

Prospects and Challenges of Implementing a Sustainable National Health Insurance Scheme: The Case of the Cape Coast Metropolis, Ghana

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Abstract

Accessibility to health services is a major development problem facing sub-Saharan African countries. The prevalence of poverty and unemployment is a major hindrance to making health services accessible to the population especially the poor. Many development theories have been on how to make basic services affordable and accessible to the poor. The World Development Report 2004 focuses on making services work for the poor. The government of Ghana introduced nationwide National Health Insurance Scheme (NHIS) with the aim of providing health insurance and making health services accessible and affordable to the average Ghanaian. The 'cash and carry system' that existed before the introduction of the National Health Insurance Scheme made health services quite inaccessible to the poor. The 'cash and carry system' compelled patients to pay for the cost of health services before they were given the desired medication. The poor resorted to self-medication with its accompanied complications and problems. The overall objective of the study was to assess the contribution of the NHIS to health care delivery in the country and examine the sustainability challenges of the scheme. The study revealed that the NHIS has assisted in increasing Out-Patients-Department (OPD) attendance, reduction of self medication and made health services more assessable to the poor. It was however, observed that for a sustainable national health insurance scheme to be achieved, issues such as maintaining and expanding the client base, regular payment of the services providers and ensuring the requisite institutional capacity should be given the deserved attention.

Keywords: Affordable, Cape Coast, Ghana, Health Insurance, premium, sustainable

1. Introduction

The relationship between health and living standards has achieved significant importance in recent development literature. Good health is seen as one of the crucial indicators of well-being. The growing emphasis on health promotion could be seen from the highlight of health issues in the Millennium Development Goals (MDGs). Goals 4, 5 and 6 specifically touch on health issues. The World Health Organisation [WHO] (2005) explains that this is in recognition of the pivotal role of health to the global ambition of reducing poverty as well as an important ingredient in well-being. Health is also seen as a prerequisite for the attainment of the other MDGs including eradication of poverty, hunger, illiteracy and promotion of gender equality.

Financing health services has been a major challenge to the governments of developing countries. The African region has appreciated the need for greater public sector contribution to health services financing. The Abuja Declaration by the heads of state of African countries in 2001 advocated for an allocation of 15 percent of public sector budget to the health sector. A similar commitment was made by the heads of state in Abuja towards access to HIV/AIDS, tuberculosis and malaria services by 2010 (WHO, 2010).

The World Bank (2013), introduces the idea of Universal Health Coverage (UHC) as very important in achieving the health development goals of a country. The institution further explains that out-of-pocket expenditures constitute a major barrier to accessibility of health services. Universal Health Coverage is therefore enhanced in situations where there is pre-payment and risk pooling. It can be deduced that health insurance is a policy that encourages pre-payment and risk pooling and the corollary is enhanced Universal Health Coverage (UHC).

The introduction of National Health Insurance Scheme (NHIS) by countries in the developing world is expected to improve upon accessibility of health services to the poor and the general public. It must however be emphasised that issues related to sustainability of the financing and maintaining of service provision should be given the deserved attention.

2. Theoretical/Conceptual Overview

2.1 Health Insurance

The Organisation for Economic Co-operation and Development (OECD, p.26) defines health insurance as “a way to distribute the financial risk associated with the variation of individual’s health care expenditure by pooling lost over time (pre-payment) and over different individuals (pooling)”. Out-of-pocket payment is distinguished from health insurance on the basis that there is no risk pooling or pre-payment of health care services. Marcinko (2006) also defined health insurance as “coverage that provides for the payment of benefits as a result of sickness or injury. Includes insurance for losses from accident, medical expenses, disability or accidental death and dismemberment”.

In an attempt to categorise health insurance schemes, DeNavas, Proctor and Lee (2006, p.20) distinguished between private and government health insurance plans. The authors defined private health insurance as “a plan provided through an employer or a union or purchased by an individual from a private company”. Similarly, government health insurance is explained to mean all government based health insurance policies at different levels of government, military health care, individual state health plans, and insurance for specialised groups such as the State Children’s Health Insurance in the United States.

