



HEALTH INSURANCE PROFILE: GHANA

Table 1: Key country indicators

Development indicators*			
Total population, 2014	27,043,093		
Population aged less than 25 years, 2010	58.3%		
Population living in urban areas, 2010	50.9%		
Gross national income per capita (US\$), 2012	1,490		
Gross national income per capita (Ghc), 2012	2,696		
Health Statistics at a Glance**			
	2003	2008	2014
Total fertility rate	4.4	4.0	4.2
Infant mortality rate (per 1,000 births)	64	50	41
Under-five mortality rate (per 1,000 births)	111	80	60
Percent of children 12-13 months fully vaccinated	69.4	79.0	77.3
Maternal mortality ratio (per 100,000 live births)***	376 (2005)	325 (2010)	319 (2015)
Antenatal care coverage (≥ 1 visit)	90.1	94.3	96.9
Births attended by skilled health personnel (percent of total births)	47.1	58.7	73.7
Unmet need for family planning	34.0	35.3	29.9
Contraceptive prevalence rate	25.2	23.5	26.7
Health care expenditure indicators (2013)****			
Expenditure ratio			
Total expenditure on health as % of GDP	5.4% <i>higher</i> than avg. low-income countries (5%) <i>lower</i> than global avg. (9.2%)		
Level of expenditures			
General government expenditure on health as % of total government expenditure	10.6% <i>below</i> targets set by Abuja Declaration (15%)		
Selected per capita indicators			
Per capita total expenditure on health (PPP int.\$)	214		
Per capita government expenditure on health at average exchange rate (US\$)	100		
Per capita government expenditure on health (PPP int.\$)	130		
Sources of funds			
General government expenditure on health as % of total expenditure on health	60.6%		
Private expenditure on health as % of total expenditure on health	39.4%		
External resources for health as % of total expenditure on health	13.2%		
Out-of-pocket expenditures as % of private expenditure on health	91.9%		

Health Financing in Ghana

Per capita health expenditure in Ghana has significantly increased over the past two decades. Total health expenditure per capita, at US\$100 in 2013, aligns with countries of similar income levels as well as the sub-Saharan African average of US\$101.

As a share of GDP, total health expenditure in Ghana, at 5.4% in 2013, is higher than the lower-middle income country average of 4.2%, whereas public spending in Ghana is about average. Ghana's government health expenditure as a share of total government expenditure was 10.6% in 2013.

Out-of-pocket (OOP) payments represent 36% of total health expenditures, which is only slightly higher than the sub-Saharan Africa average of 35%. OOP payments saw a sharp increase in 2011, despite coverage by the National Health Insurance Scheme (NHIS). Rising unauthorized charges to NHIS members have been widely practiced by health providers during this time, resulting from delayed reimbursements and National Health Insurance Agency tariffs below cost.

Ghana has also experienced high economic growth following the establishment of the National Health Insurance Scheme (NHIS)—an average of 7.3% annual gross domestic product growth from 2003-2013.

New earmarked funding sources for the NHIS—particularly the National Health Insurance Levy—as well as a portion of social security taxes, have improved the consistency of health financing and resulted in slightly higher levels of total government spending on health.

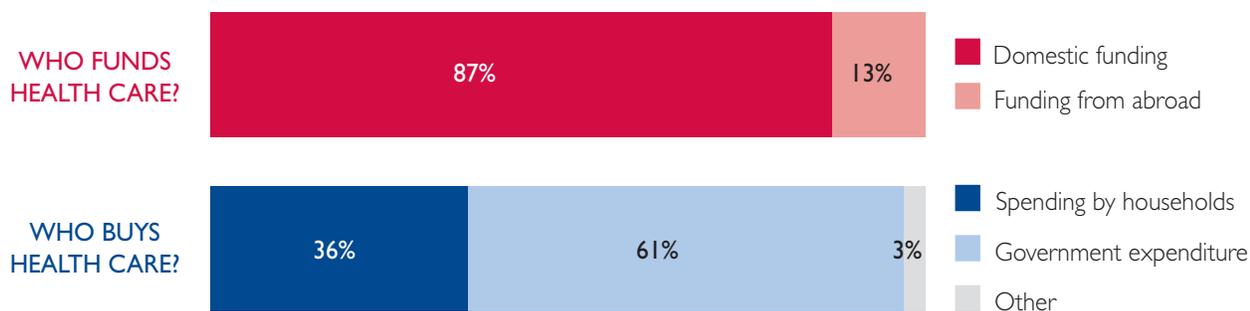
Ghana's National Health Insurance Scheme

