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CHALLENGES OF FINANCING HEALTH CARE IN GHANA: THE CASE OF NATIONAL HEALTH INSURANCE SCHEME (NHIS)

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ABSTRACT

The study examined the challenges of financing health care in Ghana. It also identified various funding mechanisms available to finance health care in Ghana. A combination of primary and secondary sources was used to collect data for the study. Stratified sampling technique was employed to select 250 respondents for the study. It was found out that inadequate funding sources, and insufficient premium were some of the challenges of financing health care delivery in Ghana. It was concluded that National health insurance should be seen as an important mechanism for removing financial barrier to achieving equitable access to health care for all citizens. Health care utilization should no longer be restrained by finance, given that one enrols onto the scheme. The study recommended that for increase uptake and effective risk pooling, mandatory enrolment on the national health insurance scheme should be instituted as is done for motor. Again relatively richer persons should pay higher premium for health insurance to help subsidize for the relatively poorer persons who would not have otherwise been able to purchase health insurance. Among the funding mechanisms recommended by the study was medical savings account.

Key Words: Health care, financing, funding mechanisms, national health insurance

INTRODUCTION

Health care financing has been a growing concern to many developing countries in recent times. Given that health financing is designed to cover formal and informal sectors, rural and urban locations, low and high income earners, it becomes critical as well as a challenge for developing countries as they seek to design, operate and manage effective health financing systems that benefit all citizens. According to Mossialos *et al.* (2002) there are basically five forms of health financing available to any country. These include taxation; social health insurance; voluntary and private insurance; out-of-pocket or cash-and-carry; and donations. It is said that identifying a sustainable source of financing health care in the world has indeed become a major issue for discussion across the world's powerful institutions and stakeholders. The United Nation and other groupings and

organs representing the continents of the world are developing strategies for sustainable health care financing. According to the World Health Organization (WHO), supporting adequate, sustainable, equitable and effective health financing to improve health outcomes is one of the most important goals of the World Health Organization. The Executive Board of WHO and the Fifty-eighth World Health Assembly have discussed and provided strategic directions on sustainable health financing, universal coverage and social health insurance.

Statement of the Problem

Health care financing has become a global challenge to all countries and all persons. The ability of national governments to provide funding for health care and to sustain the funding is a huge responsibility, Ghana is no exception. New and innovative ways are being developed by Governments all over the world to ensure that basic health care is available to all at affordable prices and is equitable. In line of the above, the study was conducted to find out the challenges of financing health care delivery in Ghana and also identify the various forms funding mechanisms.

Objectives and Research Questions

The study found out the challenges of financing health care delivery in Ghana and also the forms of funding mechanisms that can be used to finance health care. To achieve the objectives the following research questions were addressed: What are the challenges involved in financing health care delivery in Ghana? What are the various forms of funding mechanisms that can be used to finance health care in Ghana?

REVIEW OF RELATED LITERATURE

Evolution of Health Care Financing in Ghana

Ghana at independence provided free medical care for its citizens. Health facility attendance was free and did not require patients to pay any fees at points of health care delivery. This form of financing was solely tax based. This however could not be maintained for long given the competing need for financing other sectors of the economy. By the 1970s, other forms of health financing systems were introduced. One of such was the user-fee. The proposals for the user-fee regime was justified to enable government reduce its fiscal spending as well as make provisions for coverage for exempt citizens with particular severe diseases. The user-fee regime required joint management of resources generated by health facilities. Its implementation though was short-lived due to factors, including the overthrow of the Busia's regime that gave it a strong support.

Soon after, the Hospital Fees Act 387, quite similar to the user fees was passed. The Hospital Fees regime paved the way for a nation-wide fee-for-service system. Within this period, fees were raised from token levels to specific charges for services (Nyonator and Kutzin, 1999). These fees however were insufficient to meet the resource needs of health facilities. Coupled with this, government was challenged with funding health care delivery in generality. In response by the middle of 1980s,

government introduced the 'cash and carry' health delivery system. The 'cash and carry' system saw the withdrawal of the government's subsidy on health care delivery. This means that patients had to pay for the full cost of medication and service at the point of service delivery. This system was built on the quest for full cost recovery to enable health facilities to expand and upgrade their services to citizens. Secondly, the full cost recovery was targeted at reducing abuse of service through frequency of visits. In reality, none of these assumptions materialized. In turn, the implementation of the 'cash and carry' system excluded mainly the poor from accessing health care service, thereby creating vast inequalities in health care delivery system. For this, the 'cash and carry' system led to under-utilization of basic health services (Johnson and Stoskopf, 2009).

