



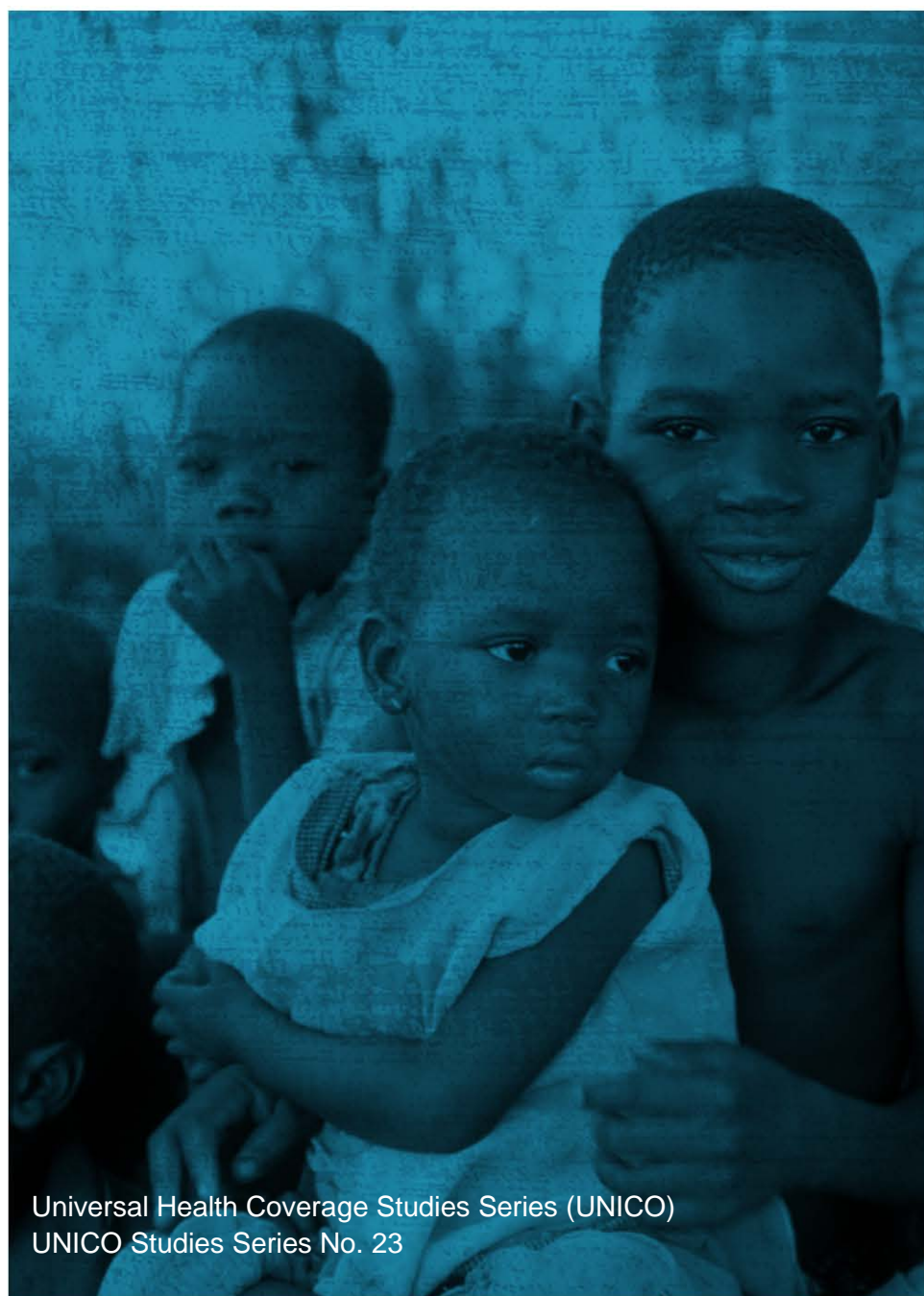
THE WORLD BANK

# Integrating the Poor into a Universal Health Program in Ghana

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Human Development Network



Universal Health Coverage Studies Series (UNICO)  
UNICO Studies Series No. 23



# **UNICO Studies Series 23**

## **Integrating the Poor into a Universal Health Program in Ghana**

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## **The World Bank’s Universal Health Coverage Studies Series (UNICO)**

