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FINANCING NATIONAL HEALTH INSURANCE IN GHANA

BY JENNA DIXON

SUMMARY

- Ghana's National Health Insurance Scheme (NHIS) has been described as 'pro-poor' because it is scaled to income, allowing access to affordable health care for low-income Ghanaians
- There is debate over the actual rate of enrolment in the NHIS; official figures put it at over 60 percent of Ghana's population, while other studies cite numbers that range as low as 18 to 34 percent.
- Despite attempts to portray the NHIS as pro-poor, there is evidence to suggest that Ghana is struggling to enrol poor segments of the population, with the rich at least twice as likely to enrol compared to the poor.

ORIGINS OF GHANA'S NATIONAL HEALTH INSURANCE SCHEME

Like many other countries in Africa, Ghana spent much of the 1980s and 1990s paying off debt and enacting austerity measures designed to shore up its economy. The country's health sector noticeably suffered under the economic cutbacks, resulting in staff shortages and poor maintenance of health facilities (Oppong, 2001: 357–70). In order to curb the deterioration of health services and to boost the quality of health care delivery, Ghana eventually implemented a pay-per-service health care model, commonly referred to as the "cash-and-carry" system.

However, the pay-per-service model inadvertently ended up discriminating against Ghana's most vulnerable communities, rendering health services unaffordable to them. Not surprisingly, a substantial decline in the number of people accessing health care services in hospitals became evident shortly after, with estimates suggesting at least a 25 percent drop in usage. The greatest declines were recorded among the poor, elderly, women, and rural residents (Anyiman 1989: 531-47; Hutchful 2002: 129-40; Konadu-Agyemang, 2000: 475—81; Waddington and Enimayew, 1990: 287-312).

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Jenna Dixon is a Ph.D candidate in the Department of Geography at The University of Western Ontario, in London, Ontario. She holds a Masters of Arts from the Department of Sociology at The University of Western Ontario. Jenna's doctoral research draws on a foundation of health geography and developmental geography in order to focus on barriers to health insurance enrolment in Ghana. Specifically, this work analyzes the roles of gender and poverty in achieving access to health care. Jenna has previously studied health care organization in the Canadian context, and has spent time working in health facilities in Kenya and Uganda.

The failure of the cash-and-carry system to cater to the health care needs of the country's most vulnerable populations placed health care services and delivery improvements on top of the country's development agenda. In 2003, the National Health Insurance Act was approved by parliament, followed by the launch of the National Health Insurance Scheme (NHIS) in 2004. The NHIS was designed to offer affordable health care to the country's poor, with adults contributing a minimal annual payment in comparison with the value of their potential health care usage.

The creation of the NHIS has been widely extolled as a progressive and "pro-poor" policy. Since its introduction in 2004, access to health care in Ghana has improved significantly, but there are many shortcomings under the program. This backgrounder explores the impact of the NHIS in Ghana, emphasizing both its accomplishments and its deficiencies.

HOW THE NHIS FUNCTIONS

Health insurance is an arrangement that provides the opportunity to contribute to a fund that can be drawn from when in need of medical care. Under Ghana's NHIS, unforeseen health care costs are transferred into fixed premiums, replacing lump-sum out-of-pocket health care payments with a more affordable and frequent expenditure in the form of premium payments. In other words, health insurance participants share the financial burden of health care costs by pooling together their financial resources (Atim, 1999: 881—96; Edoh and Brenya, 2002: 41; Ekman, 2004: 249—50). In addition to the premium payments made by enrolled adults, the NHIS also draws funding from the federal government and a 2.5 percent value added tax, applied to all goods and services.

The "pro-poor" perception of the NHIS is based on three distinct characteristics of the program. First, the liberal benefits package creates a level playing field by facilitating health care access for everyone regardless of their financial status. Second, the premium amount is measured by income, not demand, and is based on the member's ability to pay. On this sliding scale, those who earn more, pay more and those who earn less, pay less, with exact premium payments varying across the country based on the rates set at the district level. According to the National Health Authority, the annual premiums range between Ghanaian Cedis 7.20 to 48.00 (or approximately US\$4.59 to US\$30.61). Those who work

for the government are automatically covered by the NHIS through their social security payments, though they must officially register themselves within their district. Third, from its onset, the NHIS has allowed free health coverage for all those considered to be indigent and unable to pay. Under the National Health Insurance Act, an 'indigent' is considered to be any person who meets the following criteria: a) is unemployed and has no visible source of income; b) does not have a fixed place of residence according to standards determined by the scheme; c) does not live with a person who is employed and who has a fixed place of residence; and or d) does not have any identifiable consistent support from another person. The indigent exemption status is intended to protect those lacking the financial and social support necessary to acquire membership in the scheme. However, there have been many criticisms of the indigent and other exemption statuses.

POSITIVE IMPACT OF THE NHIS

Since the implementation of the NHIS over seven years ago, the country's health care system has progressively improved. In its original format, the NHIS included payment exemptions for indigents, those over 70 years of age, and members of the formal economy. Over the years, significant additions have been made to the exemption lists, including coverage of all pregnant women since 2008, in recognition of the importance of neonatal care. Most recently, children under 18 years of age whose parents are currently enrolled in the NHIS became eligible for free health coverage. In an effort to further improve youth health coverage, Ghana's government has promised since 2009 to expand this to all persons under the age of 18, and not just those with parents who are enrolled. This has not yet been rolled out.