The challenges of these various financing systems led to the search for alternative health financing mechanisms. By 2003, the passage of Act 650 established a nationwide health insurance Scheme. The national health insurance Scheme was perceived as serving as a mechanism for eradicating financial barrier to access to health care (GPRSII).

Financing for NHIS has been secured using three mechanisms including (a) consumption tax of 2.5 percent; (b) mandatory payroll deduction of 2.5 percent from formal sector workers and employers' contributions and; (c) a graduated premium from the informal sector. By Act 2003, every district should have an operational insurance scheme with membership opened to all residents. Additionally under Act 650, provisions have been made for exemptions of the poor and indigents. The National Health Insurance Scheme (NHIS) has since its implementation exceeded its target of 40 percent nationwide coverage by 2008. As at 2008, membership coverage stood at 45 percent, with one hundred and forty five (145) accredited and operational district schemes established (Ministry of Health, 2008). In addition, NHIS has also seen increase in number of accredited providers. Within five years of operation (2003-2008), NHIS has experienced major developments including the introduction of the free maternal policy, establishment of regional coordination offices and introduction of new national membership card and ICT platform. NHIS has also seen increased utilization for out and in- patients' services. This increase corresponds with government subsidy funding to schemes which has increased significantly from GH¢7.7m in 2005 to GH¢108m in 2007 (Ministry of Health, 2008).

Notwithstanding these achievements, increase in coverage puts financial strain on NHIS as NHIS income is largely tax based (90-95% from SSNIT & VAT levy) and will grow with national income and not membership numbers (Ministry of Health, 2008). The implication therefore is that the more successful NHIS becomes in terms of coverage, the greater the financial un-sustainability. Other challenges include ID cards backlogs which are printed from a central source. More importantly, whereas NHIS is technically mandatory to have universal coverage, practice has shown that economic and financial barriers still exist with membership skewed particularly against the poor.

Funding Mechanisms

Different forms of funding mechanisms available to governments include taxation, grants, loans and donations, social and private insurance, medical savings accounts and out-of-pocket payments. The health care systems of Europe rely on combination of these funding systems. The choice of combinations is usually based on their implications for efficiency, effectiveness and equity.

Direct Taxation

Health financing through direct taxation is common, for example, in Belgium and United Kingdom. Regional or local taxes are the main sources of financing health care in Bulgaria, Denmark, Finland, Norway and Sweden. Italy since 2000 began health financing through local taxes (Mossialos *et al.*, 2002). Whereas health care financing through taxation could be described as stable and reliable source of revenue generation, Mossialos (1997) argued that it could become subject to annual public spending negotiations as other sectors compete for funding. For this reason, it has been proposed that governments separate health care financing from public spending through earmarked budgets.

Social Health Insurance

Another channel for financing health care is through social health insurance which involves contributions to a health fund. Within social insurance, there are variations. The most common involves contributions. The point of differentiation of implementation of social health insurance in countries is subject to collection agent and their functions. In countries such as Croatia, Estonia, Hungary and Slovakia, the collection agent of government is a single health insurance fund. In France, the collection agents' functions are devolved to independent funds, whereas in Romania, it is devolved into local branches of national fund. In Austria, Czech Republic, Germany, Lithuania and Switzerland, the collection agents' functions are devolved into independent individual funds geographically. For Luxembourg, the practice of the collection agent of social health insurance is devolved into an association of insurance funds (Hoffmeyer and McCarthy, 1994). The argument for social health insurance is that mechanisms for collection of health insurance funds are more transparent, hence more acceptable to the public. Secondly, in theory social health insurance revenue is better protected from political interference, since budgetary and spending decisions are devolved to independent bodies (Jesse and Schaefer, 2000).

Medical Savings Account

Another mechanism for funding health care is through medical savings accounts. By this system, individuals contribute a proportion of their income regularly into their health accounts. This funding mechanism is practiced in only few countries including Singapore, US and recent times in China. In Singapore, medical savings accounts are complemented by mandatory insurance which requires premium payment. In addition, public fund set up pays for citizens with low incomes (Hsiao, 1995). In the United States, medical savings accounts are combined with deductible health plan that insures against medical costs. (Massaro and Wong, 1995) have argued that medical

savings account in the absence of other funding mechanisms does not offer any risks protection against future medical costs.

