A vision of healthcare for all Ghanaians-

Research by ISODEC, Alliance for Reproductive Health and the Essential Services Platform[i]

Policy brief for discussion

Summary Paragraph

The previous decade has seen substantial progress in health care financing in Ghana. However, the current system remains seriously inequitable and punishes the poorest. The ambition of the new government offers the chance for Ghana to build a truly universal health system, accessible to all Ghanaians, paid for from tax revenues. The obstacles are substantial, but the single premium and extensive exemption policies of the new government offer a clear opportunity to build a health care system that mirrors that of other successful developing nations such as Sri Lanka, and which could be the envy of Africa.

Killer user fees in Ghana in the past

In Ghana, after user fees were reintroduced in the country in the mid 1980s, there has been growing pressure for their abolition from a public increasingly frustrated by the inequities and well-documented[ii] suffering caused by user fees, which are considered a big burden on both poor and middle class Ghanaian families. This pressure has been most clearly demonstrated in every election held since at least the year 2000. The reduction of financial barriers to health care access has in one form or another been at the centre of these elections.

NHIS- a big improvement on fees but serious inequities exclude millions

If the public demand in this matter has been clear and unambiguous, the challenges faced by succeeding Governments in realising their election mandates in this connection have been quite daunting. The first comprehensive attempt to meet this goal was through the National Health Insurance Scheme (NHIS) Act 650 passed by the previous Government in 2003. The implementation of this law went a long way towards reducing financial barriers to health care access for millions of Ghanaians, as the data examined in our commissioned research shows.

This analysis and other evidence show, there are still many Ghanaians, and the majority of the poor, who are excluded from the NHIS and are hence unable to benefit from its generous health care package. The equity dimensions of the NHIS are very serious indeed. Only 29% of the poorest in the population are enrolled in the NHIS compared to 64% of the richest. Those outside the scheme are also often forced to pay higher user

fees, and are contributing to the costs of the NHIS by paying VAT, meaning the poor face a triple inequity which is excluding millions from life-saving care.

Healthcare for all- the vision of the new government.

The new Ghanaian government which took office in January 2009 had campaigned on a promise to go even further than the previous one did, that is, to institute a once in a lifetime premium payment for joining the insurance schemes. If current indications that this one-time payment will not be an actuarially-determined lifetime premium but a modest fee to be paid once to benefit from coverage available under the NHIS turn out to be correct, this would constitute a clear move towards health care for all with minimal financial barriers, so long as other preconditions for effectively delivering on such a promise without compromising health care quality are fulfilled.[iii,iv] This is in addition to their commitment to implement extensions to the exemptions from insurance premiums that had been promised but not fully carried out by the previous Government: especially to cover **all** children under 18 (irrespective of their parents' enrolment status, a policy known officially as "decoupling") in addition to coverage for the health care of all pregnant women. The trend is therefore clearly toward universal coverage.

Insurance or Tax financed?

Whilst described as an insurance system, the NHIS is in fact 70% funded by the National Health Insurance Levy of 2.5% added to VAT. This means that every Ghanaian is effectively contributing to the health system despite only around half of Ghanaians actually being card holders and able to access services[v]. This means what is commonly perceived as an insurance system is actually more similar to health systems relying on tax based financing, such as Canada or Sri Lanka.

When this is added to the fact that the main beneficiaries of the NHIS are from the wealthier quintiles, this effectively means that tax funds are being used to facilitate and pay for health care coverage for the better off sections of the population.

In the light of this financing picture, the new government's policy of a one-time payment is effectively a recognition of the fact that the NHIS is already a largely tax based system. Actual revenue from informal sector payments is only around 5%.

This existing reliance on tax based financing has important implications for the debate over the future of health care financing in Ghana. With widespread exemptions for all children and the move to a one off small premium there is a strong case for continued and increased reliance on tax based financing, including oil revenues, rather than trying to expand insurance schemes. This would allow all Ghanaians to access health services.

Inefficiencies in the NHIS and the potential for savings

There are significant efficiency gains, with accompanying savings, which may be possible if the NHIS had a more optimal design than at present, which could help expand coverage within the existing resource envelope.

In the desire to co-opt important stakeholders during the design of the NHIS, no mechanism was instituted to prevent providers attempting to indulge in behaviours that could exacerbate cost escalation in the system, although experience all over the world shows that when a health insurance system is put in place, there is always a tendency towards such cost escalation.

Most importantly, the payment is the default fee-for-service (i.e. the most inefficient possible). Drugs for instance continue to be paid by the fee for service method, and unsurprisingly, the NHIA reports the average number of prescriptions has more than doubled from 2.4 drugs in 2004 to 6 in 2008.

Moving to a simpler payment system based on capitation grants to facilities, which would be far simpler to administer and provides incentives to reduce costs, not increase them.

At the same time the move to a one off payment for a lifetime premium would also bring savings with the corresponding reduction in the administrative system needed to collect premiums. Schemes should be mandated to register everyone in their districts, and after an initial period of registration of all adults, there would then only be a need to collect fees from all children as they turn 18 each year, a relatively simple exercise and far cheaper to administer.

The challenge and cost of reaching Universal Coverage- who will pay?

The ILO has identified that as population coverage rises beyond a certain point, the NHIS will enter a deficit situation within the first 4-5 years of scheme operation. What is needed is an actuarial simulation of likely benefit and other costs at full coverage, of proposed efficiency savings, and the potential for other revenues sources.

Our view is that more tax based financing is feasible, especially when revenues from oil come on stream, but even without this windfall more is possible. The move to a one off premium for all is a de facto and welcome recognition of the reliance on tax based financing instead of the complex and inequitable expansion of services via insurance premia. The alternative is a system which will continue to exclude millions, particularly the poor and the majority of the 82% of adults who work in the informal sector.

