

## MICRO HEALTH INSURANCE IN GHANA

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## **Outline of Presentation**

1. Introduction
2. Evolution of MHI in Ghana
3. MHI and the Early Challenges
4. Current state of the NHIS
5. Successes
6. Challenges
7. Conclusion

## Objective

- To place the development of MHI in Ghana into a historical context
  - From the early CBMHIS to the present DMHIS
- Lessons learnt over the years and to highlight on the way forward

## Introduction

- The history of modern health care financing in Ghana have gone through a number of significant changes over the years
- Before independence – mainly out-of-pocket payments (Arhinful 2003: 26-29)
- Early independence era – “free health care for all” policy (Ghana Health Service and Abt Associates, Inc 2009: 1)
  - Private sector health services charged out-of-pocket fees at point of service usage (Agyepong et al 2007: 154)

## Introduction

- Early 1970s - small out-of-pocket payments
  - Not necessarily to recover cost but mainly to discourage frivolous usage (Agyepong et al 2007: 154)
- Early to mid 1980s - introduction of user fees popularly referred to as “cash and carry” under WB/IMF SAP
  - Main aim was to recover at least 15% of recurrent expenditure in order to supplement limited health financing resources as well as to discourage frivolous usage (Agyepong et al 2007: 154; Ghana Health Service and Abt Associates, Inc 2009: 1; World Bank 2007).

## Introduction

- Financial aims of cash and carry system were achieved (MOH 2001: 53-54), but with severe inequities in financial access to basic and essential clinical services (Waddington and Enyimayew 1990: 287-312)
- Difficulties with health access and loss of revenue by public health facilities lead to the introduction CBHIS in the 1990s

## Introduction

- GoG in an effort to offset the challenges commissioned various studies into alternative health financing, principally insurance - based.
- NHIS bill passed into law in 2003, provided the basis for the establishment of MHIS at the district level in Ghana.
- The LI which serves as a regulatory framework for the NHIS was passed in 2004

## Evolution of MHIS in Ghana

- Introduction of MHIS in Ghana was very much influenced by the introduction of user fees in 1984
  - Difficulties in affording the cost of health care
  - Loss of revenue for many hospitals
- Challenges within the health sector prompted some health care facilities, mainly mission hospitals, to introduce insurance schemes managed jointly with communities (Creese and Benneth 1997)
- The Nkoranza scheme for instance, the first MHIS in Ghana, was initiated by the Catholic Diocese of Sunyani in 1989
- Other schemes, such as Damongo and Dangme West MHIS became models for other communities to replicate

## Regional Distribution of MHIS, 2001

| <b>Region</b>         | <b>No. of MHIS</b> | <b>% of total</b> | <b>Total Enrolment</b> | <b>% of Total Enrolment</b> |
|-----------------------|--------------------|-------------------|------------------------|-----------------------------|
| Eastern               | <b>14</b>          | <b>29.8</b>       | <b>4,860</b>           | <b>16.8</b>                 |
| Northern              | <b>8</b>           | <b>17.0</b>       | <b>2,914</b>           | <b>22.6</b>                 |
| Brong Ahafo           | <b>7</b>           | <b>14.9</b>       | <b>16,147</b>          | <b>55.8</b>                 |
| Ashanti               | <b>3</b>           | <b>6.4</b>        | <b>2,079</b>           | <b>4.8</b>                  |
| Greater Accra         | <b>3</b>           | <b>6.4</b>        | <b>-</b>               |                             |
| Western               | <b>4</b>           | <b>8.5</b>        | <b>-</b>               |                             |
| Upper East            | <b>2</b>           | <b>4.3</b>        | <b>-</b>               |                             |
| Upper West            | <b>4</b>           | <b>8.5</b>        | <b>-</b>               |                             |
| Central               | <b>1</b>           | <b>2.1</b>        | <b>0</b>               | <b>0</b>                    |
| Volta                 | <b>1</b>           | <b>2.1</b>        | <b>-</b>               |                             |
| National <sup>1</sup> | <b>47</b>          | <b>100</b>        | <b>6,679</b>           | <b>100</b>                  |

Source: Adapted from Atim, 2001

<sup>1</sup> Figure for the total number of MHIS (proposed and existing) was probably underestimated. It was known that three regions (Ashanti, Greater Accra and Volta) did not adequately follow the primary methodology for collecting the data. Hence it may be safe to conclude that the inventory did not capture all such MHIS in the country.

## **MHIS and Early Challenges**

- Moral hazard, adverse selection, fraud, underestimation of dues, cost escalation among others and the lack of knowledge and capacity to manage these risks (Atim et al. 2001: 25-42)
- Small membership base of the schemes did not provide an adequate base for risk pooling and risk sharing
- Difficulties with the quality of care provided especially at the public health facilities (Atim et al. 2001: 25-42)
- Lack of suitably skilled personnel to manage MHIS
- General lack of awareness of what MHIS are and what role they should play in the health care and financing of people

## The National Health Insurance Scheme in Ghana

- Its primary goal was to improve access to and quality of basic health care services in Ghana through the establishment of mandatory district-level MHIS. The policy objective is that:
- “[...] every resident of Ghana shall belong to a health insurance scheme that adequately covers him or her against the need to pay out-of-pocket at the point of service use in order to obtain access to a defined package of acceptable, quality health services.” (Government of Ghana 2004)

