

IMANI REPORT: REFORMING THE NATIONAL HEALTH INSURANCE; PATHWAYS TO SUSTAINABLE HEALTHCARE FINANCING

Executive Summary

Health financing systems are a major factor challenging the provision of equitable and quality health care in Ghana. The National Health Insurance Scheme (NHIS), initially introduced in Ghana as an alternative to direct out-of-pocket (OOP) financing to improve access, faces considerable challenges, not least its financial sustainability. This paper comprehensively explores potential mechanisms and models for an increasing and sustainable source for Ghana's health financing system and the NHIS. This comprises of amending the current NHIS, increasing revenue source of the scheme by widening the tax base, adequately targeting services to the most vulnerable, and addressing administrative inefficiencies.

There is also emphasis on a the dual system of health financing with focus on the need to expand Private Health Insurance Providers (PHIPs) contribution in Ghana, especially among the informal sector and low income earners. Possible outcomes of the expansion include increased competition leading to lower premiums, increased negotiation power of an oligarchy of health facilities leading to higher costs for PHIPs and overall increase in access to healthcare.

Quick Read

- Although Ghana stands by its commitment to the Abuja Declaration, which requires signatory countries to allocate 15% of public spending to health, the past six years have seen a growing underfunding of the health sector by the government with an average spending of 12%.
- As at the end of June 2016, active membership of the National Health Insurance Scheme stands at 11,164,673 representing 41% coverage. However, after over a decade of implementation, the scheme has faces a financial crunch caused by growing income inequality, population changes and the rise o non-communicable diseases
- The total accumulated debt the NHIS owed to service providers was estimated to be GHS 1.2 billion, with arrears of payments of at least 12 months as at April 2017.
- Sustainable access healthcare could be achieved in Ghana by focusing the NHIS on the poorest. Those in formal employment should be encouraged to move into private health insurance schemes.
- With over 10 million Ghanaians with no health insurance cover, there is also an opportunity to expand insurance coverage through the greater use of private health insurance schemes. Currently, these are mainly used by formal employees but there is also demand for private insurance schemes to cater for the informal majority and low income earners.
- There are numerous regulatory barriers to entry for private health insurers, which should be reduced to increase competition within the sector. Further, innovations in payment technology should be leveraged to create innovative payment solutions for those without access to traditional bank accounts.

Introduction

Health has been recognized as a key aspect of human and economic development. The World Health Organisation (WHO) considers the highest attainable standard of health as a fundamental right of every human being¹. Thus, governments in most countries have committed to improving the health outcomes of their citizens through policy interventions and the provision of finance. According to WHO, the right to healthcare encompasses access to timely, acceptable, and affordable healthcare of appropriate quality. However, it has been estimated that, annually, about 100 million people globally are pushed below the poverty line because they are forced to pay for healthcare out of their own pocket², with developing countries being the most affected. The lack of appropriate financing mechanisms and sufficient funding means that rate of access to treatment, medicines and medical technologies are low throughout middle and low-income countries.

Even the implementation of social health insurance schemes in countries such as Ghana, has failed to improve the situation. Complicating factors include lack of information on the existence of the schemes, inability to pay premiums, and bureaucratic inefficiency.

As well as this, other factors will continue to have an increasing effect on the healthcare system of Ghana. For one, the treatment of non-communicable diseases (NCDs) such as cancer and diabetes, are increasing. In 1993, only 13% of women aged 15-49 were overweight compared to 30% in 2008. In 2011, 9% of Ghanaian adults had diabetes and 48% suffered from hypertension³. As well as this, factors such as increasing life expectancy, which increased from 57.6 years in 1993 to 61.5 years in 2015⁴, and the fact that country is facing a growing 'youth bulge', with 75.3% of the population aged below 35 in 2010⁵, add rising pressure to the healthcare system and demand sustainable ways of financing.

Ghana is also struggling with the fiscal challenge of properly financing its social insurance scheme with numerous sectors competing for limited revenue and the health sector is under-financed. Although Ghana stands by its commitment to the Abuja Declaration, which requires signatory countries to allocate 15% of public spending to health, recent years have seen a growing underfunding of the health sector by government. (Figure 1).