A simpler system, more efficiently administered would also mean considerable savings. Coupled with increased donor aid to fund the investment in scaling up services that will be required, our view is that a universal health system, amenable to all Ghanaians is within reach.

Learning from other successful developing countries

A small, but growing number of developing countries have managed to achieve significant increases in health care for all, even at relatively low incomes per capita. As Ghana moves into the next phase of health care reform, it is critical that the maximum lessons are extracted from these experiences.

Initial Recommendations

ISODEC, The Alliance for Reproductive Health, the Essential Services Platform and Oxfam GB strongly support the governments' policy of moving to a one off lifetime premium, and of expanding exemptions to all children.

We recognise that this means significant challenges in the years ahead, but the current system, which excludes the vast majority of poor Ghanaians, must be improved radically. Remaining with the status quo is not an option. By making healthcare a right of every Ghanaian, funded through taxes, the new Government can create a new politics of accountable services, and a health system that could be the envy of Africa. Simpler financing must be coupled with a significant expansion in the quantity and quality of publicly provided health services. The following recommendations are initial and intended to open debate.

1. Fund the mandates that legislation and Government policy impose, i.e. pay for the free health care for all that is the clear choice of the Ghanaian people and increasing direction of Government policy:

- What is needed is an actuarial simulation of likely benefit and other costs at full coverage, of proposed efficiency savings, and the potential for other revenues sources.

- Study successful tax based systems in other developing countries and draw the lessons for Ghana.

- Increase the amount of tax based financing for health care, focusing on progressive taxation opportunities.

- Introduce a National Health Oil Levy (NHOL) on all oil revenues to supplement the cost of universal coverage.

- Top up revenue from the national budget as and when costs exceed revenues to ensure a continued level of basic health services for all.

2. Increase the efficiency of the payment systems in place and crack down on provider abuse of the system:

- keep the providers on board while minimising or eliminating abuses, including over-invoicing and fraud,

- move rapidly to capitation or global budgets and away from any fee-for-service payment system

- end all attempts to expand health insurance to those employed in the informal sector

- ensure the same providers provide quality health care to patients **and** are paid on time,

3. Expand services to all

- Implement the policy of free care to all children and pregnant women

- Implement the policy of a once off lifetime small affordable premium to all adults in the informal sector to access health services. Register all adults by end of 2010.

- Invest in a programme of expanded publicly provided health services, particularly in rural areas.

ENDS

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[i] In order to assist in the search for solutions to the problems of sustainably extending health care access to all in Ghana, ISODEC, the Alliance for Reproductive Health Rights (ARHR) and the Essential Services Platform with support from Oxfam GB, decided to commission this study to analyse and propose potential solutions to the various difficulties that have begun to emerge during the implementation of the NHIS, with a special emphasis on sustainable removal of financial and other important barriers to extending free health care to all vulnerable population groups.

The research for this study was carried out by Dr Chris Atim between August and October 2009, utilising document reviews, interviews with key informants and stakeholders in the Ghanaian health system and data collection from the key national agencies involved (such as the VAT Service, the Ghana Statistical Service, the National Health Insurance Authority, the Ghana Health Service, the Ministry of Health, etc.). The title is *Towards Universal Access to Health Care in Ghana* and is available from our organisations for comment.

This policy position is based on the research and is meant to stimulate debate amongst policy makers in Ghana whilst forming the basis of civil society advocacy for health care for all.

[ii] See for instance, Rajkotia, Yogesh. November 2007. *The Political Development of the Ghanaian National Health Insurance System: Lessons in Health Governance.* Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.; Singleton, Jennifer L., 2006. "Negotiating Change: An Analysis of the Origins of Ghana's National Health Insurance Act"; Macalester College Honors Projects.

[iii] Researchers discussions with key stakeholders in September/October 2009.

[iv] The proposed one-time payment is controversial and opposed near-unanimously by other stakeholders encountered during the research, mostly on the grounds that it makes no sense in an insurance scheme; transforms the NHIS into a completely tax funded system, destroys the member ownership base and accountability of the scheme, and would be too expensive and likely bankrupt the NHIS (this latter seems highly exaggerated given that informal sector payments bring in no more than 5% of scheme income, but some of the other objections could still be valid). Eg see reported comments by Prof Badu Akosah a former Director-General of the Ghana Health Service (GHS), that the "one-time premium payment promised by government is not practicable because the system is currently under-funded." He is also reported to have insisted that the country's health system was in bad shape because "the per capita expenditure on health is very poor." www.myjoyonline.com of 24 Aug 2009; accessed on 13 Sept 2009.

[v] The official figures for the % of the population covered by the NHIA is 61%. However, these numbers are based on 2004 population figures. Our calculations are that using up to date population figures the coverage is in fact 53%. In addition there are a number of reasons why this figure is almost certainly lower. First of all, schemes do not have an incentive to clean up their membership records, ie remove inactive names, including those who registered but did not subsequently pay their premiums or have subsequently stopped doing so; those who have since moved out of their district and perhaps re-registered or not in a different scheme, etc . Secondly, and reinforcing the situation just described, schemes have a powerful incentive to present their membership figures in the best possible light, given the subsidies that are paid per exempt member on the roll. In addition, many people have registered but are still awaiting their membership cards, without which they are not yet entitled to benefits. It is estimated that between 5 and nearly 10 per cent of registered members may be facing this situation at any point in time. From the above analysis, it is reasonable to surmise that the true national coverage is probably below half of the population.

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