## **NATIONAL HEALTH INSURANCE SCHEME *Conti.***

- HI Act provides the legislative framework for the establishment of a regulatory body, the National Health Insurance Council
- The HI Act provides for the establishment of three types of schemes:
  - District Mutual Health Insurance Schemes
  - Private Commercial Health Insurance Schemes
  - Private Mutual Health Insurance Schemes

## Benefit Package

- The LI specifies the payment of an annual premium, set at a minimum of GHC7.20 per adult (currently USD 5.0)
- The benefits package cover basic health care services, including outpatient consultations, essential drugs, inpatient care and shared accommodation, maternity care, eye care, dental care, and emergency care, family planning and immunisation
- Excluded from the benefit packages are cosmetic surgery, drugs not listed on the NHIS drugs list, assisted reproduction, organ transplantation, and private inpatient accommodation

## Financing the NHIS

- The Act provides for the establishment of a National Health Insurance Fund
- To mobilize financial resources for the fund, the GoG established a NHI Levy of 2.5% on specific goods and services.
- In addition, 2.5% of the 17.5% social security contributions paid by formal sector employees will automatically be diverted to support the NHIS, and formal sector employees and their dependants (below 18 years) will automatically be enrolled
- DMHIS will raise funds from premiums for informal sector members to be set in consultation with the National Insurance Authority
- It is estimated that 70-75% of total revenue comes from the NHI levy while formal sector contributions made up about 20-25%. The informal sector premiums constituted only about 5% (Witter et al. 2009: 4)

## Percent NHIS Registration Coverage by Region, 2005 to 2007

| Region       | Estimated Population | Percent of population registered in 2005 | Percent of population registered in 2006 | Percent of population registered in 2007 |
|--------------|----------------------|--|--|--|
| Upper West   | 963,448              | 7.9                                      | 30.0                                     | 47.0                                     |
| Upper East   | 561,866              | 10.7                                     | 32.0                                     | 47.0                                     |
| Northern     | 1,790,417            | 18.7                                     | 40.0                                     | 58.0                                     |
| Brong Ahafo  | 1,968,205            | 30.1                                     | 61.0                                     | 72.0                                     |
| Ashanti      | 3,924,925            | 28.4                                     | 44.0                                     | 51.0                                     |
| Western      | 2,042,753            | 21.3                                     | 35.0                                     | 49.0                                     |
| Central      | 1,687,311            | 22.4                                     | 44.0                                     | 57.0                                     |
| Gt. Accra    | 3,576,312            | 17.0                                     | 19.0                                     | 24.0                                     |
| Eastern      | 2,274,453            | 18.3                                     | 37.0                                     | 51.0                                     |
| Volta        | 1,636,462            | 28.1                                     | 36.0                                     | 32.0                                     |
| <b>Total</b> | <b>20,425,652</b>    | <b>22.0</b>                              | <b>38.0</b>                              | <b>48.0</b>                              |

Source: GSS, National Health Insurance Authority, 2007

## Successes

- Increase in enrolment
- Increasing utilisation of health care services (Ghana Health Service and Abt Associates, Inc 2009: 42)
- Some decreases in hospitalisation rates (Ghana Health Service and Abt Associates, Inc 2009: 9)
  - Increased use of preventive care, earlier care seeking for illness associated with the NHIS
- An interview held with doctors at Damongo Hospital revealed that due to early care seeking, outpatient cases increased tremendously while inpatient cases reduced.
  - They attributed this to the NHIS because people no longer wait till their condition get bad owing to financial barriers.

## Challenges

- Financial resulting from
  - low premiums in relation to the cost of care
  - High utilisation and in some cases abuse by card holders
  - large proportion of exempt population
- Untimely release of funds as subsidies (80–90% of revenue base of the DMHIS)
- Large operational area of some of the districts
  - Difficult accessibility and increasing cost of collecting premium
- Lack of adequately qualified personnel to efficiently run these schemes and this has contributed to very high overhead costs to the various schemes

## Challenges *Conti.*

- *Alleged* corruption in most of the schemes and this is manifested through managerial inefficiency, misapplication of funds, outright corruption and leakages
- ICT challenges which make it difficult to efficiently run the schemes
- Politicization and a high turn over of its executive officers
  - Since the inception of the NHIS in five years, there has been at least three CEOs for the NHIA

## Conclusion

- Enrolment and access to MHI in Ghana has increased significantly and this has impacted positively on health care access for over 60% of the population, although the scheme is currently challenged by financial sustainability, alleged corruption, operational and legal issues
- Evidence as of December 2008 indicates that about 61% of the total population is enrolled on the scheme

- NHIS relies heavily on funding from the National Health Insurance Levy, which constitutes about 70-75% of the total revenue for the scheme
- To forestall the many challenges brought about by the delays in paying health service providers, measures must be put in place to ensure timely release of funds to the scheme
- *FINANCE, FINANCE AND FINANCE*



**Pro MHI Africa**

EU-African University Network to strengthen  
community-based micro health insurance

International Conference, Lilongwe,  
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**Thank you very much for your attention!**

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