, pregnant women, the indigent and the elderly) from paying any user fees.

Community-based health insurance (CBHI) schemes also known as mutual health organizations (MHOs) emerged in the 1990s. These schemes targeted the reduction of financial barriers to healthcare associated with user fees at the point of service. By 2002, there were 152 schemes; however, these schemes only covered 1% of the population leaving many Ghanaians vulnerable in the event of catastrophic illness. In an attempt to increase access and improve the quality of basic healthcare services, in 2005, the government introduced the National Health Insurance Scheme (NHIS) through the establishment of mandatory district-level MHOs or district wide insurance schemes.

MHOs were set up in every district in Ghana. Each district was divided into Health Insurance Communities so that health insurance could be brought to the doorstep of all Ghanaians. There are three types of schemes that can be used to collect funds;

- District Mutual Health Insurance Schemes (DMHIS) – operated on a not-for-profit basis, practice the principal of open-enrolment, focused on providing cover to a particular district and receive government subsidies.
- Private Mutual Health Insurance Schemes (PMHIS) – operated on a not-for-profit basis, restricted to citizens from specific groups (e.g. employment/ religious groups), may not have a district focus and do not receive government subsidies.
- Private Commercial Health Insurance Schemes (PCHIS) – operated on a for-profit basis with risk rated premiums, restricted to those with formal employment, may not have a district focus and do not receive government subsidies.

There are already 138 DMHISs in the country but only a handful of private health insurance schemes. Private insurance schemes only cover about 1% of the population. The rest of those covered are split between the 138 DMHISs. The NHI Act explicitly requires every citizen to belong to one of these schemes. Government subsidies are only provided for those belonging to a DMHIS, thus providing an incentive for people not to ‘opt out’ by purchasing coverage through private insurance organizations. However, all schemes shall not use the services of a healthcare provider unless the provider has been approved and accredited to the NHI authority.

Formal sector workers were automatically enrolled into the NHIS. The coverage of NHIS has been increasing steadily. Some of the poor have been enrolled in the scheme through government subsidies. Membership registration is estimated to have reached 55% as at December 2007. The majority of those not covered by the NHIS uses public sector facilities and pay user fees and a small number pay out-of-pocket to access health services from the private sector.

Contributions are payable in line with one’s ability to pay and annual premiums range from US\$5 – US\$37. For the informal sector, community health insurance committees are to identify and categorize residents into social groups to ensure individuals in each group pay in line with their ability to pay. In reality a flat premium payment of US\$5 is payable per annum due to the difficulty of categorizing people into difference socio-economic groups. These premiums are payable directly to the member’s respective DMHIS.

By law, the core poor or indigent who are unemployed and receive no consistent financial support from identifiable sources are exempted from paying contributions, and authorities are responsible to pay US\$14 per indigent annually into the NHIS fund. Children under 18, whose parents pay their own contributions are also exempted from paying any contributions. These exempt populations still have to pay a registration fee of US\$3 in order to participate in the NHIS.

To mobilize additional funds to support the district mutual insurance schemes, the government instituted a National Insurance Levy of 2.5% on specific goods and services. In addition, 2.5% of the 17.5% Social Security and National Insurance Trust (SSNIT) contributions paid by formal sector employees are automatically diverted to support the NHIS. There is no risk-equalisation between individual DMHIS at present. The NHIS secretariat merely allocates funds on the number of formal workers that the scheme registers as well as the number of indigent that have been registered.

The benefit package is fairly comprehensive and includes inpatient care, outpatient care, essential drugs, maternity benefits, emergency care and eye care. This package covers about 95% of diseases in Ghana. However, all district wide schemes have the right to cover as many diseases and services they desire, provided it is approved by the National Health Insurance Council. Certain diseases however are excluded from the benefit package as they are too expensive to be covered. The diseases currently not covered are: HIV/AIDS, chronic renal failure, heart and brain surgery, etc.

Residents who pay their contributions in full have to wait for at most 6 months before their Health Insurance identification and Health facility attendance cards are issued to them to enable them to attend any public health facility or any private accredited health facility in Ghana for both inpatient and outpatient care in line with the scheme's benefit package.