¹ WHO (2015), Health and Human Rights Fact Sheet, Available at: <http://www.who.int/mediacentre/factsheets/fs323/en/>

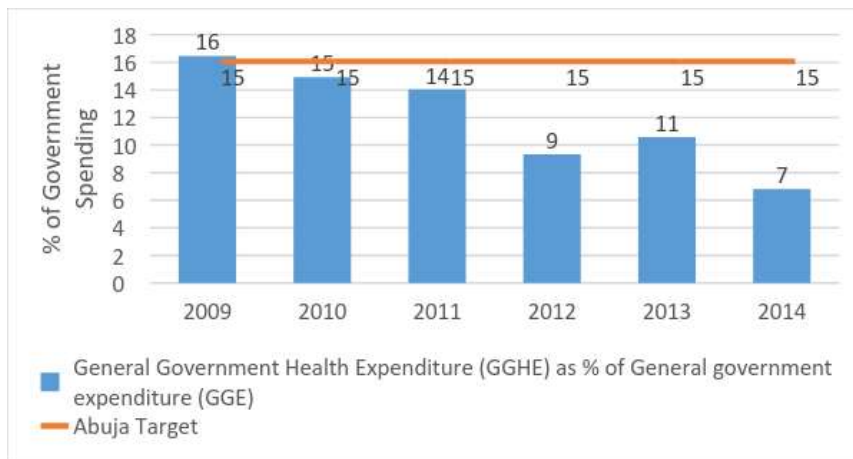
² Ibid

³ Republic of Ghana Ministry of Health. (2011). National Policy for the Prevention and Control of Chronic Non-Communicable Diseases in Ghana. Retrieved from <http://www.alwag.org/education/courses/ncd-policy.pdf>

⁴ World Bank Database

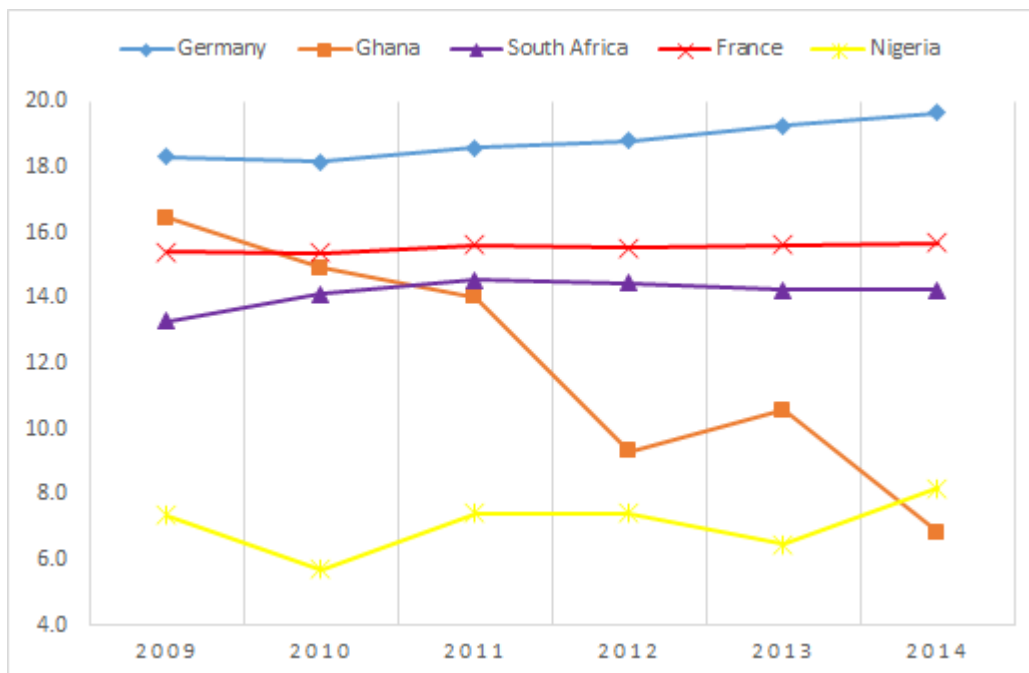
⁵ Ghana Statistical Service. (2013). 2010 Population & Housing Census Report: Children, Adolescents & Young People in Ghana (p. 5). Retrieved from http://www.statsghana.gov.gh/docfiles/publications/2010phc_children_adolescents_&young_people_in_Gh.pdf

Figure 1: Government of Ghana Health Spending (2009-2014) as a Percentage of Total Expenditure



Source: World Health Organization, (2017) Health Expenditure Indicators WHO Geneva.

Figure 2: Public Health Expenditure as a percentage of Total Government Expenditure in five selected Countries



Source: World Health Organization, (2017) Health Expenditure Indicators WHO Geneva.

According to WHO⁶, the per capita health expenditure in Ghana has significantly increased over the past two decades, though the figure is lower than that of Sub-Saharan Africa as at 2014. Total budgetary allocation to the sector has steadily increased by 77.73% from 2014 to 2017. However, data from the 2017 Budget Statement suggests the year-on-year allocation to the Health ministry will decrease by 13% (from GHS 4.9 billion in 2016 to GHS 4.23 billion in 2017⁷).