Out of Pocket Payment (Cash and Carry)

Out of pocket-payment, otherwise known as 'cash and carry' is another mechanism of health financing. This requires direct payment for cost of services by a patient at the point of delivery. Usually, out-of-payment for services occurs in three forms; payment for services which are not covered by any form of insurance; payment for services not fully covered under health insurance benefit package; and payment for services that are fully funded from pooled revenue but demands additional payment. Proponents of charges for services argue that it is a form of raising supplementary revenue for the health care system. However, Van *et al*. (1993) argued that out-of-pocket payment is valid in situations where there is non-functioning universal health care system, coupled with inadequate government resources to meet health care system requirements. Besides, fee charges can promote inequity in utilization of health services as well reduce solidarity between healthy and unhealthy people as affluent people no longer subsidize for poor people who cannot afford health care.

Loans, Grants and Donations

The final health care financing under consideration is loans, grants and donations. These are usually predominant in particularly low and middle income countries. Grants could be from international non-governmental organizations, bilateral and multilateral donor countries. For example in Africa, donor assistance averagely account for almost 20 per cent of health care expenditure and, in several countries, more than 50 percent (Schieber 1997). Criticisms against this form of financing are that there is no evidence to determine whether grants increase net expenditure on health services. In addition, long term financial sustainability of health care system cannot over depend on donor assistance as donor priorities are also changing. Lastly, grants also would have to be paid and as such put financial burden on future governments and generations.

Health Insurance Financing Models

Insurance financing models may be classified as:

- Classical social health insurance defined by McIntyre as one "legislated by government with regular, compulsory contributions which are income related and possessing a standardized, prescribed minimum package" (McIntyre et al 2003). Such systems could include multiple payers as in Germany or a single payer as in Canada.
- Community Health insurance also known as the mutual health insurance.
- Private health insurance where individuals may pay premiums to private or voluntary insurance schemes to attend to their healthcare needs. Private insurance may be bedeviled by massive exclusions of certain classes of diseases or be hit by adverse selection.

Health Care Financing in Africa

According to Leighton (1995) financing health care has become very prominent for many governments in Africa. Whereas many forms of health financing mechanisms for Europe were focused on containing costs, in developing countries particularly Africa, health financing reforms have been motivated by growing demand for better health care at a time when governments, faced with shrinking resources, can no longer honor its traditional commitment to providing free care (Vogel, 1988; Vogel, 1990) classifies health financing reforms in sub-Sahara Africa into three strategies. These include:

- Raising revenue through cost recovery techniques (e.g., user fees, community-based social financing).
- Improving allocation and management of existing health resources.
- Increasing the role of the private sector in predominantly government-based health systems.

Given the inadequate and declining government financial support to health care system, many countries in the sub-region have concentrated their health financing reforms primarily on the first strategy, which is raising revenue through cost recovery techniques. Through this system, Ministries of Health have introduced most commonly used cost recovery approaches for public health services through user fees for services, medicines or both (Langenbrunner *et al.*, 2001). Other techniques practiced include community based health insurance, pre-payment plans and private health insurance.

The second and third strategies, which are designed to improve efficiency and effectiveness of countries health systems is less widely used across many countries in the sub-region. As of 1994, about twenty African countries began health sector cost recovery reforms including Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia and Zambia who have made revenue raising the primary objective Lavy and Germain (1995). Cost recovery could be useful given the amount of revenue raised, use of revenue for intended goals and impact of use. According to The World Bank (1994) chances of success of cost recovery in sub-Saharan African countries are improved by some of these indicators;

- introducing fees alongside quality improvements, especially assuring drug availability and ploughing fee revenues back into quality improvements that satisfy patients and keep them coming back.
- establishing clear cost recovery objectives, understanding the people's demand and use patterns, and measures to cover costs of care to the indigent.
- designing fee structures to encourage efficient use of services first at the lowest appropriate level, reinforce appropriate referral patterns, and promote use of cost-effective and preventive care.

- avoiding common pitfalls such as failing to keep fees up to date, allowing too many exemptions, failing to collect from government for services provided to beneficiaries of government health plans or social assistance programmes.

