

The National Health Insurance Scheme in Ghana

Veteran health system experts Delanyo Dovlo and Chris Atim review Ghana's NHIS

The Ghana Ministry of Health in 2020 developed a Roadmap for attaining Universal Health Coverage, which emphasised the importance of ensuring universal access to quality health care for all residents. The act of parliament (Act 650) that approved the National Health Insurance Scheme and Authority for Ghana was passed in 2003¹ as part of a scheme to improve financing of health services and to reduce the burden on the population occasioned by an existing policy of out-of-pocket payment for services initiated in the mid 1990s. It was revised by parliament through Act 852 in 2012.² The National Health Insurance Scheme and its managing Authority was founded in 2004 and is now fully established as a major source of financing for health care in Ghana, with funding from both premium contributions and a general NHIS levy on Value Added Tax. It was estimated to cover approximately 35.8% of the population in 2018,³ which was a decline from 2016 coverage which was reported at about 40% of the population.

The 2020 UHC Roadmap defines UHC for Ghana as: "All people in Ghana have timely access to high quality health services irrespective of ability to pay at the point of use." The NHIS assists to facilitate the "irrespective of ability to pay" aspect of access to services.

This paper is a summary review of the National Health Insurance Scheme (NHIS) of Ghana generated from presentations and discussions during recent reviews between 2015-2016 including a Presidential Review in 2016.

Objectives and structure of NHIS in Ghana

Financing for health has three main functions:⁴ (1) to generate revenue from various sources, (2) to pool this revenue, and (3) to purchase health care services from providers of care. In some situations, these functions are separated between various agencies but in some cases, this may be the function of a single entity. In Ghana, the National Health Insurance Scheme collects and pools revenue from a set of sources and procures health services from providers in both the public and private sectors.

As with many developing countries, Ghana derives its revenue for health from various sources including (1) the national budget, (2) locally generated resources at local government or facility levels, (3) resources from



NGOs and other philanthropic organizations, (4) external development partners and donor funds, (5) payroll taxes raised from employees' Social Security contributions – 2.5%, (6) an NHIS 2.5% levy on Value Added Tax (VAT) which provides about 70% of NHIS's revenue, (7) premiums paid into the NHIS fund by individuals or employers working in the informal sector, and (8) other sources including private health insurance, and out of pocket expenses. The interaction or lack thereof between all the various sources can of course lead to fragmentation and a less efficient use of the resources needed to procure health for the population as a whole. The NHIS in Ghana therefore helps to pool the revenue generated from three main sources, i.e., the VAT levy, employee social security contributions and the premiums paid by individual subscribers and it pools these into a fund that is aimed at ensuring that "All people in Ghana have timely access to high quality health services irrespective of ability to pay at the point of use" as the UHC roadmap has indicated.

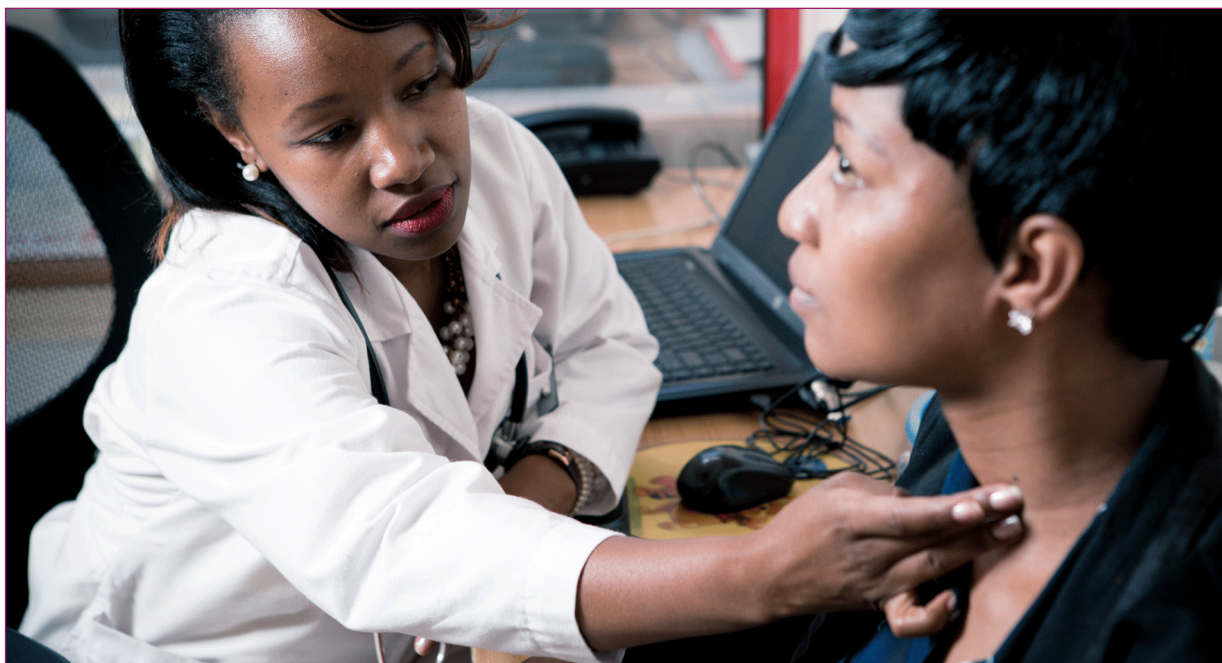
What and who is covered?