⁶ World Health Organization, (2017) Health Expenditure Indicators WHO Geneva. Retrieved August 2, 2017, from <http://apps.who.int/nha/database/ViewData/Indicators/en>

⁷ Ministry of Finance (2017) The Budget Statement and Economic Policy

Ghana's healthcare system will, therefore, continue to be underfunded, suggesting a bleak outlook for access to healthcare in the country, especially in the light of the recent Government of Ghana decision to cap grants to statutory funds. There is, therefore, a need to explore alternative ways to finance healthcare in order to increase healthcare and health outcomes. The objective of this paper is to explore potential mechanisms and models for increasing the diversity of funding sources and overall levels of funding. The paper proceeds as follows. The first section focuses on the history of health financing in Ghana, followed by an examination of the challenges facing the challenges with the National Health Insurance Scheme. This is followed by a look at the prospects for private health insurance schemes. The paper concludes with some suggested reforms to improve health financing in Ghana.

Brief History of Healthcare Financing in Ghana

Ghana's health financing system has undergone several changes as a result of the changing economic situation and government spending priorities. Healthcare in the colonial era, relied on out-of-pocket spending. The first post-colonial government, under Dr Kwame Nkrumah, in 1957, adopted the socialist approach of providing cost-free healthcare to its citizenry⁸. As a result, all charges were abolished at all government health facilities, allowing even the poorest to access formal health care. However, free healthcare was undermined by the unequal geographical distribution of health facilities and the unavailability of health staff in rural areas⁹. For instance, 76% of doctors were practising in the urban areas, though less than 70% of Ghanaians lived in urban areas at the time¹⁰. As a result, in 1960 under-5 child mortality was as high as 218 per 1,000 live births¹¹.

Despite these shortcomings, all medical services remained free until the overthrowing of the Nkrumah government, which led to the enforcement of the Hospital Fees Act of 1971 (Act 387). The Act introduced the payment of fees at the various healthcare facilities. According to a Ministry of Health 1971 report¹², though the rationale for implementing the fees was to cover costs, the gap between what was paid and the actual cost was so wide to the extent that it was regarded as a 'token' and insufficient to cover the cost of the healthcare system.

The economic downturn in the 1980s exacted a great toll on the country's health financing system. During this period, health expenditure as a share of GDP declined from 0.95% in 1980 to 0.35% in 1983, and from 6.46% of the national budget in 1980 to 4.38% in 1983¹³. Therefore, in order to ensure the stabilization of the economy, the then government adopted the IMF-World Bank program popularly referred to as the Economic Recovery Programme (ERP). The implementation of the scheme consequently led to the removal of subsidies on

⁸ Ministry of Health, (2015) Health Financing Strategy

⁹ Kennedy A. A. and John A. W. (2014), Development Policy Planning in Ghana: The Case of Healthcare Provision, *European Scientific Journal*, Vol. 10, no. 33. ISSN 1857-7881 (print), e-ISSN 1857-7431

¹⁰ Twumasi, P. A. (1981). Colonialism and international health: A study in social change in Ghana. *Social Science & Medicine. Part B: Medical Anthropology*, 15(2), 147–151. doi:10.1016/0160-7987(81)90037-5

¹¹ The World Bank. (2012a). Health Financing in Ghana at a Crossroads (Draft Final Report January 2012 No. 67325). 1818 H Street NW. Washington DC 20433

¹² Ministry of Health, (2015) Health Financing Strategy

¹³ Structural Adjustment Participatory Review Initiative, Ghana Country Report (2001)

healthcare services, a collection of health services fees and the intensification and enforcement of the Hospital Fees Act¹⁴. The Hospital Fees Regulation of 1985 required patients of public health facilities to pay fully for their drugs.

In 1992, a cash-and-carry system was instituted as a way of financing health, recovering costs and raising revenues for service providers. During this system, goods, such as drugs, were charged at the full cost, with the only respites from full payments for children and primary care facilities. The economic conditions of the citizenry in terms of income levels and poverty situations made it difficult for most people to access healthcare. As a result, outpatient visits reduced by 66%, as people were deterred from using medical facilities due to the cost¹⁵. Shortly after this, an alternative system emerged as a means to provide more social protection and spreading risk, especially for those in the large informal sector.

From the early 1990s to the early 2000s, mutual health insurance schemes gained great popularity in Ghana. At the time, they received abundant support from the Ministry of Health and donors such as the Danish International Development Agency (DANIDA), and the U.S. Agency for International Development (USAID)¹⁶. The period saw a growth in the popularity of mutual health insurance schemes as a way to provide social protection. The number of these schemes increased from 4 in 1999 to 47 in 2001 and 159 in 2002, spreading to 67 out of the 138 districts throughout the ten regions in Ghana¹⁷. The types of mutual initiatives ranged from district-wide, such as in Dodowa, to different community groups, based on factors such as occupation, religion and gender.

