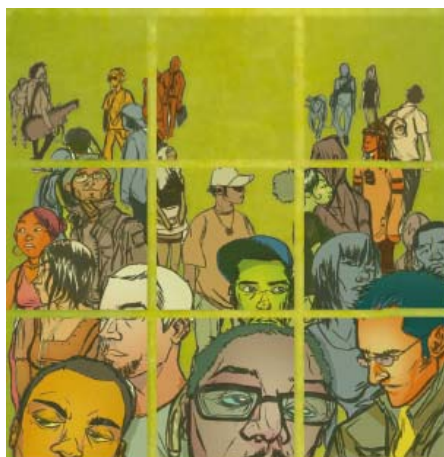




Ghana's approach to social health protection

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1 Social health protection context in low-income countries

The need to develop domestic health financing systems that offer social health protection is now well established and much of the rationale was set out and discussed previously.¹⁻⁷ Almost half of the world's population lacks social health protection and therefore, has to mobilize out-of-pocket resources for health care and cope with any loss of earnings due to illness from their own resources. More than 90% of the people who are unable to seek appropriate care live in low-income countries. Within countries, the risk of severe illness, early death and financial catastrophe linked to high out-of-pocket health expenditures is highest among the poorest sections of the populations. Therefore, the key challenge in, but not limited to, many low-income countries is to establish and sustain national policies, systems and institutions that protect people against the financial risks of obtaining health - to allow them to seek needed care without the risks of financial catastrophe and impoverishment. Realizing the importance of strengthening domestic financing, the (then) 192 members of WHO joined together in May 2005 to endorse a resolution entitled 'Sustainable health financing, universal coverage and social health insurance' urging member states to develop their financing systems to ensure that their populations have access to needed services without the risk of financial catastrophe.⁸

Following the resolution, there have been increasing demands from countries, both low- and middle-income, for technical support to develop their health financing and social security systems to increase the level of social health protection. Extension of the coverage of social protection in health can be addressed by combining complementary mechanisms for resource mobilization with strategies to reach broader segments of the population (e.g. through subsidy structures for the poor, incentives for the informal sector, increasing coverage through health insurance schemes). These measures are aimed at strengthening the demand side for quality health services while ensuring the financing of those health services (supply side). The expansion of social protection in health needs to be in line with other complementary social protection interventions (such as basic social protection).

Ghana has already shown the way to similar comparable nations by reorienting its health financing system towards attaining social health protection for the poorest and other disadvantaged populations. This paper focuses on what is currently being done in Ghana with a particular emphasis on social health protection and lessons to be learnt from the experience.

2 Ghanaian health system in brief

Located on the west coast of Africa and bounded by Burkina Faso on the north, Cote d'Ivoire on the west, Togo on the east and the Gulf of Guinea on the south, Ghana has an estimated population of 23.48 million accounting for 2.97% of the African population⁹; 49% of the population lives in urban areas (regional average 37%). Ghana has relatively better health system indicators in the region. In 2007, life expectancy was 57 years (52 years in the WHO African region and 57 years in low-income countries), maternal mortality ratio was 560 per 100,000 live births (900 in the region and 650 in low-income countries), infant mortality rate was 73 per 1,000 live births (88 in the region and 80 in low-income countries), antenatal care (at least 4 visits) coverage was 69% (45% in the region and 38% in low-income countries) and proportion of births attended by skilled health personnel was 50% (46% in the region and 41% in low-income countries). Similarly, number of outpatient care visits per capita is increasing at the rate of 3.9% per annum.¹⁰ There are a few concerns too. Ghana's human development index (HDI) worsened from 0.563 in 2001 to 0.520 in 2005.¹¹ Similarly, infant mortality rate rose from 71 in 2000 to 73 in 2007.⁹ The level of health spending is low at 5.1% of GDP with household out-of-pocket spending accounting for 51.2% of it.

Table-1

Key health economic indicators in Ghana^{9,12-14}

GDP Growth (2008, %)	7.2
Incidence of Poverty (2006, %)	28.5
Life expectancy at birth (2007, years)	57.0
Infant Mortality (2008, per 1000 live births)	50.0
Under-5 mortality (2008, per 1000 live births)	80.0
Maternal mortality ratio (2007, per 100,000 live births)	580.0
Antenatal care coverage (2000-08, at least 4 visits, %)	69.0
Births attended by skilled health personnel (2000-08, %)	50.0
Median availability of essential medicines in public facilities (2008, %)	80.0
Total health expenditure (2006, % of GDP)	7.2
General government health expenditure (2006, % of total health expenditure)	34.2

The country has recently established a National Health Insurance Scheme (NHIS) to enhance the performance of its health system, particularly concerning the poor. This technical brief discusses the NHIS approach to social health protection.