The scheme has covered an ever-increasing scope of conditions estimated to cover over 95% of disease conditions and services in the country.⁵ But it also carries the burden of some 60% of its members who are exempted from premium payments and contributions for various reasons.

The NHIS benefits package covers outpatient services; inpatient services; oral health; eye care; maternity; emergencies. It excludes cosmetic surgery and aesthetic care; HIV retroviral drugs; assisted reproduction; echocardiography; angiography; dialysis for chronic renal failure; heart and brain surgery other than those resulting from accidents; cancer treatment other than cervical and breast cancer; organ transplants and also conditions requiring diagnosis and treatment abroad.⁶

The persons exempted from paying premiums are also well laid out and includes contributors to the Social Security and National Insurance Trust (SSNIT) who do

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not directly pay to join the scheme but do contribute indirectly via 2.5% SSNIT contributions taken from their payroll. Others completely exempted are children up until 18 years of age; the elderly above 70 years of age; indigents and pregnant women.⁵

The NHIS purchases services from primary preventive and care services to tertiary care levels as indicated in the scope of coverage and the exemptions schedules mentioned above. Care is procured from both public and private service providers at all levels of services delivery. An assessment of coverage indicates that some level of equity in health insurance coverage has been achieved between the different wealth quintiles in the country since its inception.⁷

Utilisation of health services are estimated to have quadrupled between 2003 to 2016 from 0.4 per capita to 1.6 per capita in most regions [6] and Out of Pocket expenditure on health (OOPs) is said to have reduced by 50% for curative care and 44% for deliveries! The Health Information System (DHIMS2 data for 2008 – 2015) assessed that some 83% of OPD attendees have been insured.⁸

It must be noted that the Government of Ghana also contributes to the financing of health through four channels i.e., payment of health worker salaries, investing in health infrastructure and in procuring various goods and services in support of the sector.

What works and how well?

The Ghana NHIS has had certain design advantages that have been recognized as good prospects for the scheme. These include the fact that the key sources of revenue (VAT, SSNIT and premiums) are effectively pooled under the scheme and thus reduces fragmentation in the purchasing of health care. It also has the advantage of having its main source of revenue coming from general public resources (taxes, levies) and not from individuals' premiums (which constitute only small proportion of NHIS revenue) and this is in line with

WHO advice on publicly financed social health insurance principles. This helps to at least aim at obtaining an equitable benefit package for all members. Purchasing of services also comes from this revenue pool and is the responsibility of the same organisation.

At 35-40% coverage of the population more could be desired but for a 16-year-old scheme this is quite an achievement, though it is rather worrying that the membership has stagnated at that around that figure for some years now, or even declined slightly recently and annual Membership renewal has been an identified challenge. Linked to this is the over 80% of OPD users that are found to be covered and also the apparent impact it has had on OOPs in Ghana and on utilisation rates as indicated in the introductory section of this paper.

What issues and challenges are currently being faced by the NHIS?

There have been calls in the recent past for a review of the NHIS amid increasing media criticism that resulted in a review initiated by the presidency to assess the scheme in 2015/16.⁸ This arose from a variety of concerns and their likely political implications and included issues from the providers side of operations such as unauthorized charges or illicit 'co-payments' at point of services; difficulties and long waiting lines for registration to join the scheme; suspicions of fraud and abuse in the claims system; dissatisfaction of providers with the NHIS tariff levels and thus the amount of reimbursements providers received. Additionally, there has been serious provider dissatisfaction with much delayed payments with reimbursements sometimes being received as much as 8-10 months after submitting claims. There have been issues of the effective identification of clients and in avoiding impersonation by ineligible persons.