These types of insurance schemes provided social protection, especially for vulnerable groups. Premiums for such schemes were a minimum of current-day GHS 2 per adult per year, which is the equivalent of about US\$0.45¹⁸. The premiums took into account the number of people enrolled in the scheme and the services they provided. Many of these schemes, recognizing the inability of the poor to be able to pay the full premiums provided subsidies through methods such as church collections. However, in 2003, the then New Patriotic Party government fulfilled one of its popular manifesto promises while in opposition, by implementing the National Health Insurance Scheme (NHIS). The scheme sought to replace the existing out-of-pocket method, popularly referred to as the ‘cash-and carry’ system. The system subsequently overtook the Mutual Health Insurance schemes, although legislation enabled private mutual and commercial health insurance schemes to operate alongside the national scheme.

¹⁴ Ministry of Health, (2015) Health Financing Strategy

¹⁵ Hsiao, W., & Shaw, R. (2007). Social Health insurance for Developing Nations. In WBI Development Studies (p. 66). World Bank. Retrieved from https://cdn1.sph.harvard.edu/wp-content/uploads/sites/100/2012/09/hsiao_and_shaw_2007_-_shi_for_developing_nations.pdf

¹⁶ (Aiken 2003; Apoya and others 2001; Atim 2000; Atim, Grey, and Apoya 2002). As cited in Hsiao, W., & Shaw, R. (2007). Social Health insurance for Developing Nations. In WBI Development Studies (p. 66). World Bank. Retrieved from https://cdn1.sph.harvard.edu/wp-content/uploads/sites/100/2012/09/hsiao_and_shaw_2007_-_shi_for_developing_nations.pdf

¹⁷ Ibid

¹⁸ Using a rate of GHS 1: USD 4.41, as Retrieved on 05/09/17 from <http://www.xe.com/currencyconverter/convert/?Amount=2&From=GHS&To=USD>

Era of Social Health Insurance Scheme in Ghana

The National Health Insurance Act, 2003 (Act 650), established the National Health Insurance Authority and mandated it, among other functions, to secure the implementation of a national health insurance policy that ensures access to basic healthcare services to all residents. There are two categories of membership under the Scheme: annual premium paying members and exempt group members. The exempt group members include Pregnant women, Indigents, Categories of differently-abled persons determined by the Minister responsible for Social Welfare, Persons with a mental disorder, SSNIT pensioners, Persons above seventy years of age (the elderly) and other categories prescribed by the Minister. The aforementioned group are exempted from paying annual premiums.

The implementation of the scheme requires premium paying members to register for the service and renew their membership annually through the payment of premiums. Though premiums are supposed to pay based on income levels, lack of data has made it almost impossible for the Scheme managers to calculate those in the informal and private sectors.

As at the end of June 2016, there were 11,164,673 active members of the scheme, representing 41% coverage¹⁹. This indicates, over 15 million people in the country are not members of the NHIS, leaving them to access healthcare with either private insurance or out-of-pocket means. Though no reliable statistics exist on the number of people covered by the private health insurance schemes, it is highly probable that the number may be far fewer than that of the NHIS, taking into consideration the amount of premium charged and the current minimum wage of GHs 237.60 per month. While the NHIS currently charges GHs 20 (\$4.6) as annual premium, Private Health insurance premiums are an average minimum of GHs 900 (\$209).

Those covered by the NHIS are entitled to free medical services at any NHIS accredited health facility, provided his/her sickness falls within the scheme's approved list of sickness and medicines. The scheme is quite extensive and covers a greater proportion of primary healthcare and most common illnesses, such as malaria, fever, etc. Overall, this accounts for the treatment of about 95% of diagnosed conditions²⁰. There is also a noticeable emphasis on female reproductive healthcare. For instance, expectant mothers enjoy free pre-natal care and free healthcare for the first three months post-delivery under the scheme. However, disease/Conditions that require huge financial commitments such as dialysis and organ transplants are not covered by the scheme. Also exempt from coverage are treatments, such as physiotherapy and HIV antiretroviral medications. Despite the extensive medical coverage

¹⁹ Ministry of Finance (2017), Budget Statement and Economic Policy of the Government of Ghana