One form of health insurance that is popular in OECD countries, some Latin American countries, and Egypt and Senegal in Africa is Social Health Insurance (SHI). There is an element of compulsion in joining the SHI. Some categories of workers are by law required to be members of the SHI in these countries. The amount of premium paid is a proportion of the income of the individual’s income (Oxfam, 2008). Although social health insurance originally developed as work based intervention in the developed world, it has now been extended to cover other non-working segments of the population in the developing world (Acharya et al, 2013).

National Health Insurance Schemes have lately been popular in a number of developing countries. Kooijman (1999, p.6) explains National Health Insurance to mean when “state functions as a single-player intermediary between health care provider and health care consumer”.

2.2 Health Insurance and Social Inclusion

The World Development Report (2004) notes that efficient health services contribute to greater self-reliance and a recipe for social inclusion of the poor (The International Development Bank/World Bank, 2003). An efficient and affordable insurance scheme will increase accessibility of the poor and the vulnerable to health services. A study in Kenya revealed that the poor are most often overburdened by out-of-pocket (OOP) health expenditures. It was further explained that such costs represent a sizeable proportion on income of the poor (German Technical Cooperation [GTZ], 2010). Health insurance is therefore seen as an avenue for social inclusion of the poor in health care services.

In Bangladesh, accessibility of health services to the very poor who are under the Grameen Micro Credit scheme improved appreciably with the introduction of the Micro Health Insurance in the late 1990s. Saddled with the problem of lack of a functional social insurance scheme to address the needs of the poor in the formal sector and the government’s inability to meet the health care needs and challenges of the poor; the Micro Health Insurance scheme is seen as a great relief to the very poor. It has afforded the poor under the Grameen Micro Credit scheme the opportunity to be included in the provision orthodox health services (Hamid, Roberts, & Mosley, 2010).

In discussing the role of health insurance in providing social inclusion, attention could be focused on the role of health insurance schemes in reducing the vulnerability of the poor against sudden illness of members of the household. With health insurance the poor is guaranteed access to affordable health services. The assurance of health services in the event of sickness in itself is a guarantee of social security and a reduction of the vulnerability context of the poor. In the explanation of the vulnerability context, Department for International Development [DFID] (1999) explains that people’s livelihoods and assets are affected by trends, seasonality and shocks. Human health shock is identified as one of the shocks that affect the vulnerability context. Health insurance is hence, an avenue for protection of the poor against shocks and for ensuring social inclusion.

2.3 Health Insurance in Developing Countries

Health insurance has in recent times been very popular in some developing countries. This could be attributed to the overarching need to pull resources together for pre-payment of health services and for risk pooling. In the British Virgin Islands, the NHIS is managed by the Social Security Board (SSB). As part of the health reforms of the country, the government also embarked upon infrastructural development, particularly a conscious effort to upgrade community health clinics and the construction of new hospitals. Premiums paid by the beneficiaries of the NHIS are based on ability to pay and not on the health status of the individual. The Social Security Board allocates a portion of the contribution of members of the scheme to a special fund, reserved to supplement premiums paid by contributors of the NHIS. What is interesting about the NHIS in the British Virgin Islands is the establishment of Medical Review Committee (MRC) with the responsibility of setting out the modalities and processes for approving bills from health care of members generated from abroad. In effect, there is an insurance cover for beneficiaries of the NHIS travelling outside the country (HUE, Centre for Health Economics of the University of West Indies, 2012).

A number of public health insurance schemes have been introduced in India. The International Bank for Reconstruction and Development/The World Bank (2012) identified one central government sponsored and five state insurance schemes in 2010. The objective of the government sponsored schemes in India is to provide financial support against catastrophic health shocks which are determined in terms of the in-patient stay. The schemes are fully subsidised, mass coverage in nature, and are targeted towards the poor (International Bank for Reconstruction and Development/The World Bank, 2012). In an effort to classify health insurance schemes in India, Vellakkal (2007) identified three main categories. Public (Social) Health Insurance Schemes are mainly for the salaried class in the formal sectors of the economy. The second category, Micro Health Insurance (MHI) Schemes, targets the under-privileged and socially excluded in the society, operating under the basis of the non-for-profit principle. The third category, Private Health Insurance (PHI) Schemes, is often operated by insurance companies and it is open to all with enrolment into the scheme not restricted by legislation.