On the part of the National Health Insurance authority, there are issues with procuring health services as its potential for "strategic purchasing" appears under-utilised though its role as a 'single purchaser' is partly

undermined by the fragmentation from the other health system financing sources outside its ambit.

It has been felt that services procurement skews unfavorably towards hospitals and clinical care with preventive and promotive care less prioritized. A recent Ghana Health Service (GHS) Primary Health Care (PHC) Strategic Implementation Plan document indicates that primary care CHPS zones are challenged in meeting core accreditation criteria which tends to favor clinical care services.⁹

The scheme tended to offer higher levels of reimbursements for private providers than public ones, not only because, unlike public providers, the private ones required to be compensated for their staff salaries as well, but also because the latter are better able to meet some technology and equipment gradings in accreditation. This also raises issues of how to target incentives to providers to not only focus on equipment but also on quality of care and outcomes to clients.

For the clientele, there are broader issues of provider quality across the country and at different levels of care as well as how clients' interests can factor into the incentives given to providers for a good delivery of care. It is also unclear (sometimes to both provider and clients) under the broad areas of benefits covered as to what will be paid and what will not be paid for.

The divesting of public health worker salaries to another source may also influence how well the insurance scheme can influence incentives.

Engaging on preventive and promotion services has been a challenge even as non-communicable conditions have become a major component of the burden of disease alongside the existing infectious diseases but without commensurate efforts at health prevention and promotion coverage.

The National Health Insurance Authority (NHIA) indicates that 10% of its funding goes directly to the Ministry of Health to support Public Health and preventive actions and it is unclear how the results of these are defined and accounted for.

The relatively high overhead costs, combined with rather low premium collection, has also been raised as an issue with examples from various countries showing that operating expenses of similar schemes ranged from 1% (Estonia) to 4.4% (South Korea) either legally restricted or as part of efficiency measures.⁶

While an estimated 95% of services are covered, it is clear that service scope and quality are not evenly distributed across the country and therefore the question arises as to whether the expected benefits are received in full everywhere and of the same quality. In addition, the SDG Tracker that tracks global progress towards UHC shows Ghana as having a service coverage index of less than 50%, at 47% in 2017 (World Health Statistics, 2019).

The way forward

The reviews of the NHIS raises some issues of sustainability some of which are positive. The 2.5% VAT as a major funding source has allowed NHIS revenues to grow broadly in line with economic growth though this may affect sustainability as the linkage to expenditures

and membership growth is not clear.

The health sector has also gradually expanded its reliance on the NHIS as the major funding source with possible erosion in the other complementary sources e.g., government budget. For example, it was estimated that the ratio between MoH expenditure and NHIF expenditure had decreased from 2.9 in 2012 to 1.7 in 2014.⁷

The NHIS also shall need to deal with various inefficiencies and certain processes that need to be tightened to close loopholes. The year-round voluntary enrolment designed around individuals and not the family may favour adverse selection (though a one-month waiting period is required).

Subscribers to the scheme seemed to have been little empowered to play roles and to demand efficient operations and are not incentivised to behave responsibly and feel ownership of the NHIS, including a lack of adequate information and efforts to show the consequences of certain health related behaviours including diet and lifestyle choices that may result in a drain on resources. NHIS may therefore be essentially paying for consequences of under-performance of the country's public health preventive and promotive programs and the lack of investments to tackle the causes of infectious diseases and NCDs as well as a high maternal and child morbidity and mortality.

There is a need to reduce operational inefficiencies of the purchaser and have more effort made at strategic purchasing and reduce a susceptibility to fraud and abuse. Expansion in the use of technology has started and needs to be enhanced in enrolling subscribers, processing claims and managing expenditures more effectively.

There is a major need for continuous public information and awareness building, and to expand coverage to the remaining 60% of the population and in so doing, also try and do the politically difficult task of implementing budget-neutral payment mechanisms (such as capitation and global budgets) to constrain NHIS expenditures and promote efficiency, potentially involving some form of rationing of non-emergency, and especially elective, care.

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