MUTUAL HEALTH INSURANCE VERSUS NATIONAL HEALTH INSURANCE IN GHANA

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OUTLINE

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INTRODUCTION

- Health care financing is of primary necessity, as health care itself.
- Access to health care largely determined by health care financing
- The WHO has itemized health care financing among four essential needs every country has to take care of
- Emerging and promising awareness of need for health insurance in the context of sustainable poverty reduction and social protection, e.g., increasing MHI access across SSA, Ghana (since mid-80s)

Objective of study

- Compare MHI & NHIS:
- Designing
- How each works—management, benefit, etc
- Aid/support
- Socio-political environment
- MHI household survey respondents' comparison of the two schemes
- ProMHI Respondents' appreciation of the NHI
- Lessons learned, etc

Methodology

- Mostly literature review
- Basic information from ProMHI study in two partner districts—Dangme West and Gonja West
- Comparative

LITERATURE REVIEW

History of health care financing in Ghana

- Pre-independence financing for modern health care services was mainly by out-of-pocket payments at the point of service use (Arhinful 2003: 26-29)

- Immediate post-independence “free health care for all” policy (GHService & Abt Associates, Inc 2009: 1)

- Challenges due to economic decline necessitated the introduction of user fees from the late 1970s to the 1980s

- Culminated in the introduction of very small out-of-pocket payments at the point of service usage within the public sector health care services in 1972; not to recover cost but to discourage frivolous usage (Agyepong et al. 2007)

LITERATURE REVIEW

History of health care financing in Ghana

- 1983 PNDC/IMF/WB SAP => 'cash & carry' system in 1985 (LI 1313) to recover at least 15 percent of recurrent health expenditure (Agyepong et al 2007; GHService & Abt Associates, Inc 2009; WB, 2007).
- Consequent inequities in financial access to basic and essential clinical services (Waddington and Enyimayew, 1990; Atim, 2000)
- Resultant community-based health insurance schemes introduced mostly by mission health facilities in conjunction with communities, mostly in early 1990s (Creese and Benneth 1997).
- Nkoranza scheme (the first MHIS in Ghana), which was initiated by the Catholic Diocese of Sunyani in 1989

Design: MHI vs. NHIS

MHI	NHIS
Mostly in response to ‘cash and carry” system of mid to late 80s	In response to fall out of ‘cash and carry‘ system
Initiated since 1989 with Nkoranza MHI as pioneer	GoG in an effort to offset the challenges commissioned various studies into alternative health financing, principally insurance – based.
Initially CHAG initiated mostly	Gov’t initiated,
Community based, organized, managed; with multi-party involvement (various opinion leaders, Formal Dept heads, etc)	Mostly district-based, replica of national structure; less community involvement
More community involvement	Very little community involvement; mostly central gov’t directed
Mix of bottom-up & top down mgt	Mostly top down management, etc (‘health workers disrespect card holders’)
Open or more than once registration period (convenient times based on knowledge of community), e.g., harvests	Open registration period

Design/how it works: MHI vs. NHIS

MHI	NHIS
Reliable service providers (e.g., Mission hospitals and their staff), and volunteers promoted commencement and implementation	Gov't LI started it; service providers are not automatically enrolled
Some schemes are registered with Registrar General's Dept, others not	Three different operators allowed by LI
Independent entities; no government support; support of donors	Mostly government support
Not-for profit providers, management	Service providers are for profit
Shorter window period (usually 3 months)	Longer window period: six months but could be more than one year
Limited benefits package, e.g., Dangme west scheme is for in-patient care only	More extensive package, at least in name
No exemptions/no free riding	Exemptions

How it works: MHI vs. NHIS

MHIS	NHIS
Several criteria are considered before fixing premium	NHIS decides automatically,
Individual centered premiums	same
but premium is fixed for all	premiums are based on categorization of incomes; and are progressive
Communication easier between operators and beneficiaries	Communication more difficult between parties
Viewed as more transparent	Not viewed as very transparent (‘preference for the rich’)
Easier to access benefit package	More difficult to access benefit package