3 National Health Insurance Scheme (NHIS) in Ghana

3.1 Health financing context in which it was introduced

Ghana's health-care system was founded on the basis of the 'free health care' model. Under this system, the tax-financed public institutions directly delivered health care to the people of Ghana. The model, however, could not be sustained for long and token user fee was first introduced in 1972.¹⁰ Full-fledged user fee scheme, backed by legislation, came into effect from 1985 in the name of 'Cash & Carry' with an aim of recovering 15% of the operating costs. Although vulnerable groups such as the poor, pregnant women, and children and diseases of public health interest were exempted from paying the user fee, the policy had limited success in removing the financial barriers to health services because the exemption package was not clearly specified and adequately funded; there were also managerial and operational difficulties¹¹. As a result, an alternative health financing system using health insurance schemes with community and NGO participation was introduced. Such insurance schemes probably laid the platform for the NHIS, which was a major campaign issue during the 2000 election in Ghana.

3.2 What does it try to achieve?

The 'Cash and Carry' system was not considered as an ideal system for Ghana given its socio-economic-cultural and political context. The NHIS emerged as an alternative with the main purpose of extending social health protection to the poor and other disadvantaged populations by improving financial access to quality health services.¹⁵ It attempted a kind of social reform through which the most vulnerable in the society are empowered through the principles of equity, solidarity, risk sharing, cross-subsidization, reinsurance, client and community ownership, value for money, good governance and transparency in the health-care delivery. The advantage of the NHIS is that it is a prepaid and risk pooled health financing mechanism. It is also linked with the country's poverty reduction strategy.

3.3 The 'poor first' approach

The salient feature of the NHIS is that it included the poor first and tried to reach out to the rest from there. The initial goal was to bring every resident in Ghana under a health insurance scheme within five years (i.e. by 2009). The ultimate aim is to make it the main purchasing mechanism for health services throughout the country. As a result, the 'Cash and Carry' system of paying for health services is being phased out. Its key design principles are 'equity' defined as equal access to benefit package irrespective of one's socio-economic status and 'risk equalization' meaning the financial risk of illness is equally shared among all. In other words, disease burden and mortality pattern serve as the main basis for the allocation of funds to geographical areas in the country. Financial contributions to

insurance schemes are designed in such a way that they are graded according to people's ability to pay, the rich and the healthy subsidized the poor and the sick, and the economically active adults paid for the children and the aged. There is also a government desire to step in to provide government funds to bridge the gap, if any, resulting from unbalanced contributions. Moreover, there is a strong emphasis on community participation and client ownership.

Figures in Table-2 and Table-3 indicate that the most disadvantaged districts and population groups have higher NHIS coverage and vice versa. About 14% of the population are employed in the formal sector (including the public sector) while 69.2% are in the informal sector; the rest are unemployed or in business.¹⁵ The informal sector employs 92% of all employed persons in the rural areas and 75% in the urban areas.

Table-2
Registration under the NHIS by region

Region	Population (2008, million)	Incidence of poverty (2006, %) ¹⁶	Female literacy (2003, %) ¹⁷	Health care < 30 min reach (2003, %) ¹⁶	Population Registered under NHIS (2008, %)	Population Holding NHIS cards (2008, %)
Ashanti	4.72	20	83.2	69.1	59	50
Brong Ahafo	2.21	29	72.6	53.9	67	60
Central	1.88	20	74.8	67.2	54	13
Eastern	2.36	15	84.1	60.3	59	52
Greater Accra	4.10	12	87.6	81.2	35	32
Northern	1.90	52	21.2	35.0	67	56
Volta	1.98	31	79.3	49.7	48	40
Upper East	1.00	70	27.6	20.9	60	56
Upper West	0.66	88	36.7	30.4	70	67
Western	2.48	18	77.7	46.9	48	43
Total	23.29	29	71.8	57.7	53.3	45

Key message: *NHIS coverage is relatively high in districts where the incidence of poverty is high, female literacy is low and health-care facilities are located far away from people.*

Table-3**NHIS registration by population groups, 2008**

Population group	Approx. population (million)^a	Share in population (%)	No. of card holders (million)	Share in total membership (%)	Population coverage (%)
Under-18	10.47	44.6	6.31	50.5	60.3
Informal sector	7.26	30.9	3.73	29.9	51.4
Aged (> 70 years)	1.08	4.6	0.82	7.2	75.9
Formal sector	3.29	14.0	0.81	6.5	24.6
Pregnant women	0.75	3.2	0.43	3.5	57.3
Indigent	0.63	2.7	0.30	2.4	47.6
Total	23.48	100.0	12.47	100.0	53.1