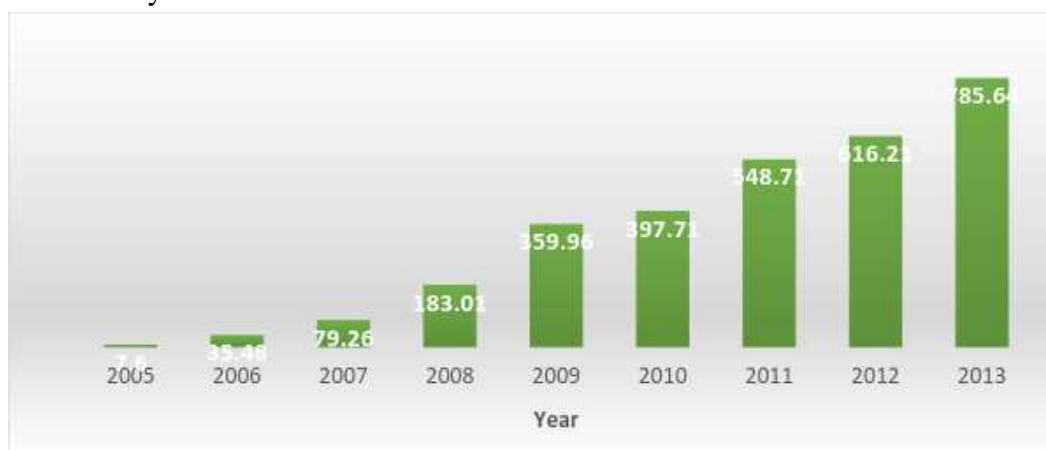
²⁰ Wang, Huihui, Nathaniel Otoo, and Lydia Dsane-Selby. 2017. Ghana National Health Insurance Scheme: Improving Financial Sustainability Based on Expenditure Review. World Bank Studies. Washington, DC: World Bank. doi:10.1596/978-1-4648-1117-3. License: Creative Commons Attribution CC BY 3.0 IGO

on the NHIS, patients are still asked to pay for certain services and medicines out-of-pocket, due to the insecurity of reimbursement by the government to service providers²¹.

The premium paid by subscribers, donor funds, and formal sector employees contributions together with 2.5% VAT as well Government of Ghana contributions are used to run the operations of the Scheme.

Recently, there have been some challenges with the scheme. Firstly, increased coverage without a corresponding increase in resources or premiums has created a significant financial burden for the country. For instance, boosted membership has led to claims payments skyrocketing from GHS 7.60 million in 2005 to GHS 758.64 million in 2013 representing 78.5% of the entire consumption of the NHIA²². Yet 69% of its members do not pay premiums. As a result, NHIS premiums only cover about 3.4% of the NHIS' funding

Fig 3: Claims Payment trend from 2005 to 2013



Source: National Health Insurance Authority, 2013

Despite the system being financed by a statutory fund and the amount allocated to this fund increasing year-on-year, the NHIS is presently in debt, unable to pay health care providers on time. As of April 2017, the total debt of the NHIS owed to service providers was estimated to be GHS 1.2 billion, with arrears of payments of at least 12 months. Because of this delay of payment, many service providers are intermittently wary to accept NHIS cards as a form of payment, while others have halted the provision of service to scheme members leaving patients with no other choice but to pay out-of-pocket for treatment. From 2009-2013, average general government expenditure on health was 13%, compared to average out-of-pocket expenditure on health, which was 20% of total health expenditure for the same period²³. This has necessitated the call for a sustainable way of financing the scheme because of the fear of reintroduction of the cash-and-carry system (A popular term in Ghanaians' term to denote out-of-pocket healthcare financing) should the NHIS collapse without a meaningful alternative in place.

²¹ Seiter, A. (2015). How Can Universal Health Coverage Address Out-Of-Pocket Payments For Medicines? Investing In Health: News and Views in Healthy Development. Retrieved from <http://blogs.worldbank.org/health/how-can-universal-health-coverage-address-out-pocket-payments-medicines>

²² NHIA Annual Report

²³ Out-of-pocket expenditure on health as a percentage of private expenditure on health (US\$). (2017). World Health Organization. Retrieved 8 August 2017, from http://www.who.int/gho/health_financing/out_pocket_expenditure/en

The Sustainability of the National Insurance Scheme

Ghana's National Health Insurance Scheme (NHIS) has achieved considerable success but is beset with challenges that have placed the survival or sustainability of the scheme under threat. While many of these are not new, their intensity and impact pose a central risk to the scheme. Outstanding among the challenges is the lack of funds that have contributed to a persistent indebtedness to service providers by the NHIA, which stood at GHS 1.2 billion as of April 2017²⁴.

Children, informal sector workers and exempt group make up more than 80% of total membership yet often contribute little or nothing to the state in the form of tax and premium payments. This puts the scheme adequately under genuine strain. Also, previous attempts to increase membership, especially against the background of slow economic growth, and low tax revenue mobilization have worsen the situation²⁵. This admonishment is only a confirmation of the numerous reports on the scheme from many credible sources, including that of the World Bank. In 2013, the bank stated that Ghana's NHIS could go bankrupt if it continued with its current funding mechanism²⁶.

The urgent need for reforms propelled the Vice-President of Ghana, Dr Mahamudu Bawumia, while instating a new 17-member Board for the NHIA in July this year, to charge the board to "save and resuscitate the NHIS"²⁷.

