

NATIONAL/MUTUAL HEALTH INSURANCE IN GHANA— INTRODUCTION, ACCESS, FRAMEWORK

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Outline of Presentation

1. Introduction
2. Evolution of MHI in Ghana/historical perspective
3. The NHIS & its current state
4. Access to DMHIS
5. Theoretical framework for access
6. Perceptions about DW & GW DMHIS
7. Conclusion

Introduction/Lit review

- 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/Lit review

- 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/Lit review

- 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 mid-to-early 1980s

Evolution of DMHIs in Ghana

- LI 1313 introduced in 1985 mandated user charges for health services
- Inability to pay led to decline in use of health services

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

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

Source: Adapted from Atim, 2001

¹ 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.

Introduction of NHIS in Ghana

- 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

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 MHI. 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 ??
- 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
Total	20,425,652	22.0	38.0	48.0

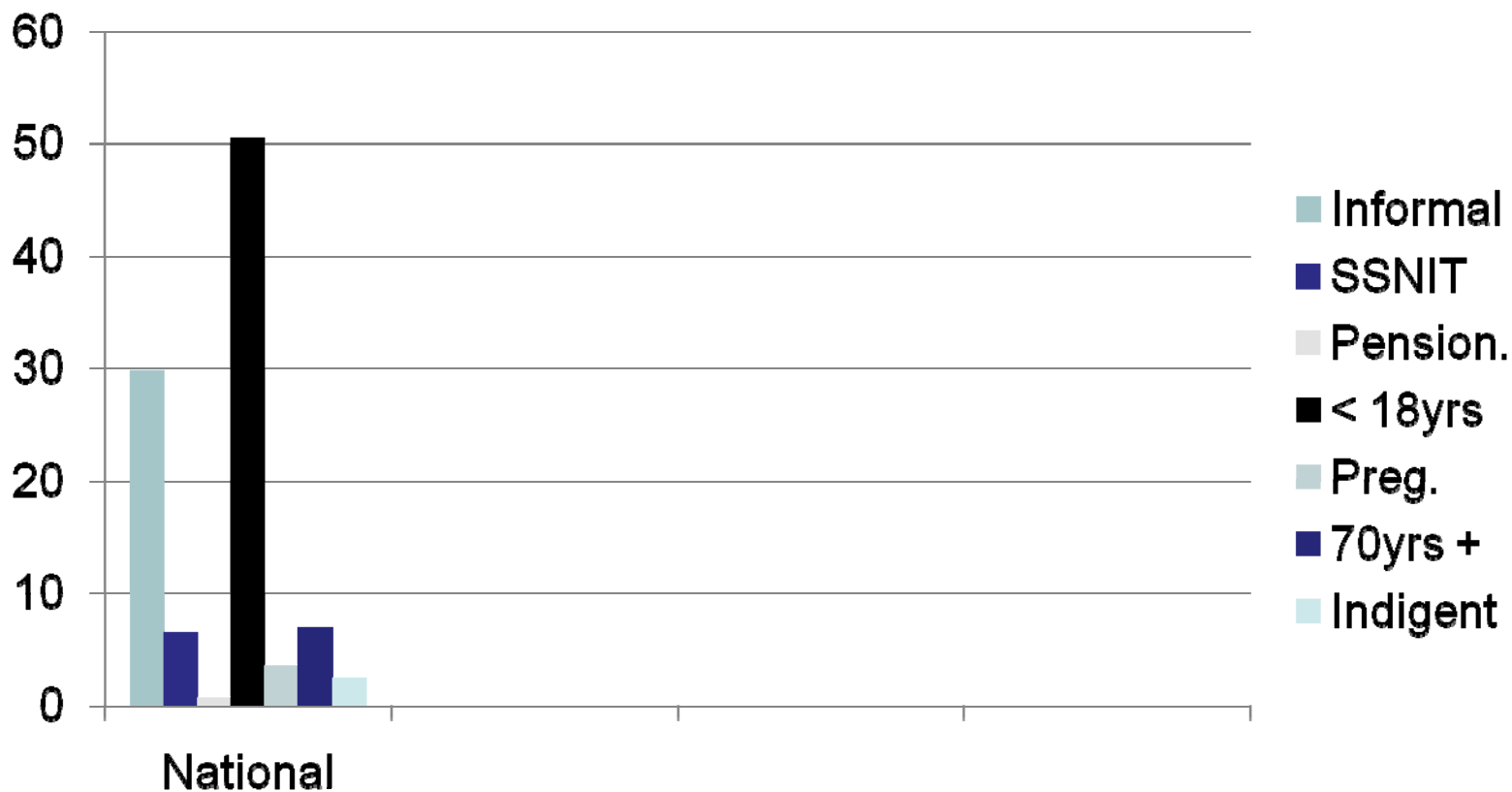
Source: GSS, National Health Insurance Authority, 2007

NHIS membership by categories (National)