Columbia operates a dual system of health insurance. One is a contributory monthly regime that targets workers with monthly income levels of US\$170 or above and a government subsidised health insurance scheme for the poor. In Ethiopia, a pilot community health insurance scheme by a Dutch Non-Governmental Organisation (NGO) charges US \$0.60 per month. It has been analysed that although this amount may seem very minimal, if universal coverage of the scheme is assumed in Ethiopia, it will generate about 631 million Birr (equivalent to US \$75million) per annum from the country's 1.57 million urban households and the 9.5 million rural households (International Food Policy Research Institute [IFPRI], 2007). This provides the basis to argue that in situations where people make little meaningful contribution to health insurance, the benefits are quite broad and sustainable.

Some researchers have observed that a number of countries operating national health insurance in low-income and the developing world face a number challenges. The International Bank for Reconstruction and Development/The World Bank (2007; p.3,4) identified three major challenges that are associated with health care including: collection of revenue, financial risk management, and spending of resources on service providers. Other challenges identified were weak institutional capacity for effective management, ineffective or unenforced regulatory mechanisms, rigid administrative procedures, and entrenched customs and practices that are difficult to change.

2.4 Historical Context of Health Care in Ghana

Ghana enjoyed improved health conditions during the early post independence era. Appreciable improvement was achieved in fighting communicable diseases such as measles, poliomyelitis and diphtheria, and infant mortality. The progress made could be attributed to the adoption of science and technology and improvement in medicine (Ministry of Health, 2007). In the 1970s and 1980s, Ghana's economy witnessed deterioration which affected gains in health indicators and infrastructure and services negatively. To overcome the challenges that were associated with health delivery in the country, the government of Ghana introduced the cash-and-carry system of financing health services delivery in the country.

The cash-and-carry system that was introduced in the 1980s as part of Ghana's structural reforms compelled patients to make up-front out-of-pocket payment for health services. Oppong (2001; cited in Mensah et al, 2010) explains that the cash-and-carry system compromised accessibility to health services. It resulted in low-income households in the country postponing attendance to medical facilities for treatment. Self medication, traditional

medicine and faith healers became popular although such services were quite unregulated.

Ghana passed the National Health Insurance Act in 2003, paving way for establishment district-wide Mutual Health Organisations (MHOs) or district-wide insurance schemes. Enrolment of an individual with a MHO became the most important determinant of affordability and accessibility of health services. It also curtailed the tendency for an individual to be detained in a hospital for non-payment of medical bills. To help finance the National Health Insurance Scheme (NHIS) the government introduced the National Health Insurance levy on specified goods and services (Sulzbach, Garshong & Owusu-Banahene, 2005). The government also channelled 2.5 percent of the 17.5 percent social security contribution of formal sector employees to support the NHIS. With this arrangement, the NHIS automatically covered the formal sector employees and their dependents. The informal sector was categorised based on income status and premiums charged to reflect income levels (Government of Ghana 2004; cited in Sulzbach et al, 2005).

3.0 Study Area, Data and Methods

The study area, Cape Coast Metropolis, is the capital of Central Region in Ghana and located at the southern portion of the country. It shares boundary with the Gulf of Guinea to the south; Komenda-Edina-Eguafo-Abirem Municipality to the west; Abura-Asebu-Kwamankese District to the east; and Twifo-Hemang-Lower Denkyira to the north (Ref. Figure 1). It is the smallest metropolis in the country (Ghana Districts, 2013). According to Ghana Statistical Service, the Metropolis had a population of 169,894 in 2010 with a female percentage ratio 48.7:51.3 (Ghana Statistical Service, 2012).

Cape Coast became a good ground for investigation into the operation of National Health Insurance Scheme because the city boasts of a fair array of health services. The city has a regional hospital, metropolitan hospital, health centres, clinics, pharmacies and Community Health Planning and Services (CHIPS) compound. The health services providing institutions could also be classified into government and private entities. The Central Region has also been witnessing a reduction in poverty levels. Poverty level in the region reduced from 31.0 percent below the poverty line in 1998/1999 to 9.7 percent below the poverty line in 2005/2006 (NDPC, 2010). It therefore became important to examine how the NHIS programme has been contributing towards the reduction of social exclusion by getting all segments of the population access to health services, especially the poor.