Key message: *NHIS coverage is high for disadvantaged populations such as the elderly.*

3.4 The implementation process

Initiated in 2001, the NHIS was legalized in 2003 by the National Health Insurance Act (Act 650) through the process of law making involving a series of actions such as initial drafting by the Ministry of Health, Cabinet review, AG review, parliament passage, the President's approval and gazette notification.¹⁵ The Act facilitated establishment and regulation of health insurance schemes, imposition of a health insurance levy, accreditation and monitoring of health-care providers, and establishment of a National Health Insurance Fund for subsidizing the schemes. The NHIS was formally launched in December 2004 and it was made mandatory for all residents in Ghana to be enrolled into one of the three types of permissible health insurance schemes viz., district mutual health schemes (public sector)^b, private commercial insurance schemes and private mutual health schemes.^c

3.4.1 Sources of funding

The National Health Insurance Fund pools NHIS resources from the following seven different sources:

1. Earmarked budgetary allocation through a system of 'ring-fencing' (introduced in 2007)

^a *Estimated based on UNDP 2007 data*

^b *These schemes could receive government subsidy*

^c *A private mutual health insurance scheme is not entitled to receive government subsidy*

2. A national health insurance levy imposed at the rate of 2.5% on the supply and import of goods and services
3. Social security contribution
4. Ministry of Finance resources for exempted persons
5. Parliament allocations
6. Investment returns
7. Voluntary contributions such as grants, donations, and gifts

As per the ring-fencing system, the Ministry of Finance ring-fences (earmarks) budgetary funds meant for health with a 5-year programme of work; over 30% of this envelope is channelled through the NHIS. The estimated transfer in 2009 is GH¢ 233.4 million.¹⁸ The national health insurance levy is payable at the time of their supply or import; the estimated value of this levy in 2009 is GH¢ 306.6 million. Social security contributions for the NHIS come from about 15% of individual contributions to the Social Security and Pensions Scheme Fund; the estimated value of this contribution in 2009 is GH¢ 42.5 million. For exempted persons, the Ministry of Finance pays GH¢ 14 per exempted person per annum to the National Health Insurance Authority as a contribution to the NHIS. Earmarked funding from specialized agencies and development partners too continue to be a significant source. Central funds are also set aside to recapitalize schemes in time of distress.

3.4.2 Premiums and benefit package

Enrolees pay differential premiums ranging between GH¢ 7.20 and GH¢ 48 depending on the socio-economic status, as assessed by a committee of local experts. The extreme poor, children (< 18 years) whose parents are enrolled, the elderly (>70 years), indigents, pensioners under the social security scheme, and pregnant women are exempted from paying the premium. In addition, there is a one-time registration fee of GH¢ 4; no client is exempted from paying this. Efforts are in progress to introduce a one-time premium payment so that the enrolees can be permanently covered.

Almost all outpatient and inpatient services targeting over 90% of the disease burden including essential medicines (as included in the NHIS approved list) are offered to the insured without any co-payments. The insurance is cashless and the insured are not required to make any payment at the time of health-care delivery. Payments for referrals (under the gatekeeper system) up to teaching hospital are covered. However, HIV retroviral drugs, hormone and organ replacement therapy, heart and brain surgery other than the ones caused accidents, diagnosis and treatment abroad, dialysis for chronic renal failure and cancers are excluded from the insurance package.

3.4.3 Providers

Health care for the NHIS clients is provided by accredited and contracted providers (both government and non-government); in 2008, there were 1,551 accredited non-government providers (400 hospitals/clinics, 237 maternity homes, 451 pharmacies, 329 licensed chemical shops and 128 diagnostic facilities) in addition to public providers; private providers account for about 30% of the NHIS health-care provision.

4 Impact of the NHIS on health-care coverage

By the end of 2005, the population coverage was 27% and by June 2009, the coverage went up to 67.5% with majority of the poor and disadvantaged people finding their way into the system. Only 30.6% of enrollees pay any premium, which is graded according to the socioeconomic status. Population coverage, however, varies across Geographic regions. Health-care coverage has increased mainly because more patients with health insurance have been treated. In response to an increased demand, outpatient care services have grown more than inpatient services. At the national level, the number of outpatient care visits has increased from about 12 million in 2005 to 18 million in 2008.¹⁹ On the other hand, inpatient care admissions have increased from 0.8 million in 2005 to 0.9 million in 2007 before declining to about 0.85 million. Each hard holder, on the average, visited the health-care facility about once a year; each visit costs about GH¢ 13.