Source: Citizens' assessment of NHIS, 2008: 4

Region	SSNIT	Spens.	<18 yrs	Preg.	70yrs +	Indigent	<i>Inform.</i>
Nat.	6.5	0.6	50.4	3.5	6.9	2.4	2.4

NHIS membership by categories (National) --2008



NHIS membership by categories (National)

- Key features--
- 50.4% < 18 yrs
- 29.8% informal
- 6.9 aged
- 6.5 SSNIT contributors
- = huge dependency on the National cofers

Access of MHIS in Ghana: 2001

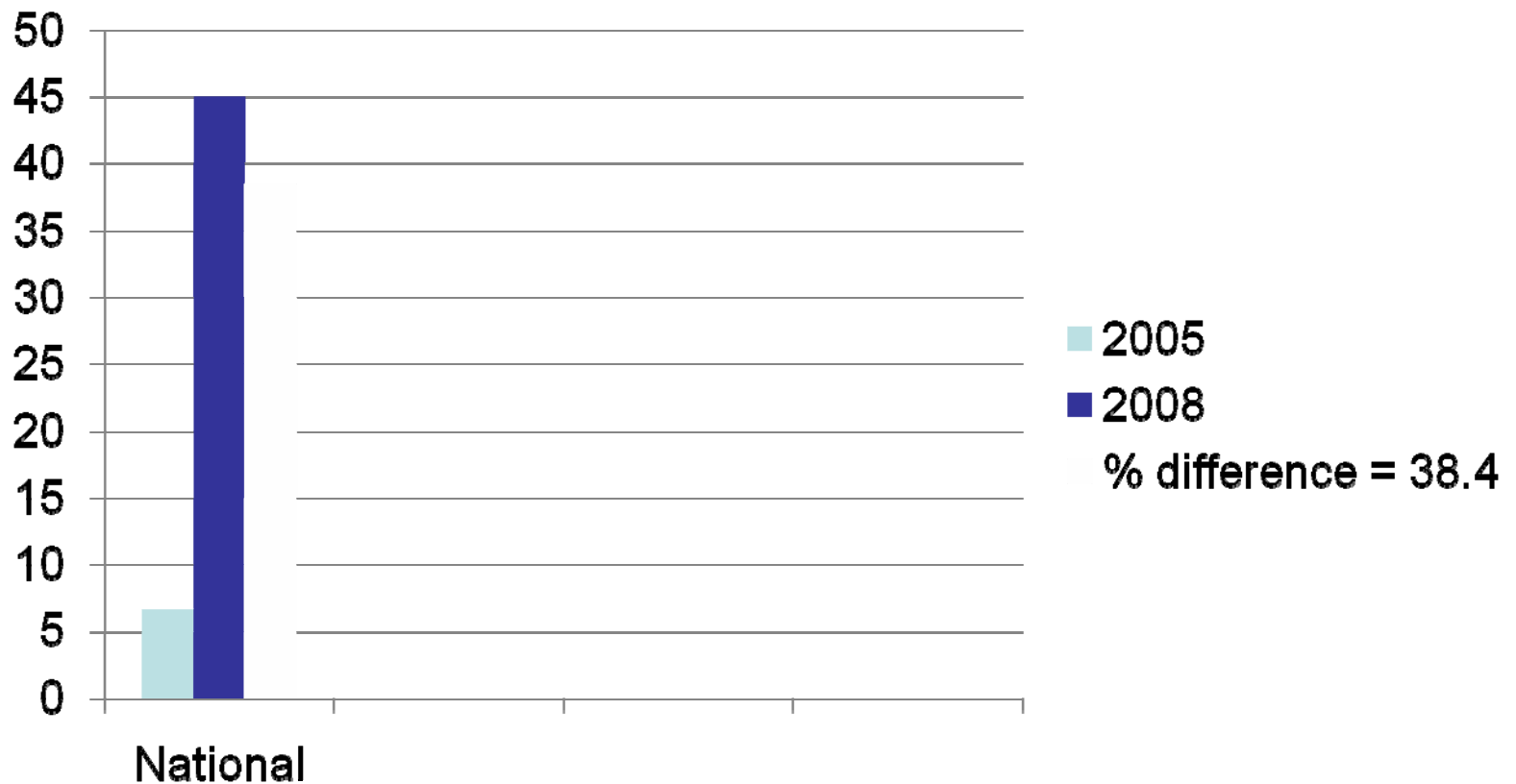
(Atim et al. 2001: 46: Nat. Census. 2000)

Reg.	Total MHIS	Tot. enrollment
ER	14	14,582
NR	8	19,606
BAR	7	48,441
AshR	3	4,158
GAR	3	-
WR	4	-
UER	2	-
UWR	4	-
CR	1	35
VR	1	-
Nat.	47	86,822

Membership categorizations of NHIS (2008)

Informal employment	29.8
SSNIT Contributors	6.5
SSNIT Pensioners	0.6
Under 18yrs	50.4
Pregnant women	3.5
Aged	6.9
Indigent	2.4