Currently, the two main funding sources (VAT and SSNIT contribution) of the scheme fall short of their potential. Therefore, widening the tax base and social security nets (taxing the informal sector) by reducing bottlenecks in business registration and tax payment would go a long way to improve the finances of the scheme. However, in the short term, an upward review of the premiums and the reduction of the exemptions is necessary. NHIS suffers from high payment arrears since the levies do not go directly to the health authorities. To address this, there is the need to automate the transfer of funds to avoid delays.

While is important to increase the levies and premiums, it is also vital to extricate the scheme of the administrative inefficiencies such as poor payment of premium and membership card administration. There is the need to introduce innovative strategies and cost containment measures that can save the scheme from collapsing and prevent unnecessary delays in claim payments. Developing systems to track abuse and erroneous claims, creating platforms to

²⁴ 233 News. (2017), NHIS Is Broke, We Can't Pay Our Debts – CEO Cries. 233 Live News. Retrieved from <http://233livenews.com/2017/05/19/nhis-is-broke-we-cant-pay-our-debts-ceo-cries/>

²⁵ The Economist Intelligence Unit (2016) Challenges facing Ghana's health insurance scheme Retrieved 8 August 2017 http://country.eiu.com/article.aspx?articleid=1144455298&Country=Ghana&topic=Economy_1#

²⁶ Schieber, George, Cheryl Cashin, Karima Saleh, and Rouselle Lavado. 2012. Health Financing in Ghana. Washington, DC: World Bank. doi:10.1596/978-0-8213-9566-0. License: Creative Commons Attribution CC BY 3.0

²⁷ Dery, S. (2017). Ghana news: Veep tasks new NHIA Board to rescue, resuscitate scheme. Graphic Online. Retrieved 4 September 2017, from <https://www.graphic.com.gh/business/business-news/veep-tasks-new-nhia-board-to-rescue-resuscitate-scheme.html>

enhance interactions between fund managers and members can ensure efficient claims management and payment²⁸. Also, the International Labour Organisation²⁹ recommends simple community-based methods for identifying the poor and targeting healthcare services to them as a means of ensuring financial sustainability of the NHIS³⁰.

The Role of Private Health Insurance Schemes in Health financing in Ghana

It has been estimated that over the next 20 years, changes in population size and structure will increase total healthcare spending needs by 52% in Sub-Saharan Africa, as compared to 14% in Europe and Central Asia³¹. The proposed increase in health spending must be considered in the context of fiscal space. Ghana's NHIS encounters some challenges which render it incapable of absorbing this expected expenditure. With low revenues, tight fiscal space, dwindling flow of aids and grants and the ever-growing expenditure burden on government spread over more ministries and sectors than ever before, there is the need for alternative and sustainable health financing in Ghana.

In the midst of the woes of the NHIS, there exists a group of private health insurance providers (PHIP), who provide health insurance schemes to some sections of the Ghanaian population. With the right reforms and conducive environment, the PHIPs will be able to extend health insurance to a greater portion of the population, thereby reducing catastrophic out of pocket payments.

The alternative to the national health insurance system is the private health insurance system. As of July 2017, there were eleven private health insurance companies accredited by the governing body, the National Health Insurance Authority, which also manages the National Health Insurance Scheme. Six offer packages for individuals; the others offer packages as part of a group, family or a corporate group. Premiums range from about GHS 600 to 1,100 per person per year³².

However, there are challenges faced by the private health insurance companies, such as barriers to entry, which discourage entrants into the market and hence limits competition. Barriers include capital requirements, such as the requirement for private mutual health insurance companies to have minimum initial capital of GHS 1 million, as well as sequestering 20% of the capital requirement for the reserve fund. For private commercial health insurance providers, the minimum capital requirement is GHS 5.5 million with 10% required as a security deposit in a Bank of Ghana account. These requirements and others

²⁸ Wang, Huihui, Nathaniel Otoo, and Lydia Dsane-Selby (2017), Ghana National Health Insurance Scheme: Improving Financial Sustainability Based on Expenditure Review. World Bank Studies. Washington, DC: World Bank. doi:10.1596/978-1-4648-1117-3. License: Creative Commons Attribution CC BY 3.0 IGO

²⁹ ILO (2005), 'The Role of Private Health Insurance Schemes in Health financing in Ghana'

³⁰ The International Labour Organization. (2005). Improving Social Protection for the Poor: Health Insurance in Ghana: The Ghana Social Trust pre-Pilot Project. Retrieved from <http://www.moh.gov.gh/wp-content/uploads/2016/02/Health-Insurance-in-Ghana-Improving-Social-Protection-for-the-Poor-ILO.pdf>

³¹ Pablo G. and George S. (2006), Health Financing Revisited a Practitioner's Guide, The International Bank for Reconstruction and Development / The World Bank.