Ghana's NHIS has captured the global health community's attention as one of the most ambitious plans for universal health coverage (UHC) in Africa. The Ghana case holds a number of lessons for other countries striving to increase access to affordable health care, such as how to raise revenue, pool health and financial risk, and organize purchasing from public and private providers.

The NHIS was established by an Act of Parliament in 2003 (Act 650) to promote financial risk protection against the cost of health care services for all residents of Ghana.¹ The NHIS licenses, monitors, and regulates the operation of health insurance schemes in the country. It was formally enacted into law in December 2004 and subsequently revised and replaced in 2012 by Act 852, which presently governs health insurance schemes in Ghana.

*Ghana Statistical Services **Demographic and Health Survey Program
***WHO, UNICEF, UNFPA, World Bank Group, and United Nations Population Division
Maternal Mortality Estimation Inter-Agency Group
**** WHO Health Expenditure Database, Ghana

Figure 1: Health funding source and health care purchasing



Source: WHO Health Expenditure Database, Ghana, 2013. Extracted January 2016.

The NHIS is governed by the National Health Insurance Authority (NHIA), a centralized government agency with headquarters in Accra. Act 852 established a unitary scheme with offices throughout the country, including a Head Office, Regional Offices, and District Offices. The NHIA accredits public and private providers and is responsible for policy and overall operations of the NHIS.

NHIS Financing

The NHIS is financed on a national basis from a single National Health Insurance Fund (NHIF)—a pool for the sharing of health and financial risk. All funds are channeled through the NHIS.

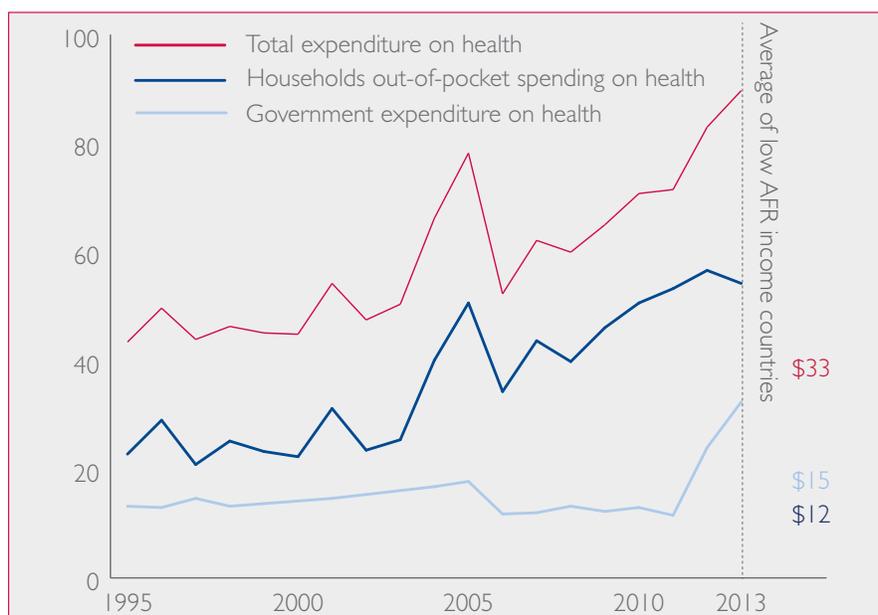
The main source of financing is the VAT-based National Health Insurance Levy (2.5% VAT). Earmarked funds constitute over 90% of total inflows; over 70% derive from the NHI levy and roughly 20% from contributions made by formal sector workers to the Social Security and National Trust (SSNIT). An additional 10% comes from other sources, including premium payments.