Given the emphasis on cost recovery in Africa, a question often times asked is whether cost recovery affects access to health care? It is argued that user fees create much less of a barrier to utilization than may have been expected, especially in the case of primary and preventive care services, particularly when other factors affecting demand for health services are taken into account. In a study conducted in Cameroon, it was found that the probability that a sick person would visit a government clinic was 25% higher when fees were charged and quality improvements were also made (Leighton, 1995).

However on the other hand, cost recovery could hinder access to health service for the poor in particular. Because poor households have less cash, they have less likelihood to borrow funds as well as sell off assets for cash to pay for health service. Evidence however is inconclusive on wealth and purchasing power of health by the poor, given that many studies conducted on fees and utilization did look at income levels. Few studies however conducted in countries such as Cote d'voire, Kenya, Cameroon and Niger have suggested that the poor are more sensitive to the quality and time-price of health care than the non-poor but not necessarily to prices by user fee level (Nolan and Turbat, 1993).

Social and private financing is another funding source for health financing in sub-Saharan Africa includes. Social financing involves spreading risks and cost of medical care by pooling resources, usually through premiums or tax payments to central or local governments (Ndiaye, 2006). In sub-Saharan Africa, individual financing predominates in traditional health care, with social financing predominating in western medical care. Social financing health insurance is practised in different forms in Africa, however generally, social financing is mainly in the form of government provided, tax-financed health services for the whole population (Vogel, 1990; Ekman, 2004). For example in Senegal and Mali, there is the compulsory social security for the entire formal sector. In Zaire, there is government mandatory employer coverage of health care for employees. Kenya practises the National Hospital Insurance Fund for formal employees. The employer-sponsored health insurance is practised in countries such as Zambia, Nigeria, Liberia, Senegal, Zaire and Kenya (Vogel, 1990).

Other forms of social financing, not limited to the formal sector are also practised in some countries including community-sponsored prepayment and rural insurance plans in Zaire (Bwamanda rural hospital insurance programme); Guinea-Bissau (community-level prepayment funds for primary health); and Kenya (Harambee movement funds for catastrophic illnesses). In Côte d'Ivoire, Ghana, Kenya, Senegal, Zimbabwe, group and individual private insurance are practised (Forgia and Griffin, 1993; Atim, 1998). Supporters of social financing emphasize that

when successful, social financing can ensure equitable access to quality care through limiting benefits giving consideration to expected utilization patterns to keep premiums affordable (Filmer *et al.*, 1997).

Challenges faced by National health Insurance scheme(NHIS) in Ghana

The implementation of NHIS has been confronted with some challenges. In terms of coverage, whereas NHIS is technically mandated and should have universal coverage, practice has shown that economic and financial barriers still exist with membership skewed against the poor and marginalised. Procedures for identification of the poor unto NHIS have proved inefficient and ineffective. Means test for identifying the poor has been described as rigid as it has little reflection of the local contexts. For this reason, enrolment of indigents has been declining over the years.

Another challenge faced by NHIS is the institutional framework as provided for in the NHIS Act. The application of the framework has led to governance, operational, administrative and financial challenges (Government of Ghana, 2009). District schemes by law are autonomous of national health insurance authority (NHIA) and operate under the Company's Code of Ghana. Meanwhile, district schemes are partially funded and receive reinsurance from NHIA. Given these, there exists a system without appropriate layers of authority and oversight, supervision and clarity of roles between NHIA and district schemes. This raises questions of accountability, as NHIA is limited by the extent to which it can demand accountability from district schemes as legal entities with their independent boards (district scheme boards were however dissolved in 2009).

District schemes at their levels are challenged with operational issues particularly on claims processing and payment. Given the volume of claims submitted by providers, coupled with manual vetting systems, delay in release of subsidy and reinsurance, many schemes are unable to process claims for timely payment to providers. Whereas L.I 1809 stipulates that providers submit claims within sixty days of rendering service, and the scheme unless any impediments pays claims within four weeks after submission, these schedules are barely followed in practice. Additionally, there exist issues of weak system and human capacity for claims management, audit and fraud control. These in turn create some setbacks. Schemes approve claims, including wrong and fraudulent ones; and delay in claims payment cause agitation by providers, undermining quality of service delivery to clients. Granting these challenges identified with claims processing and payment in all 145 insurance schemes, for efficiency and effectiveness gains, the argument has been made for recentralization of claims processing to fewer key centers (Government of Ghana, 2009).