³² Data from Private Health Insurance in Ghana

have led to the National Insurance Commission calling on insurance companies to merge, stating that there are too many insurance companies with low capacity in the country³³. Lack of reliable and sufficient data on individuals in the country has also affected the ability of PHIPs to expand their coverage. PHIPs also faces the incidence of adverse selection due to the voluntary nature of the programs and the corresponding low numbers of clients thereby leading to high premiums charged and creating artificial barriers for those with low income to access³⁴. Also, it has been argued that the private insurance industry will be hard-pressed to offer competitive premiums due to the current company-run health care programs they seem to have adopted³⁵.

³³ Segbefia, L. (2017). Merge to meet capital requirement- NIC urges insurance companies. CitifmOnline. Retrieved 4 September 2017, from <http://citifmonline.com/2017/04/11/merge-to-meet-capital-requirement-nic-urges-insurance-companies/>

³⁴ Center for Pharmaceutical Management.(2003), Access to Essential Medicines: Ghana. Prepared for the Strategies for Enhancing Access to Medicines Program. Arlington, VA: Management Sciences for Health.

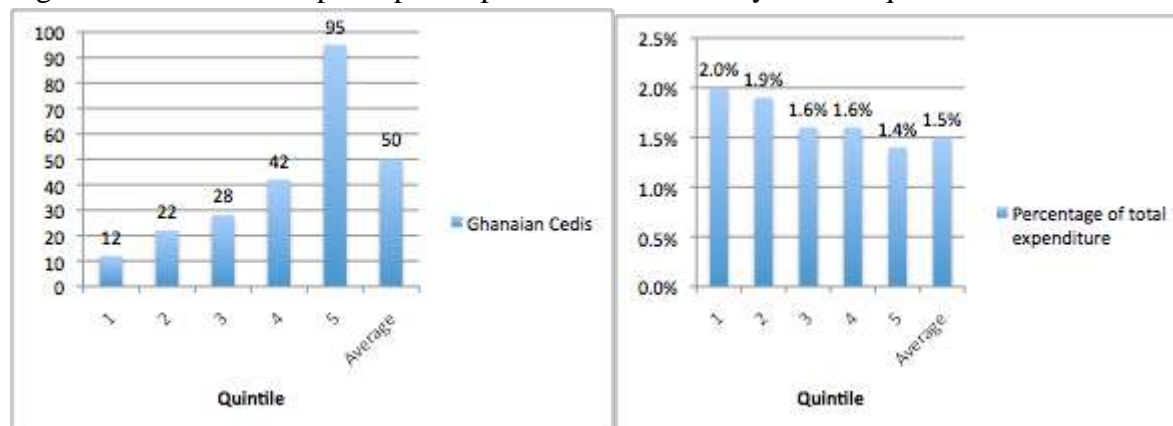
³⁵ Ibid

Other Reforms to Healthcare Financing in Ghana

Reform is necessary to rectify the problems of the current system and to ensure that access to healthcare is available to all. Solutions include the introduction of a dual health insurance system. One side of the system would lower costs to the national purse by targeting the coverage of the NHIS to those with the lowest incomes. This would ensure that those who would not otherwise be able to afford private health insurance maintain access to necessary healthcare. The other side of the reform would be increasing significantly private health insurance coverage, which would ensure that those in formal employment have high-quality coverage without placing excess pressure on national budgets.

Taking into account that, with 24.2% of people in 2013 living under the poverty line, and income inequality in the country increasing (the Gini Index rose from 37% in 1992 to 41% in 2013)³⁶, the cost of providing such a service should be efficient, one reform that could prevent the NHIS from failing is to only offer it to those who would have no alternative source of healthcare financing. Figure 4 shows that, as of 2014, despite the richest quintile spending five times the amount on health annually that the poorest quintile spent, the poorest quintile on average spent 2% of their annual expenditure on health, compared to the 1.5% of the expenditure of the richest quintile³⁷.

Figure 4: Mean Annual per capita expenditure on health by income quintile



Source: Ghana Living Standards Survey 6, 2014

Since 69% of those on the NHIS are exempt from paying premiums, it can be assumed that they are children, pregnant women, the elderly, or those in the informal sector, who may be vulnerable in society and need social protection. This means that up to 31% of those who use the NHIS could potentially be in the formal sector and be able to afford private health insurance premiums. If 31% of people were taken off the NHIS, given that claims were GHS 758.64 million in 2013, an estimated GHS 235.18 million could be saved in claims to service providers. With an annual population growth rate of 2.2% in 2016, the financial burden on

³⁶ UNICEF, Ashesi University, University of Sussex. (2016), the Ghana Poverty and Inequality Report - 2016. Retrieved from

[https://www.unicef.org/ghana/Ghana_Poverty_and_Inequality_Analysis_FINAL_Match_2016\(1\).pdf](https://www.unicef.org/ghana/Ghana_Poverty_and_Inequality_Analysis_FINAL_Match_2016(1).pdf)

³⁷ Ghana Statistical Service. (2014). Ghana Living Standards Survey Round 6 (GLSS 6) Main Report (p. 142). Retrieved from http://www.statsghana.gov.gh/docfiles/glss6/GLSS6_Main%20Report.pdf

the National Health Insurance Scheme will only intensify as time goes on, connoting that reforms of this type are needed to ensure sustainability. However, to make this targeting truly effective, there is a need for National Identification Registration. This registration should provide the government with the necessary data to ensure that the NHIS covers those living in poverty in dire need. The National Identification Registry will also aid private health insurance companies in their quest for data on clients, which would enable them to offer more packages to individuals, rather than taking the less risky option of offering packages to groups.