All people aspire to receive quality, affordable health care. In recent years, this aspiration has spurred calls for universal health coverage (UHC) and has given birth to a global UHC movement. In 2005, this movement led the World Health Assembly to call on governments to “develop their health systems, so that all people have access to services and do not suffer financial hardship paying for them.” In December 2012, the movement prompted the United Nations General Assembly to call on governments to “urgently and significantly scale-up efforts to accelerate the transition towards universal access to affordable and quality healthcare services.” Today, some 30 middle-income countries are implementing programs that aim to advance the transition to UHC, and many other low- and middle-income countries are considering launching similar programs.

The World Bank supports the efforts of countries to share prosperity by transitioning toward UHC with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, successful implementation requires that many instruments and institutions be in place. While different paths can be taken to expand coverage, all paths involve implementation challenges. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Study Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the *nuts and bolts* of programs that have expanded coverage from the bottom up—programs that have started with the poor and vulnerable rather than those initiated in a trickle-down fashion. The protocol consists of nine modules with over 300 questions that are designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following: (a) manage the benefits package, (b) manage processes to include the poor and vulnerable, (c) nudge efficiency reforms to the provision of care, (d) address new challenges in primary care, and (e) tweak financing mechanisms to align the incentives of different stakeholders in the health sector. To date, the *nuts and bolts* protocol has been used for two purposes: to create a database comparing programs implemented in different countries, and to produce case studies of programs in 24 developing countries and one high-income “comparator,” the state of Massachusetts in the United States. The protocol and case studies are being published as part of the UNICO Studies Series, and a comparative analysis will be available in 2013.

We trust that the protocol, case studies, and technical papers will provide UHC implementers with an expanded toolbox, make a contribution to discussions about UHC implementation, and that they will inform the UHC movement as it continues to expand worldwide.

Daniel Cotlear  
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## **Abbreviations**

BBP	basic benefits package
CHAG	Christian Health Association of Ghana
CHPS	community-based health planning and services
DMHIS	District Mutual Health Insurance Scheme
GDP	gross domestic product
GDRG	Ghana diagnosis-related grouping
GHS	Ghana Health Service
LEAP	Livelihood Empowerment Against Poverty
MESW	Ministry of Employment and Social Welfare
MOH	Ministry of Health
NHIF	National Health Insurance Fund
NHIS	National Health Insurance Scheme
NHS	National Health System
SSNIT	Social Security National Insurance Trust

## **Executive Summary**

This case study presents an overview of Ghana's efforts toward achieving universal health coverage, the progress it has made, and the challenges it is facing, with a focus on Ghana's attempt to integrate the poor into the program. The study assesses whether Ghana was able to give due consideration to equity while adhering to its goal to increase overall levels of coverage, and to provide access to health care more equitably. It assesses the effect of the universal health coverage program on health outputs of the poor.

The case study shows that the Government of Ghana intended to ensure that the National Health Insurance Scheme (NHIS), launched in 2005, would cover the vulnerable population. However, vulnerability was not strictly defined as economic deprivation. All but 10 to 15 percent of the poor are among the exempt category. However, the cost of such a system is that tax financing subsidizes not only the economically deprived, but the nonpoor, as well.

The NHIS sources of financing are mixed, although mostly progressive. Benefit incidence is, however, regressive. More of the nonpoor received subsidies for registering with the NHIS than the poor, and more of the nonpoor used public facilities than the poor. The case study finds, however, that there is a multiplicative effect of insurance on the poor; that is, the insured poor are better off than the uninsured poor. This finding suggests that the NHIS has a progressive effect when the poor are insured. Unfortunately, the proportion of insured poor over insured nonpoor is small.

Besides a comprehensive benefits package offered under the NHIS, beneficiary registration remains stagnant at close to 40 percent of the population in 2008. Furthermore, the NHIS has missed some poor, either because of mistargeting or adverse selection. This is a critical concern because those uninsured poor are still suffering, and still have low health service use and poor health outcomes. Under the current system, the uninsured are expected to pay out-of-pocket. This is a bigger worry for Ghana.