Financial Risk Protection

One of the main goals of the NHIS is to reduce exposure to financial risk for all Ghanaians. Individual enrollment is mandated by law but not enforced in practice. The majority of the population is exempt from paying premiums. Children under 18 years, pregnant women, the elderly (≥ 70 years), SSNIT pensioners and the “core poor” are exempted from paying premiums. Other members must pay annual premiums ranging from US\$8-12. According to law, members do not pay deductibles or copayments when accessing health care, however, providers have been widely known to charge insured users unauthorized fees in what are inaccurately described as “copayments”, resulting in a sharp rise in OOP payments in 2011 and beyond (see Figure 2 for households OOP spending on health).

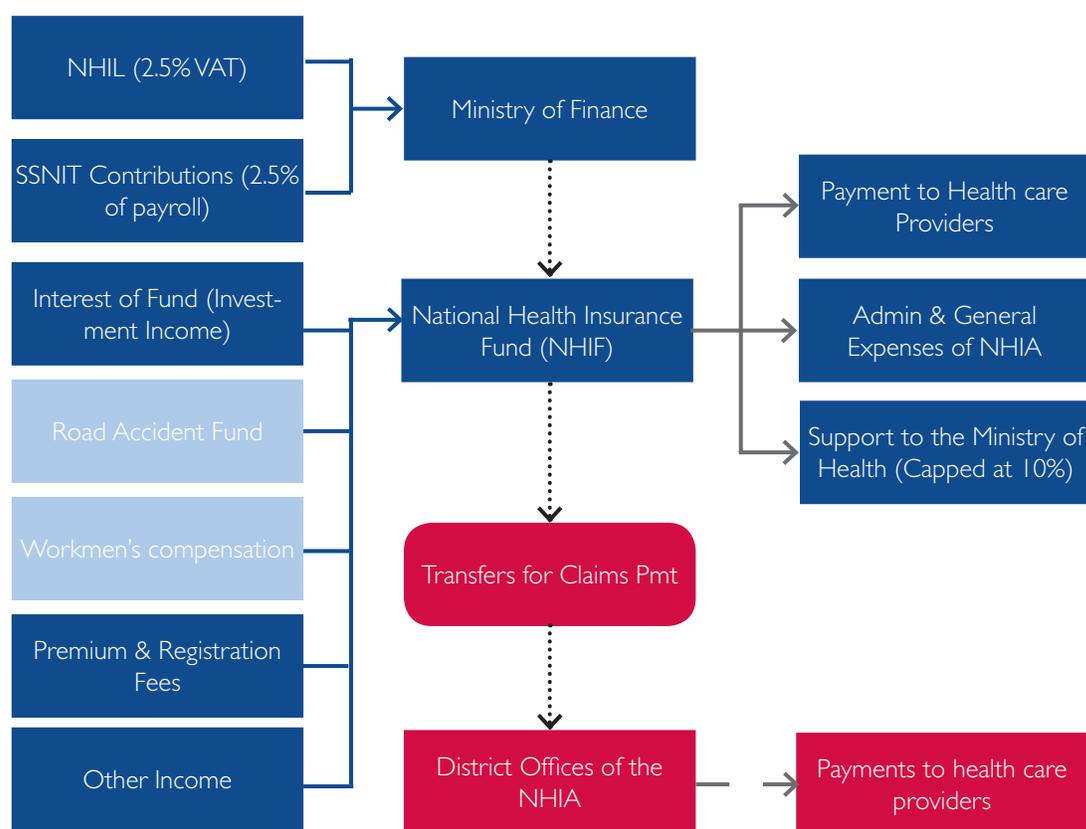
Although the benefits package covers 95% of disease conditions in Ghana, many insured patients still made OOP payments at NHIS accredited health facilities.

Figure 2: Per capita expenditure in US\$ (constant 2013 US\$)



Source: WHO Health Expenditure Database, Ghana. Extracted January 2016.

Figure 3: NHIS Revenue Sources and Allocations



Source: National Health Insurance Authority²

A 2015 study examined the extent to which the NHIS protects its members against the financial consequences of ill health.³ Results showed that the insured were more likely to seek health care and also had significantly lower OOP payments compared to the uninsured.