The third challenge is that whereas health insurance is a social protection policy and a fund into which citizens contribute, consumer voice on its operations is very limited. Even as provisions have been made for establishment of such structures as complaints system and community insurance committees, many schemes never established and regularly used them. Relating to this is also the issue of limited community involvement, knowledge and information on NHIS operations.

METHODOLOGY

This research employed survey design involving both quantitative and qualitative methods. The population consisted of Pensioners, the aged, the unemployed, workers (non-employees of NHIA/NHIS, the unemployed, children under 18 years, and employees of national health insurance authority and schemes. In effect all Ghanaians formed the population of the study.

Stratified sampling technique was used to select 250 respondents made up of 50 pensioners and unemployed, 100 workers (a combination of formal and informal sectors) who are not employees of national health insurance authority or national health insurance scheme, 50 children under 18 years, and 50 employees of national health insurance authority and schemes. All the 10 regions in the country were represented.

Since some of the respondents are illiterates and semi-literates, the research used a combination of interview and questionnaire to collect the primary data. The researcher engaged research assistants who travelled throughout the country with the researcher to administer the questionnaire and also conducted the interviews.

Secondary data mainly involved a review of related literature on health care financing in Ghana and the world at large. Simple frequency tables were generated to present and analyse the data collected from the primary source.

ANALYSIS AND DISCUSSION OF RESULTS/FINDINGS

Characteristics/Status of Respondents

Table-1. Characteristics/status of respondents

Status/characteristics	Frequency	Percentage
Pensioners/unemployed	50	20%
Workers(non-employees of NHIA/NHIS)	100	40%
Children	50	20%
Employees of NHIA /NHIS	50	20%
Total	250	100%

Source: Field survey, 2012

From table 1, 100 respondents representing 40% of the sample size belong to the working class, 50 each representing 20% are pensioners including the unemployed, children and employees of national health insurance authority or national health insurance scheme respectively. The researcher interviewed the respondents to find out what in their views are the challenges confronting national health insurance schemes and hence challenges of financing health care in Ghana. Secondly they were asked to suggest various ways of funding health care in Ghana.

Challenges of Financing Health care in Ghana

On the issue of challenges of financing health care in Ghana, out of the 250 respondents 100 representing 40% mentioned inadequate funding sources as the major challenge facing national health insurance. Another 40% were of the view that competing needs of financing other sectors of the economy is not making the government release enough funds to finance health care, while 20% of the respondents believe that insufficient premium paid by the beneficiaries is a major challenge. This confirms the findings of the research conducted by (Nyonator and Kutzin, 1999).

Forms of Funding Sources

On the issues of various funding sources to finance health care, the respondents mentioned the following: Direct taxation, social health insurance, medical savings account, cash and carry, and loans, grants and donations.

Currently the national health insurance scheme is financed from consumption tax of 2.5%, mandatory pay roll deduction of 2.5% from formal sector workers and employees' contributions, and a graduated premium from the informal sector. The first two falls under taxation.

Majority, about 75% of the respondents, are of the view that being a developing country with a high level of unemployment, the government of Ghana should increase its percentage or consider other forms of funding mechanisms or sources.

CONCLUSIONS AND RECOMMENDATIONS

The National Health Insurance Scheme is seen as an important mechanism to removing financial barrier to achieving equitable access to health care for all citizens. By this goal, health care utilization should no longer be restrained by finance, given that one enrols onto the Scheme. Whereas Act 650 prescribes that 'residents of geographical areas are required to seek membership of the Scheme', it does not make it obligatory for all residents to do so. For this, enrolment is determined by choice, and undermines NHIS goal and contribution of achieving universal coverage. Additionally, even as formal sector workers contribute to NHIS through mandatory deductions, their representation in the Scheme appears quite low. For increased uptake and effective risk pooling, mandatory enrolment onto NHIS should be instituted.

Furthermore, to further benefit from the concept of risk pooling and social solidarity, government and national health insurance authority should enforce the application of the income classification category with the accompanying appropriate premium. Whereas provisions have been made for this, the practice has been different, with district schemes applying flat rates for premium payment across categories. This undermines the concept of social solidarity, where relatively richer persons pay higher premium for health insurance to help subsidize for the relatively poorer persons who would not have otherwise been able to purchase health insurance.

The country and for that matter the government should in addition to the above consider other forms of funding mechanisms like medical savings account.

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