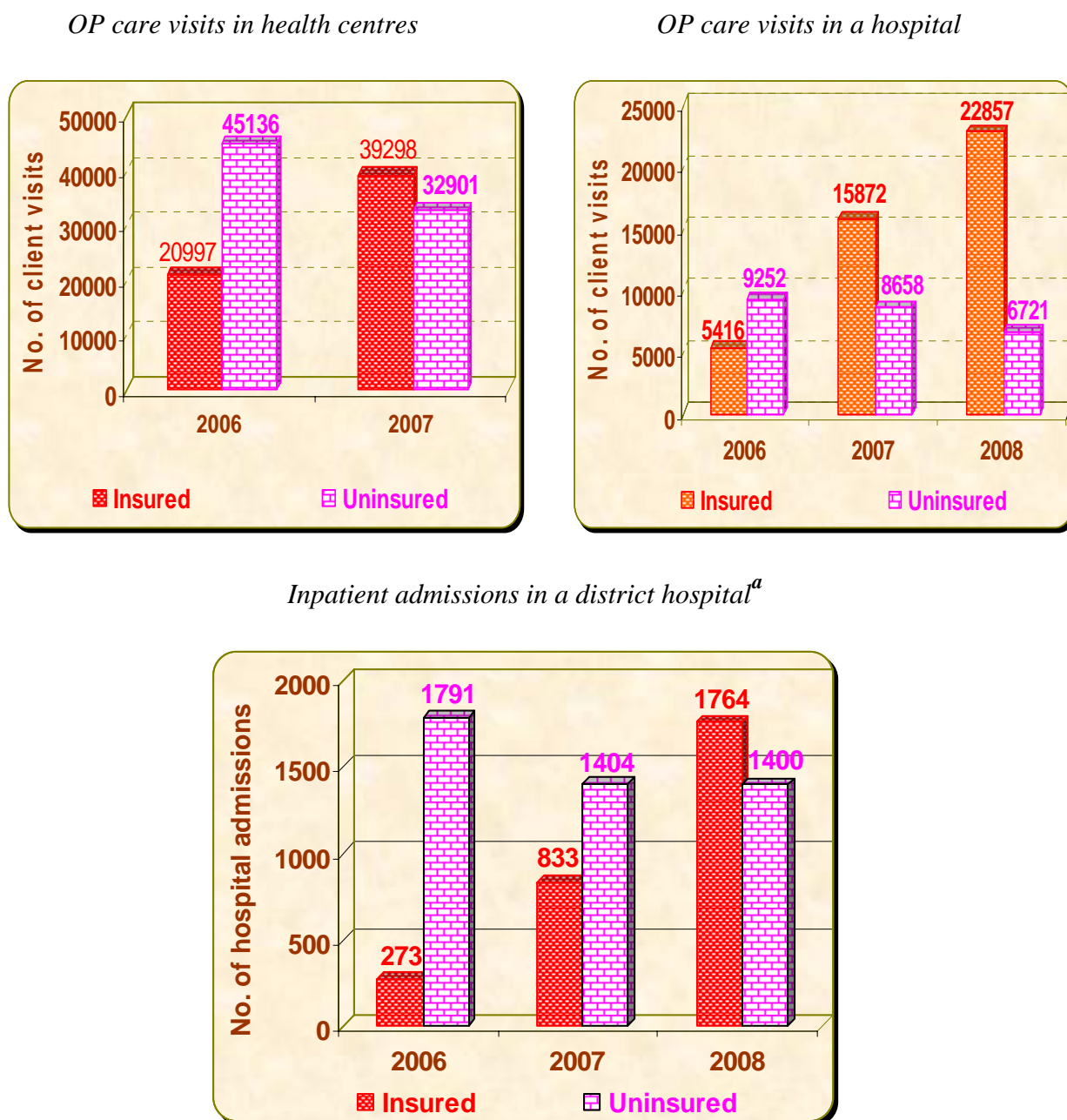
A before-after study indicated that there has been an increase in the use of formal care among the insured members.¹⁸ There was a modest decline in the share of out-of-pocket spending in private health spending after the introduction of the NHIS. However, no difference was found between the insured and others in the use of maternal care (ANC, deliveries or caesareans).

Figure-1 provides clear evidence on the client shift towards the NHIS in a Ghanaian district. As it can be seen, both the total number of visits and visits by the insured have increased indicating that the NHIS has been able to draw generate patient visits. A household survey in two forest districts indicated that the level of satisfaction among the NHIS clients is high regardless of their socioeconomic status and they are willing to renew their membership.