Reports show that NHIS coverage has been an important tool in increased utilization of health facilities (Ministry of Health Ghana, 2010: 35; Witter and Garshong, 2009: 6). In-patient utilization increased from 28,906 in 2005 to 846,311 in 2009 (National Health Insurance Authority, 2010: 31). The number of out-patient visits increased to 18.7 million in 2010 (from 2.4 million in 2006) and the Ministry of Health reports that the vast majority of these patients were covered by the NHIS (Ministry of Health Ghana, 2011: 39). As well, when compared to women who were not enrolled, women enrolled with the NHIS are more likely to use prenatal care, deliver

in hospitals and be attended by trained professionals, and by result, are less likely to experience birth complications and infant deaths. (Mensha, Oppong and Schmidt, 2010: 102–4).

SHORTCOMINGS OF THE NHIS

While initial figures are promising, the actual number of Ghanaians enrolled in the NHIS remains a subject of debate and controversy. The National Health Insurance Authority put the country's enrolment at over 60 percent in 2009, out-performing targets set for the year 2015. But independent studies and reports have questioned these official figures. For instance, a study in 2011 indicates that the enrolment rate sits closer to between 18 and 34 percent if factors such as population increases and non-renewal of memberships are accounted for (Apoya and Marriott, 2011; 58–61). Similarly, data from the 2008 Ghana Demographic and Health Survey found enrolment to be between 30 and 40 percent (see Dixon, Tenkorang and Luginaah, under review).

Even more concerning is the fact that the number of affluent individuals participating in the NHIS is far greater than the number of poor Ghanaians enrolled in the scheme. Despite attempts to portray the NHIS as pro-poor, individuals with low incomes covered under the scheme are outnumbered by affluent ones and a significant portion of poor people still do not have health coverage. Furthermore studies show that (though figures vary by region) the rich are often twice as likely to enroll in the scheme as compared to the poor (Asante and Aikins, 2008: 3; Jehu-Appiah, Aryeetey, Spaan, de Hoop, Agyepong and Baltussen, 2011: 157–63; Dixon, Tenkorang and Luginaah, under review; Health Systems 20/20, 2009: 12; Sarpong et al., 2010: 195; Witter and Garshong, 2009: 6).

FACTORS OF EXCLUSION

There is a long list of reasons that hinder the participation of poor people in the scheme. Firstly, paying health insurance fees on an ongoing basis is often too expensive for poor people, despite the long-term benefits of enrolling in the scheme. As individuals begin to pay into the scheme, the immediate impact of health insurance fees can translate into a decrease in funds for food, communication, or transportation expenditures (Koch and Alaba, 2010: 180–1). With the implicit tradeoff between basic necessities

and health insurance, NHIS premiums may be deemed to be an impractical expense by individuals with low incomes.

Although the scheme has made room for exemption statuses, there have been problems in their actual execution. For instance, only one percent of those living under Ghana's poverty line were registered for the NHIS in 2008 (Witter and Garshong, 2009: 5), which seems to suggest the ineffective implementation of the indigent status exemption. It has been argued that the criteria for the indigent exemption are too strict and should take into account specific local constructs of poverty in order to reach those truly in need of exemptions (Aikins and Dzikunu, 2006: 12).

What impact does this have on those who cannot enroll? Besides missing out on the advantages of health insurance coverage outlined above, those who are not covered under the NHIS may be facing a harder time now than they did under the previous pay-per-service model. Since the NHIS came into effect, the cost of pay-per-service treatment has gone up significantly (Witter and Garshaong, 2009: 6). As well, the 2.5 percent tax added to support the cost of the NHIS applies to all purchases, regardless of personal enrolment status. Ironically, those that are most affected by a regressive flat tax are the least likely to be enrolling in the NHIS (Apoya and Marriott, 2011: 26).

A discussion on the shortcomings of Ghana's health care system cannot conclude without mention of the impact of mishandled bureaucracy, fraud and leakages. For instance, the registration system is inefficient and impractical—names and identities often get lost in the system resulting in people ending up either without coverage or being forced to pay unnecessary fees (Health Systems 20/20, 2009: 17; Apoya and Marriott, 2011: 30—1). Fraudulent claims are also a major concern. In 2010, the National Health Insurance Authority's own audits found that 13 percent of claims were unjustified. Furthermore, observers posit that because of the prevalence of improper screening methods, a proper audit is likely to find that 20 percent of claims are without merit.

ADDRESSING LOOPHOLES IN THE NHIS

While Ghana's health care system has seen marked improvement in recent decades, several critical areas of concern remain. In order to achieve a

well-functioning and accessible health care system, Ghana must take steps to address the disproportionate under-enrolment of the poor in its national health insurance scheme. Some have suggested that this means transitioning away from the premium based insurance model and into a fully universal, free at point-of-service model of health care (Apoya and Marriott, 2011). Alternatively, the National Health Insurance Authority has begun investigating the possibility of a single payment for lifetime membership. It is argued that the government can “assur[e] unhindered financial access to healthcare for residents of the country through a One-Time Premium Payment” (National Health Insurance Authority, 2010: 17). While the financial feasibility of both strategies require further investigation, neither will succeed without simultaneously addressing the other challenges to accessing health care in Ghana. Namely, NHIS enrolment is meaningless without due funding of quality clinics, hospitals and health care staff within easy to reach distances.

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