Enrollment and access after intro of DMHIS: card holders, 2005, 2008



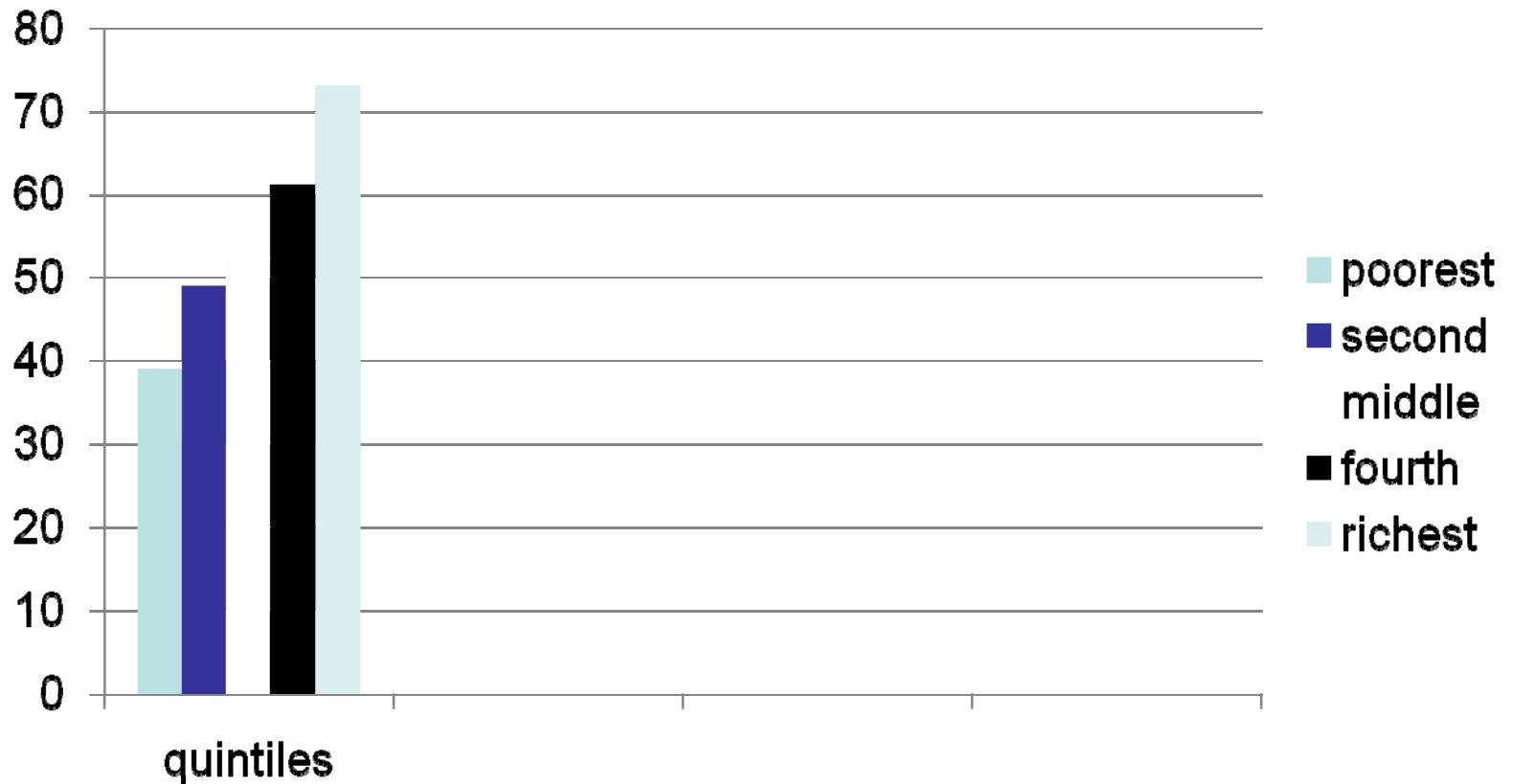
Access to DMHIS—Key features

- Initial concentration of enrollment in BAR, NR, ER (2001)
- Currently: UWR, BAR, UER, NR leading
- Least registration in CR, then GAR
- Reasons for picture.....

Determinants of MHI in Ghana—Analytical Framework (adapted from Carrin, 2003; NDPC, 2009)

- Affordability
- Unit of Membership
- Distance
- Timing of collecting premium
- Trust
- Exemptions
- Educational Background

Determinants of MHI in Ghana—Registration by SES quintile



Household survey—DW & GW, 2009

- About 60% of respondents: Positive views of NHIS:
 - > ‘Very good’
 - > “Better than ‘cash and carry’”
 - > ‘Has made health care affordable’
 - > etc.

Negative perceptions: DW & GW

- Poor accessibility
- Delay in processing cards
- Too expensive
- Approved drug list is limiting
- Poor attitude of health care providers towards card holders

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

Conclusions

- Most persons positive towards NHIS/DMHIS
- 30-40% of respondents in GW & DW have a negative view of the NHIS and called for its improvement



Thank you very much for your attention!

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