In 2009, the NHIS is accounting for 41% of the total public resource envelope. It is also able to generate more revenue to health-care units so much so that some hospitals depend up to 90% on NHIS resources. Insurance schemes, on the other hand, rely on government subsidy to the extent of 80-90%.

However, the premium revenue is likely to go up because the premium revenue potential has not been exploited fully.

Figure-1. Outpatient care visits in a Ghanaian district under the NHIS



Key message: *There is a clear shift away from the 'Cash and Carry' system*

^a Estimated based on hospital records.

5 Lessons to be learnt from Ghanaian experience

The major advantage of Ghana's NHIS is its focus on the poor and social health protection. Clients, irrespective of their socioeconomic status, seem to have had satisfactory experience with the system and are willing to remain insured in future. More people are able to gain access formal health care through the NHIS and there is a clear shift away from the 'Cash and Carry' system in favour of the NHIS. Hospital authorities have indicated that there had been a decline in the proportion of hospital deaths among the insured due to early treatment as indicated by the observed higher utilization of outpatient care coupled with a modest decline in inpatient admissions.

Although its impact on the disadvantaged populations appears to be positive, certain lessons can be learnt from the Ghanaian experience. **First**, there are many practical barriers to entry – economic, Geographic, political and cultural. There are many people living remotely who do not have easy access to health facilities and therefore may not perceive the benefits of membership. For instance, data from two districts found that renewal of membership was affected by location – 88% of urban members said that they were willing to renew, compared with 57% of rural residents. Similarly, the strict income norm for exempting the poor actually excluded the marginal poor, who are not able to pay the premium; in some cases, an ILO programme and some NGOs stepped in to pay the premium on their behalf. All the children (under 18 years) could not be covered because of the condition that their parents have to be insured first; efforts are now on to decouple them from their parents. In some areas, people refused to get enrolled themselves into the scheme due to their political differences with the political party in charge of the government; this situation too has changed. Some others could not really foresee potential benefits of the NHIS. After they witnessed benefits received by the enrolees, they are slowly getting into the system. As in the case of many other countries, identification of the indigents for free health care is a difficult task in Ghana too; definition of the indigents itself is restrictive. Many districts rely on community groups to identify the poorest, but it is not clear how effective this strategy is. This experience highlights the need for a coordinated effort across different government ministries including the MoH and the Ministry of Social Welfare (for example, to use their “Livelihood Empowerment Against Poverty (LEAP)” strategy in Ghana) to successfully target the poor.

Second, the potential of a well-functioning health financing system can be fully utilized only when it is supported by a well-functioning health-care delivery system. In Ghana, the health-care delivery system including the referral system appears to be functioning sub-optimally. Besides constraining

people's access to health care, it facilitates frequent patient visits to higher level facilities, which results in higher reimbursement per episode. There are also instances of malpractices in ensuring free care to the insured; informal payments are reported in the form of charging of services provided outside office hours, and asking patients to pay for drugs not in stock and/or not provided under the MoH's Essential Drug List. About 40% of the insured clients seem to be making informal payments. If the health-care delivery system fails to operate optimally, it would be difficult to sustain benefits of a health financing system like the NHIS.

Third, concerns are being voiced about its sustainability. Its financial sustainability is threatened by a number of factors including the following:

- There seem to be provider incentives to over-prescribe
- Very generous benefit package to cover 95% disease burden
- Ineffective referral system due to which patients are able to seek care from higher level facilities
- Under-developed monitoring systems within the NHIS

These concerns are partly addressed by the fact that the NHIS revenue is more stable due to earmarked tax revenue and that there are potential rich clients left to be covered. The share of paid enrollees has increased along with the decline in the 'Cash and Carry' payment in all the regions and the NHIS revenue is a dominant contributor to hospital revenues. There are discussions to expand the sources of fund for the NHIS.

Fourth, certain past health system structures such as vertical control programmes, which are continued along with the current NHIS system, introduce some management challenges. This is in addition to the inadequate technical and managerial capacity of the staff running the scheme.

Fifth, in Ghana, money follows the infrastructure. That is, areas and institutions with better health-care infrastructure tend to generate more income than others with poor infrastructure. While the population coverage is higher in areas where the infrastructure is scarce, financial coverage seems to be higher in areas where the infrastructure is relatively stronger. This will also create 'perverse incentives' to provide more curative health care.

The NHIS is still young and subject to many pressures - financial and political. No formal evaluation of the NHIS has been carried out to understand its dynamics and impact on access to health care.

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