Figure 1: Cape Coast Metropolis in Regional and National Context
 Source: Department of Geography and Regional Planning, UCC (2011)

The main objective of the study was to assess the sustainability challenges of the National Health Insurance

Scheme. There was therefore the need to target individuals, scheme managers and services providers. The research employed both primary and secondary sources of data. Primary data was obtained from 130 individuals being: 75 insured persons; 25 uninsured persons; 5 pharmaceutical operators; and 5 staff of the Cape Coast Metropolitan Mutual Health Scheme (Oguaman Mutual Health Insurance Scheme) office. Additionally, 10 health workers each (nurses and doctors) were interviewed from private and government health institutions (as indicated in Table 1).

Table 1. Respondents of the Survey

Category	Number of Respondents
Insured Persons	75
Uninsured Persons	25
Pharmaceutical Operators	5
Doctors/Nurses (Government Hospitals)	10
Doctors/ Nurses (Private Hospitals)	10
Staff of Cape Coast Mutual Health Insurance	5
TOTAL	130

Source: Field Survey (2011)

Officials from the various institutions were purposively selected based on their level of influence over the national health insurance programme. The research design was mainly qualitative combined with quantitative approach. Interview schedule was used in gathering information from the subscribers and non-subscribers who in most cases had poor reading and writing skills or were not willing to fill a questionnaire. Interview guide and questionnaire was used in gathering information from officials of the relevant stakeholder institutions who had the requisite educational level to go through questionnaire administration. Secondary information was obtained from the review of annual and quarterly reports and other documents mainly from stakeholder institutions.

3.1 Demographic Characteristics of Respondents

Analysis of socio-economic characteristics of respondents is restricted to respondents from the general public but not respondents of the stakeholder institutions. This would assist in distinguishing the socio-economic characteristics of the insured and the uninsured as well as between different groups and occupations. Forty-seven (62.7%) of the 75 insured respondents were female while 28 (37.3%) constituted males. Whereas there were 16 (64%) males who responded as uninsured, 9 (36%) women responded as uninsured. This therefore shows a domination of female insured over their male counterparts in the study. It is also a reflection of studies by Sapienza, Zingales, and Maestripien (2009) and Booth, Sosa and Nolen (2011) that indicated that women are generally more risk averse than men. It can be appreciated that women would be prepared to take measures that will reduce their vulnerability to falling sick without a means of securing health care. With regards to the age distribution of respondents, majority of the insured were in the age groups; 19 years and below, accounting for 20 (27%), and 20 to 29 years being 25 (33%). The least insured age group was 60 to 69 years (constituting 1 percent) as indicated in Table 2.

Table 2: Age Distribution of Respondents

Age Group	Insured	Uninsured
≤ 19	20 (27.0%)	4(16.0 %)
20-29	25 (33.0%)	5(20.0%)
30-39	15 (20.0%)	6(24.0%)
40-49	9 (12.0%)	4(16.0%)
50-59	3 (4.0%)	2 (8.0%)
60-69	1(1.0%)	2(8.0%)
70+	2(3.0%)	2(8.0%)
Total	75 (100)	25 (100%)

Source: Field Survey (2011)

3.2 General Operations of the Scheme

The daily operations of the Cape Coast Mutual Health Insurance scheme is handled by the management team which is appointed by the board of trustees. The management team is made up of: the scheme manager, an accountant, Management Information System (MIS) manager, claims manager, publicity and marketing manager, and data entry operator. There were other 8 support staff and 13 persons on post-tertiary National Service duty. The number of registered members of the Cape Coast Mutual Health Insurance scheme stood at 150,903 in May, 2011.

The aged above 70 years, the physically challenged as well as the core poor enjoyed free registration. All others within the private, the university and informal sector paid between Gh¢ 7.20 (US \$3.60) and Gh¢ 48.00 (US \$ 25.30) as annual premium. The contribution by workers from the formal sector was by the outright deduction of 2.5 percent of their 17.5 percent social security contribution. This was similar to what pertained in the British Virgin Islands, in the operation of the National Health Insurance System (NHIS). The Social Security Board, the management institution of the NHIS in the British Virgin Islands, allocates a portion of the contribution of members of the scheme to a special fund, reserved to supplement premiums paid by contributors of the NHIS (HUE, Centre for Health Economics of the University of West Indies, 2012).