The questions that remain unanswered and that need critical attention are: How long will it take the government to scale-up the common targeting approach to identify the economically deprived for the program? How long will it take the NHIS to ensure that all the economically deprived populations are counted under the "vulnerable" category, are registered, and have access to quality and affordable health care? Will there be sufficient funds and risk pooling, and administrative support to meet the 2015 Millennium Development Goal targets? Should Ghana return to its previous national health system?

If the disparity in coverage is not addressed with some urgency, then Ghana is likely to continue to underperform in health outcomes.

In conclusion, several challenges remain in improving the equity, efficiency, and sustainability of the NHIS. The biggest challenge is how to ensure that 100 percent of the poor receive affordable and quality health care. The case study recommends options to improve these aspects.





## 1. Introduction

Five principles of integrating the poor into universal health programs will be addressed in this case study: (a) the National Health Insurance Act and Legislative instruments: the government's objective of addressing the needs of the poor, the vulnerable, and the underprivileged; (b) targeting: the means of identifying the poor, the vulnerable, and the underprivileged, and ensuring (through targeted interventions) that the programs are reaching these subgroups; (c) sustainable financing: to ensure the government has a balance of resources allocated to illnesses of the poor, cost-effective interventions, and services accessible to the poor, vulnerable, and underprivileged; (d) health outputs: to reduce the inequity among population subgroups (for example, among consumption quintiles) in health service use and coverage; (e) financial protection: to reduce the inequity among population subgroups (for example, among consumption quintiles) in financial protection of the population against illness costs; and (f) discussions on the political economy, policy implications, and the pending agenda.

The case study will address these principles in the context of Ghana to assess what steps the country has taken toward achieving universal health coverage, with special attention to the poor, and what the results have been of the integration of the poor into the program. The case study also presents an overview of Ghana's efforts toward universal health coverage, the progress it has made, and the challenges it is facing with a focus on Ghana's attempt to integrate the poor into this program. In an attempt to improve absolute levels of coverage, countries often overlook equity dimensions. The study assesses whether Ghana was able to give due consideration to equity, while adhering to its aim of increasing overall levels of coverage, and to provide access to health care more equitably. It will assess the effects of the universal health coverage program on health outputs of the poor.

## 2. Background

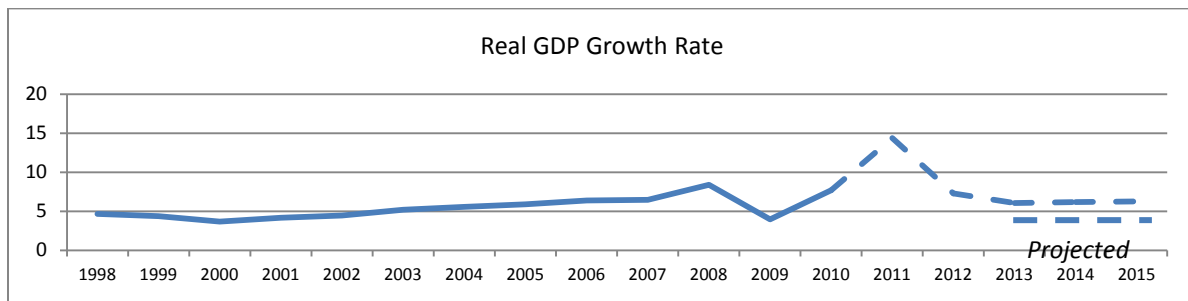
Ghana is a low-middle-income country with a per capita gross domestic product (GDP) of US\$1,150 (2010), and a GDP growth rate of 7.7 percent (2010). Inflation rates and fiscal deficits declined between 2008 and 2010. Projections suggest that the real GDP growth rate will stabilize at around 6 percent between 2012 and 2015 (World Bank 2011a) (table 1 and figure 1).

**Table 1 Trends in Ghana's Macroeconomic and Fiscal Performance**

<b>Economic and Financial Indicators (annual changes unless otherwise noted)</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>
Real GDP	8.4	4.0	7.7
Real GDP per capita	5.7	2.0	3.1
Consumer price index	16.5	19.3	10.7
Current account balance (millions of US\$)	-3,079	-1,034	-2,252
Fiscal deficit (percent of GDP)	8.5	5.8	6.5

*Source:* Ministry of Finance and Economic Planning and Controller and Accountant General Department reported in World Bank (2011a).