Those within a certain income level could also be taxed a percentage of their income, contributing towards the NHIS Statutory Fund. This would ensure another steady income stream for the scheme, making defaults on payment less frequent. This type of compulsory contribution has already had great success for financing the French healthcare system. In France, the government taxes 5.25% of earned incomes for the purpose of covering the statutory healthcare plan, with the government refunding 70% of general healthcare services and 100% of costs for long-term ailments. There, 90% of the population also subscribes to private insurance for the services that are not covered by the government³⁸.

Another reform, in order to adequately ensure that nobody in society is left without healthcare coverage, is to encourage companies to enrol their employees on schemes with private health insurance providers. This could be enforced with legislation and sanctions for employers who don't adhere.

Since Ghana has a large informal sector, estimated to contain 80% of the workforce, innovative ways to adequately provide healthcare services are needed. The large informal sector in the country has been to the detriment of the NHIS in the past since taxes and SSNIT contributions cannot be collected from them to serve as revenue streams for the scheme. By legislating that they, as well as employers in the formal sector, should enlist private health insurance schemes, the financial cost of providing services to this group is taken away from the purse of the NHIS. Private health insurance schemes that the citizenry choose themselves have the advantage of better tailoring their services to suit their clientele.

Currently, many of the accredited private health insurance offer services for different company sizes, targeting their services to the types of clients they serve. Innovations, such as health insurance through mobile phone carriers, are also helping to expand their reach and the ease in which people receive healthcare services. The private health insurers could even take their adaptive innovations further by offering those who don't have monthly salaries the option of paying a daily rate through mobile money. The benefit of this reform is that it will lead to an increase in competition in the private health insurance market, driving down the cost of premiums to customers, and raising the quality of services to attract more clientele. In

³⁸ Sandier S, Polton D, Paris V, Thompson S. France. In: Dixon A, Mossialos E, eds. *Health Care Systems in Eight Countries: Trends and Challenges*. London, England: London School of Economics and Political Science; 2002: 30–45.

2015, a study by the London School of Economics (LSE) examined the health insurance market in California (US), where the three largest private health insurers dominated 75% of the market. It was found that when an insurance plan was removed from the market, the cost of premiums increased by 10%³⁹. With more competition, the cost of premiums should decrease.

One possible disadvantage to the expansion of private health insurance coverage in the country is that large medical providers could use the increased competition to gain leverage, setting insurers against one another when bargaining. This could lead to these medical providers setting higher prices for their services, and could possibly lead to an oligopoly, where a small number of medical providers have the majority of the market power, tempting them to collude. This could cancel out the positive effect of increased competition in the private health insurance market, which is the reduced premiums for customers.

However, this type of situation would depend on the market conditions. Actions, such as the way hospitals and other medical facilities bargain with private health insurers, need to be taken into account. In the 2015 LSE study, it was also found that in cases where employers, on the behalf of their employees, were strong negotiators with private health insurers, or where there was the presence of effective regulatory policies, private health insurers had less freedom to set high premiums, and so negotiated reductions in prices with hospitals more. This had the effect of passing on the benefit of low premiums to consumers⁴⁰.

Conclusion

Ghana's health sector financing woes will continue to have a significant impact on the performance of the sector. The halting of the rapid growth of NHIS debts, while extending healthcare access, quality and the health insurance coverage to all should be the primary objective of healthcare reform. This problem is not one that is unique to Ghana; many countries in Sub-Saharan Africa, such as South Africa, also struggle to find adequate methods of financing efficient national health systems. The need to introduce innovative strategies and cost containment measures that can save the NHIS from collapsing and the addressing the challenges of the PHIP is paramount. Ghana can learn from the health insurance experience of France, which is seen as among the best in the world, by partnering government and private sector involvement. In the bid to reform the health financing to one of sustainability, collaboration is necessary.

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³⁹ Ho, K., Lee, R. (2015). Is health insurance competition good for consumers?. *London School of Economics Business Review*. Retrieved from <http://blogs.lse.ac.uk/businessreview/2015/10/05/is-health-insurance-competition-good-for-consumers/>

⁴⁰ Ibid. 36