After a registered member of the scheme has utilised a health care facility, the bill is forwarded to the claims office for vetting. A bill for claim may be rejected on the account of over-billing or prescription of drugs or medical treatment outside the approved NHIS drugs list or medical treatment list. Payment is made to the health care service provider within a period of between one month and three months after the submission of the forms.

3.3 Successes of the NHIS

Successes of the scheme are discussed in relation to the main objective which is to provide accessible and affordable health care to all segments of the society, including the poor and the vulnerable. When respondents were asked about whether in their opinion, the introduction of the NHIS has brought improved health care accessibility to the poor and the vulnerable; the responses were quite encouraging. Forty percent (40%) of the 75 insured respondents very strongly accepted that the NHIS has made health care more accessible with 52 percent strongly accepting the statement. Only 8 percent did not believe that health care has not been more accessible with the introduction of the NHIS.

There was the need to compare the perception about accessibility of health facilities with empirical evidence from some health services providers. Out-Patients-Department (OPD) attendance for both the insured and uninsured for 2009, 2010 and the first quarter of 2011 was reviewed from two major hospitals (the Central Regional Hospital and the Cape Coast Metropolitan Hospital).

Table 3: OPD Attendance in Selected Hospitals

YEAR	OPD ATTENDANCE			
	CENTRAL REGIONAL HOSPITAL		METROPOLITAN HOSPITAL	
	INSURED	UNINSURED	INSURED	UNINSURED
2009	66,458	40,911	37,062	18,553
2010	76,963	26,395	40,643	14,795
2011 (First Quarter)	17,783	9,160	9,487	3,934
TOTAL	161,204	76,466	87,192	37,282

Source: Field survey (2011)

From Table 3 whereas the OPD attendance for the insured was 66,458, the number of uninsured that attended the Central Regional Hospital in 2009 was 40,911. Similarly, 37,062 insured persons attended the Metropolitan Hospital as against 18,553 uninsured persons. The same pattern of results are presented in 2010 and the first quarter of 2011. This observation is in consonance with the findings of Hamid, Roberts and Mosley (2010) that the accessibility of health services by the poor under the Grameen Micro Credit scheme in Bangladesh improved appreciably with the introduction of Micro Health Insurance.

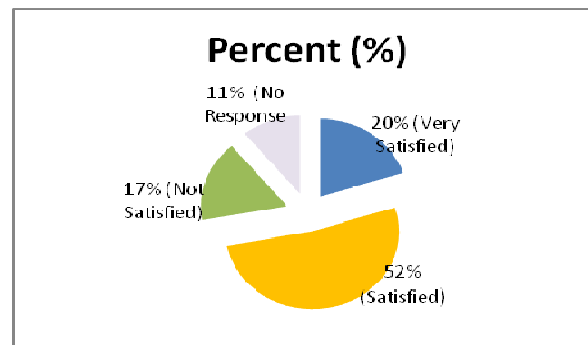


Figure 2: Level of Satisfaction with Healthcare Services

Source: Field Survey (2011)

Enquiries were also made about the level of satisfaction of health services by the insured persons. From Figure 2, 20 percent were very satisfied with 52 percent satisfied. However, 17 percent responded as not satisfied. In the main, the confidence in the level of satisfaction with services provision assisted in the increase in use of health care facilities by the insured.

3.4 Sustainability of the Scheme

The introduction of the NHIS has brought relief to many Ghanaians and reduced self medication and incidence of quack medical professionals providing services to the very poor who cannot afford services provided by hospitals and health centres. These challenges were characteristics of the period before the introduction of the NHIS as noted by Oppong (2001; cited in Mensah et al, 2010). It is therefore crucial to examine the sustainability challenges of the scheme. Sustainability of the NHIS could be examined with regards to different elements such as adequate logistics, regular payments of premium, broad membership base, adequate and regular payment of services providers. Other issues of interest include financial sustainability and institutional capacity of the scheme to deliver efficient services.