**Figure 1 Ghana: Real GDP Growth Rate, 1989–2015**



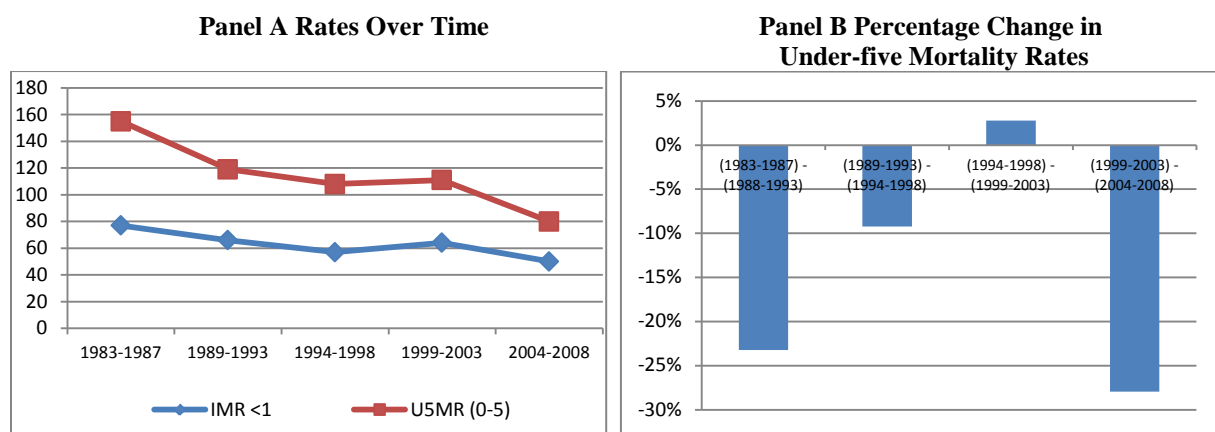
Sources: Schieber and others 2012. Data are from IMF Article IV.

Ghana has entered a demographic transition, with lower population growth and lower fertility rates. The population in 2010 was 24.66 million, and the growth rate during 2005–10 was 2.1 percent. In 2010, 52 percent of country's population lived in urban areas. Seventy to 90 percent of the labor force is in the informal sector. About 29 percent of the population lives below the poverty levels, and in 2006, 18 percent were categorized as extreme poor (World Bank 2011).

Infrastructure development needs to be scaled up. A significant proportion of the population—86 percent—had access to improved water sources in 2010. However, a very low proportion of the population—13 percent—had access to improved sanitation in 2010. This leads to a poor public health environment. Although communicable diseases are declining, they are still highly prevalent in Ghana. Vector-borne diseases such as malaria are among the leading causes of death among children under five years of age. Under-five mortality estimates—80 per 1,000 live births in 2008—and maternal mortality estimates—350 per 100,000 live births in 2010—are far above the average for countries of similar income and health spending.

During 2004 to 2008, there was a declining trend in the under-five mortality rate, but this was not always the case. Between 1989 and 2004, the decline in the under-five mortality rate slowed significantly, and even showed a rising trend between 1994 and 2003 (GDHS 2004, 2009) (figure 2, panels A and B).

**Figure 2 Under-five Mortality and Infant Mortality in Ghana, 1983 to 2008**



Source: Ghana Statistical Service 2004, 2009. Data are from the Ghana Demographic Health Survey.

The reasons for the slower declines in mortality have often been related to both demand- and supply-side consequences, that is, to the economic crisis and the low allocations of public resources for health and the consequent low quality of health services. Prior to 1985, government health facilities subsidized and offered free health care. As a consequence of the 2008–2009 economic crisis, government health facilities faced severe supply-side constraints, had limited human resources, and faced drug stock-outs and other challenges. This resulted in poor-quality care being delivered at these facilities, and may have also resulted in unofficial payments by patients.