Another 2015 study on the effect of insurance enrollment on maternal and child health care found that the likelihood of seeking formal medical care and fever treatment is higher among the insured. When a fever or cough has been reported for a child, NHIS coverage increases the likelihood of seeking formal medical treatment by 65.5 percent and increases the likelihood of receiving malaria medication by 71.8 percent.⁴ Among those who reported a fever and sought care, the uninsured were more likely to rely on informal care to treat malaria compared to the insured who were more likely to seek care in a public clinic or regional/district hospital. Among the insured, 15 percent chose informal care compared to 48 percent among the uninsured.⁵

Although the NHIS has not completely eliminated catastrophic health expenditures among its members, it provides significant financial protection in times of ill health for insured households. This is consistent with the general observation that the NHIS is making positive impacts on reducing the financial barriers to health care in Ghana.

Benefits Package

The NHIS includes a nationally standardized and comprehensive benefits package. It is intended to cover 95% of disease conditions and includes primary, tertiary, and pharmaceutical goods and services. NHIS enrollees may access benefits at NHIA-accredited public and private providers; members must first report to a primary care facility, and subsequently to second and third levels of care by way of referral. Exemption from copayments or fees at the point of service is mandated by law but not enforced in practice.

The minimum benefits package includes general outpatient and in-patient care, oral health, eye care, comprehensive delivery care, diagnostic tests, generic medicines, and emergency care. The NHIS maintains an exclusion list of health problems, including cancer treatment other than breast and cervical cancers, dialysis for chronic renal failure, organ transplants, and services provided under government vertical programs (antiretroviral for the treatment of HIV/AIDS, immunization and family planning), among other tertiary services. Female reproductive health, however, is emphasized in the benefits package. Benefits for maternity care include antenatal care, caesarean sections, and postnatal care for up to six months after birth.

Future Plans

Since the NHIA's inception, it has seen significant improvement in its operational results. The NHIA has helped to create a major new revenue stream—the national health insurance levy—and set the important political precedent for the attainment of UHC. The scheme is credited with improvements in the health-seeking behavior of many people in the country, with membership and utilization of care growing significantly. By the end of 2015, the NHIS covered approximately 11.1 million active subscribers (close to 40% of the population) and had enrolled over 4,000 health service providers. Among the successes of the NHIS are the development of accreditation and clinical audit systems, support for the development of health infrastructure, free maternal care services, and an increase in the number of accredited facilities to improve access to care.

The NHIS is a pro-poor program focused on targeting the poor for exemption. As a result of challenges in targeting and correctly identifying the poor; however, it does not provide equitable coverage of the poor.

Identification (ID) card management also presents an important challenge. Delays exist along the entire ID card management chain, comprising data entry, card production and distribution to members. In 2013, the NHIA began rolling out biometric ID cards that can be issued instantly and contain key membership

information. These new cards are expected to address the issue of ID card management, improve membership data integrity and better improve claims management.

Finally, improved management practices remain the most significant challenge to the long-term feasibility of the NHIS, given the increasing demand for health insurance, an increase in health service utilization, and Ghana's growing population. Reform of provider payment and claims submissions is needed to ensure simpler and more efficient operational processes. Computerization and investment to improve the administration capacity for both purchasers and providers will be crucial in any future reform of the NHIS. Additional innovative cost containment strategies may also be needed to ensure continued financial sustainability.

Endnotes

1. Joint Learning Network. [Ghana: National Health Insurance Scheme](#) (NHIS).
2. National Health Insurance Authority. November 2013. "National Health Insurance Scheme in Ghana: Reforms and Achievements."
3. Kusi A, Schultz Hansen K, Asante AF, and Enemark U. [Does the National Health Insurance Scheme provide financial protection to households in Ghana?](#) BMC Health Services Research. 2015; 15:331.
4. Gajate-Garrido, G. and Ahiadeke, C. [The effect of insurance enrollment on maternal and child health care utilization: The case of Ghana.](#) IFPRI Discussion Paper: 2015.
5. Fenny, AP, et al. [Malaria care seeking behavior of individuals in Ghana under the NHIS: Are we back to the use of informal care?](#) BMC Public Health 15:370, 2015.