3.5 Premium Affordability

The study sought to investigate whether the premium paid by subscribers was within their means. Whereas 41 percent saw the premium paid as affordable 59 described premium paid as not within their means. This implies that any increase in premium paid should be weighed carefully as it may have impact on the ability of many subscribers to renew annual premium payment and hence threaten the sustainability of the scheme.

3.6 Relationship with Service Provider

The ability of service providers to remain with the scheme to provide excellent services to the insured and help attract the uninsured to join the scheme depends on the relationship between the scheme and service providers. The service providers recognise that there has been appreciable increase in the number of clients patronising their respective services because of the NHIS scheme as expressed by one pharmaceutical shop owner:

“these days most of our drugs are not in stock for more than three months unlike when we had not joined the scheme where drugs could be in stock for more than six months”.

One cardinal element that service providers consider is the early repayment of services rendered to subscribers of the scheme. On the average, the minimum duration for the repayment of claims to service providers is six weeks and twelve weeks as the maximum. However, service providers particularly the private hospitals and pharmaceutical operators expressed worry about excessive bureaucracy and delay in the repayment of bills submitted to the scheme secretariat. Linked to this is the rejection of some bills due to reasons such as the bills not having OPD numbers. When owners of five pharmaceutical shops were asked if they were frustrated by the delay in the repayment of bills and have intentions to renounce service to the scheme; three (3) responded in the affirmative. The implication is that the sustainability of the scheme will partly dwell on the ability of the scheme to pay service providers regularly.

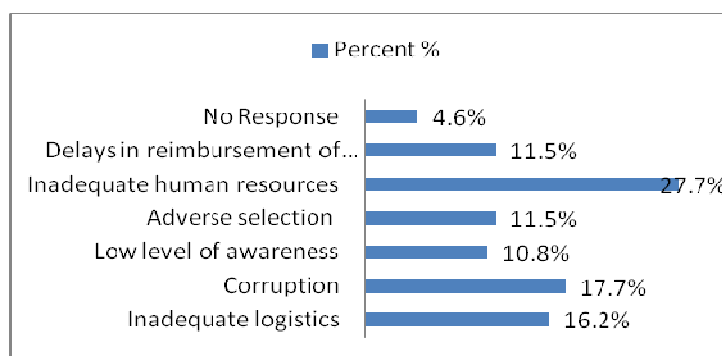


Figure 3: Challenges of the Scheme

Source : Field Survey (2011)

In examining the sustainability challenges of the scheme, there was the need to enquire from the service providers whether the challenges could actually be dealt with. Although all the challenges were viewed as formidable, respondents described some to be more alarming as shown by the responses in Figure 3. The major challenges identified by the respondents included inadequate human resource (27.7%) delay in reimbursement of claims (11.5%) and adverse selection (11.5%). Corruption accounted for 17.7 percent which should be an issue of great concern. Perception of corruption could be very dangerous to instilling trust among the subscribers and the service providers. Measures that would ensure transparency and effective reporting and accountability should be encouraged.

4.0 Conclusion and Policy Implications

The paper has highlighted the important contribution of NHIS in the provision of health services to the poor and hence its contribution to social inclusion. Sustaining the NHIS will be in the interest of all, especially the very poor. It was also revealed that there are a number sustainability challenges that require attention by the necessary stakeholders. It could be inferred that the ability of the scheme to continue enjoying the trust of subscribers and service providers will depend on the capacity of the scheme to deliver. Effort should therefore be made at promoting the NHIS to get many people to join the scheme in their own long term interest. This will ensure regular premium payment and enable the scheme to maintain levels of premium charged to make it affordable to the poor.

Weak institutional capacity is identified by the International Bank for Reconstruction and Development/the World Bank (2007) as a major challenge to healthcare financing. It is therefore recommended that organisational capacity development for the scheme should be given the necessary attention. The recruitment and training as well as re-training of staff should be given the deserved support. Capacity development in the procurement laws of the country, accounting and the development of an organisational culture that puts premium on client satisfaction should be of great concern to the scheme managers and service providers.

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