National Health Insurance Scheme (NHIS) in Ghana

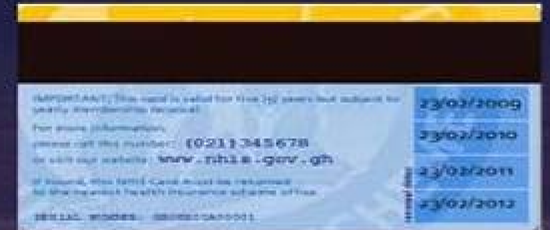
Process to NHIS

- 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

YOUR NEW NHIS ID CARD

National Health Insurance Scheme

NATIONAL HEALTH INSURANCE AUTHORITY



Your Passport To Health Care

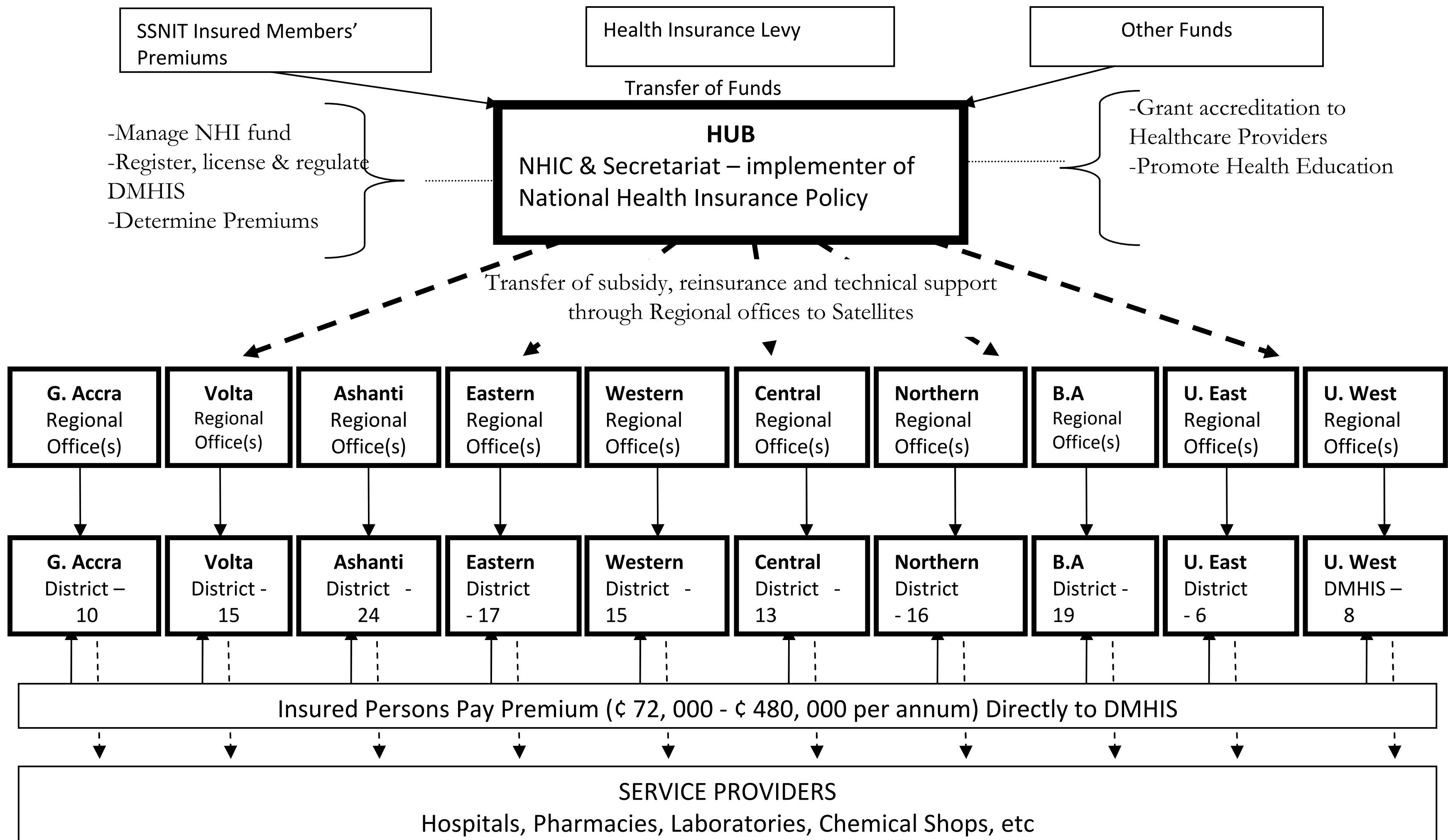
NHIS In Ghana

- The NHIS is operational; number of functional DMHIS (on basis of mutual schemes): 145 (2008), currently in almost all the 170 districts in the country.

- The NHIS LI allows for the concurrent operation of the District-wide (public) MHIS, Private MHIS, and Private Commercial Health Insurance

- Exemptions: children below 18 when both parents are insured, very poor and elderly above 70 years

Institutional Framework – NHIS Ghana (Source: Ras Boateng, 2007)



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

Source: Citizen’s Assessment of the NHIS 2008 p. 4

Categorization of registrants

- Three main categories:

> 1. Made part payment

> 2. Fully paid, waiting for card

> 3. Fully paid, has card, access benefits

Proportion of NHIS Card Holders—National: 2005 and 2008

Year	2005	2008
	6.6%	45%

Percentage difference = 38.4

Source: Compiled from Witter S. et al, 2009 p. 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

- Challenges & successes—ALREADY DISCUSSED

Perceptions (ProMHI Study: W. Gonja & Dangme W. districts)

- 30-40% of respondents have a negative view of the NHIS and called for its improvement:

**Poor accessibility/no networking, portability; poor management

**Delay in processing cards

**Too expensive premiums

**Approved drug list is limiting

**Poor attitude of health care providers towards card holders

Most persons positive towards NHIS