Provision of NHIS care is by both public and private not-for-profit providers, the latter mainly faith based facilities which have similar levels of quality care as the public facilities. At inception of the NHIS, all public providers were given immediate accreditation (blanket cover), however private not-for-profit providers needed to be accredited on an individual basis as the quality of care provided needed to be assessed to ensure that the NHIS standards were met.

The NHIS has a retrospective provider payment mechanism that is decentralized to the DMHIS. The DMHIS paid providers on a fee-for-service basis during 2005/06; however, payment by DRGs was introduced in 2007/08. There has been a recent trend towards accumulated unpaid provider bills by DMHIS. In the greater Accra region alone (constitutes almost 15% of Ghana's population), the NHIS owed public sector providers over US\$ 2 million in unpaid bills by the end of December 2008. The problem of unpaid insurance bills appears to be related to management rather than lack of funds.

There is a relatively small number of private for-profit health facilities, mainly concentrated in the two big cities of Accra and Kumasi, which serve the wealthiest group. Private for-profit providers are not part of the NHIS and are paid on a fee-for-service basis through out-of-pocket payments.

Human resources in the health sector is a challenge. There are about 10 000 people per doctor, and 1 587 people per nurse in the public sector. Although the majority of health care professionals work in the public sector, Ghana is faced with the challenge of losing its physicians to the private sector.

Lessons for South Africa:

- There is no focus on clinical quality or service delivery.
- There is also a severe shortage of providers leading to long waiting lists in the NHIS. Beneficiaries have been found to pay user fees and skip NHIS queues and join cash queues which move much faster.
- Both public and private providers do not receive payments timeously from the DMHIS due to administrative inefficiencies.
- There is very little competition in the system.

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C. SHIELD PROJECT on Ghana

SHIELD is the acronym for Strategies for Health Insurance for Equity in Less Developed Countries. The SHIELD project is co-ordinated by Prof Di McIntyre of UCT and the project web-site is: <http://web.uct.ac.za/depts/heu/SHIELD/about/about.htm>

"SHIELD is a 3 year project which critically analyses alternative approaches to health insurance in Ghana, Tanzania and South Africa as a mechanism for addressing health system equity challenges and in turn contributing to achieving the Millennium Development Goals. This will be achieved through evaluating the distribution of the burden of health care financing between socio-economic groups, and the factors influencing this distribution will be evaluated. Concurrently, the distribution of health care benefits across socio-economic groups and health system related factors that influence this distribution of benefits will be assessed."

"This will be complimented by an identification and critical evaluation of current experiences, and options for the likely future development, of health insurance mechanisms (particularly mandatory insurance and insurance for non-formal sectors) in and between Ghana, South Africa and Tanzania. Assessment of health insurance options will particularly focus on their actual and/or potential equity impact and their feasibility and sustainability given the attitudes and preferences of key stakeholders. Finally, the project will develop strategies and policy recommendations on health insurance mechanisms that will most appropriately address the identified health system equity challenges."

The first report from the SHIELD project dealing with Ghana is:

A CRITICAL ANALYSIS OF GHANA'S HEALTH SYSTEM WITH A FOCUS ON EQUITY CHALLENGES AND THE NATIONAL HEALTH INSURANCE, by John Gyapong, Bertha Garshong, James Akazili, Moses Aikins, Irene Agyepong, Frank Nyonator. <http://web.uct.ac.za/depts/heu//SHIELD/reports/Ghana1.pdf>

Accessed March 2010.

D. The Joint Learning Workshop on Universal Health Coverage: Ghana

"The Joint Learning Workshop on Universal Health Coverage, held in Gurgaon, India on February 3-5, 2010, convened 120 representatives from six countries – Ghana, India, Indonesia, Philippines, Thailand and Vietnam – and several international organizations to share experiences in carrying out health coverage reform domestically, as well as to learn from the experiences and challenges of reform processes in other countries."

<http://jlw.drupalgardens.com/>

The site has one report on Ghana:

"A brief description of the context and history of health insurance reforms in Ghana, as well as the design, implementation and operations of the current national health insurance scheme."

<http://jlw.drupalgardens.com/category/tags/delegation/ghana>

Accessed March 2010.

These notes have been collated for IMSA from submitted research material.
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Professor Heather McLeod

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