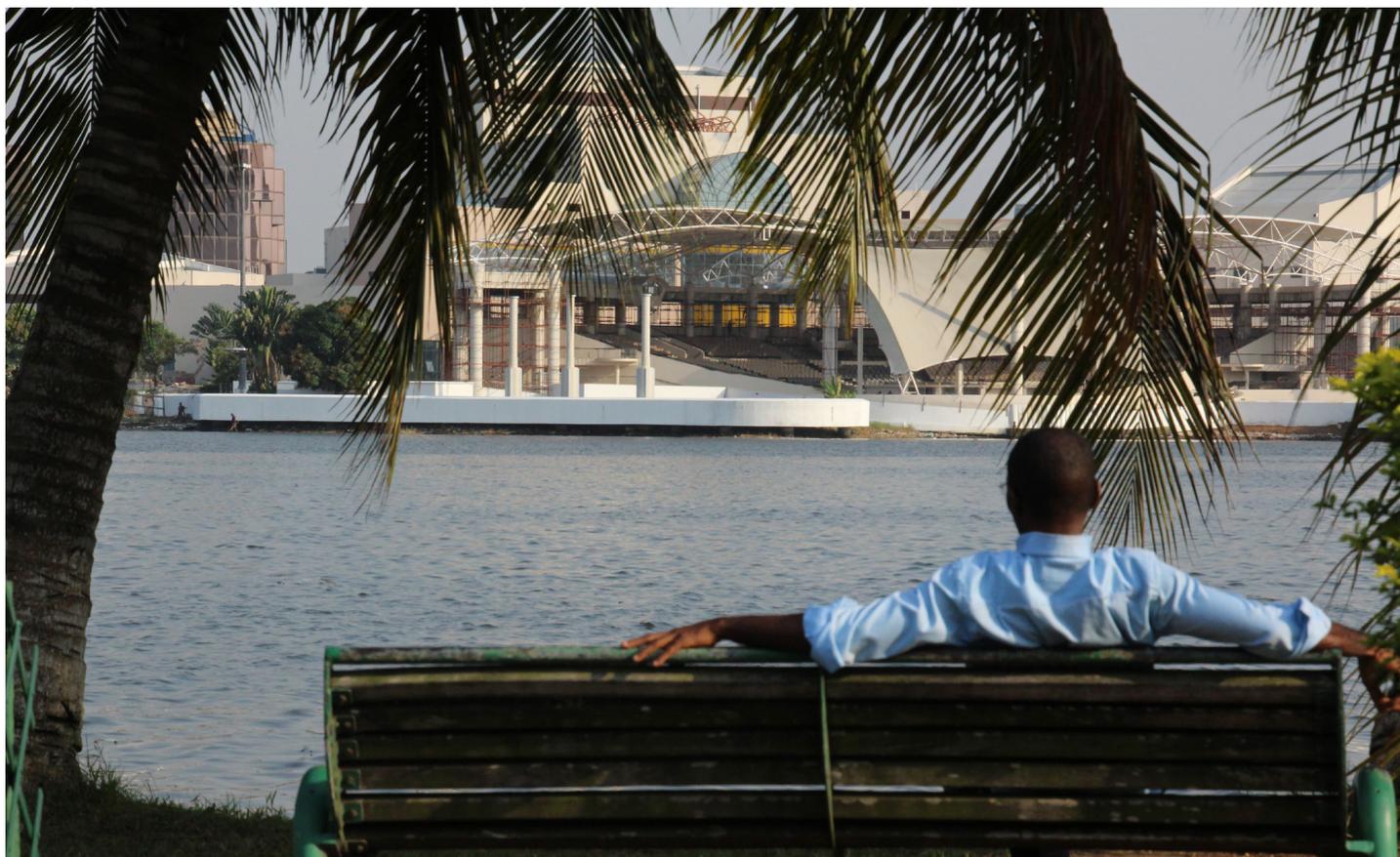


Photo by Pinky Patel

Additional information can be obtained from:
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