MoH study (Ghanaweb, Nov. 26, 2009): 59% respondents satisfied with NHIS

Pro-MHI study: about 60% satisfied with NHIS (descending order mentioned most):

**very good/helpful; helped improve health care services

**reduces poverty/doing well for the poor

**helps solve health needs/protective

** “biggest property country has”

**etc

Comparison of MHI with NHIS (ProMHI respondents)

	Frequency	Percent
Much more/more satis	257	44.6
Same	55	9.5
Less/much less satisfie	24	4.2
Cannot say	241	41.8

Recommendations for Improvement—ProMHI Study respondents

- Pay premium once
- more public education on it
- Should be maintained/continued by all gov’ts
- Extend drug list to cover all drugs
- Exempt the poor, aged, accident victims

Conclusions

- Both schemes developed in response to crisis health care financing in Ghana, & to provide better social protection in health care
- NHI designed to take advantage of gains, strengths of MHI and improve upon it
- NHIS mostly overshadowed MHI, but will not be able to cater for MHIs 'PERSONAL & COMMUNITY-BASED nature'

Conclusions

- ProMHI study respondents slightly more in favor of NHIS
- NHIS seen as more favorable than otherwise
- Yet about 40% of respondents have a negative view of the NHIS and called for its improvement;
- Poor accessibility/no networking, portability; poor management, & delay in processing cards are main complaints

Recommendations

- Gov't should consider allowing MHIs to operate in addition to NHIS for 'top up' social protection
- Some positive aspects of MHI could be introduced into NHIS, e.g., community-based, personal character
- Specified/recommended improvements be made in NHIS