Around the mid-1980s, under the structural adjustment program (and the treasury's revenue constraints), Ghana, like several other African countries, agreed to impose user fees (a cash and carry system, [Legislative Instrument (LI) 1313, 1985]) in government-owned health facilities. Additional revenue generated was expected to reduce some of the supply-side constraints and improve the quality of health care. This, in turn, would improve health service use and consumer satisfaction. However, as a result of the economic crisis, households, too, were financially constrained. The poor were simply priced out of health care, and a two-tier health delivery system evolved with better facilities for those who could afford to pay.

As a consequence of the cash and carry system, and to ease the cost burden on the poor, in the late 1980s, missions initiated (voluntary) community-based health insurance schemes; however, coverage remained low at about 1 percent of the population (McIntyre 2008). In the late 1990s, through donor support, several voluntary mutual health organizations were established at the district level (Agyepong and others 2008). The country formalized mutual health organizations and scaled up the concept nationwide as District Mutual Health Insurance Schemes (DMHISs). Building on lessons learned from mutual health organizations, the Ministry of Health (MOH) decided to scale-up demand-side financing interventions and in 2003 developed a model for a national health insurance program.

### **3. Ghana's National Health Insurance Program and its Objectives for Universal Health Care**

Following campaign promises made in 2003, the Ghanaian parliament ratified the Ghana Health Insurance Act (Act 650, 2003). The legislative instruments (LIs) were developed in 2004 (LI 1809), and the National Health Insurance Scheme (NHIS) began to be implemented in the latter part of 2005. The NHIS was established with the objective of improving affordability of health care by the Ghanaians: (a) between 1999 and 2003, health outcomes, such as infant mortality, started deteriorating; and (b) by 2002, out-of-pocket health expenditures had increased to about 51 percent of total health spending. The NHIS Act, 2003, was the government's attempt to address what had become a perennial problem, and to provide for safe and affordable health care to all residents of Ghana (Wahab 2008) (box 1).

*“An Act to secure the provision of basic healthcare services to persons resident in the country through mutual and private health insurance schemes....” (Act 650, 2003).*

### **Box 1 The National Health Insurance Act**

The National Health Insurance Act has 10 objectives: (a) equity, (b) risk equalization, (c) cross subsidization, (d) quality of care, (e) solidarity, (f) efficiency, (g) community or subscriber ownership, (h) partnership, (i) reinsurance, and (j) sustainability.

The policy objective states: “*Within the next five years, every resident of Ghana shall belong to a health insurance scheme that adequately covers him or her against the need to pay out-of-pocket at the point of service use in order to obtain access to a defined package of acceptable, quality health services.*” (Government of Ghana 2004).<sup>a</sup>

The National Health Insurance Act (Act 650), 2003, was established to:

- Secure the provision of basic health care services to persons resident in the country through mutual and private health insurance schemes;
- Establish a body to register, license, and regulate health insurance schemes and to accredit and monitor health care providers operating under the health insurance schemes;
- Establish a national insurance fund that will subsidize licensed district mutual health insurance schemes (DMHISs);
- Impose a health insurance levy and provide for related matters.

*Source:* Ghana: National Health Insurance Act, Arrangement of Sections, Schedule, p. 4 (Act 650, 2003).

a. USAID 2005.

The NHIS includes (a) the National Health Insurance Authority (NHIA), which makes rules, administers the National Health Insurance Fund (NHIF), and regulates the DMHISs, (b) the NHIF, which is the fund, and (c) DMHISs which, under independent boards, are implementers responsible for population enrolment and for purchasing provider services. The NHIS does not include private health insurance schemes. The MOH is the policy maker and is responsible for monitoring the overall situation of the population.

The Act stipulates that NHIF is responsible for:

*“[S]ubsidies of a level determined by the Council to DMHISs; reinsurance of DMHISs against random fluctuations on cost under conditions to be determined by the Council; monies to set aside from NHIF to provide the health care cost of indigents; support to facilitate provision of or access to health service; investment in any other facilitating programme to promote access to health service determined by MOH in consultation with the Council.”* (section 77 of the National Health Insurance Act).

The act specifically mandates that the Ministry of Finance and Economic Planning is responsible for the budgetary allocation for indigent’s coverage under the scheme, and designates that the identification of indigents is the responsibility of DMHISs and the validation of indigents is the responsibility of the NHIS Council (or Board).

The act stipulates that all Ghanaians must enroll in some type of health insurance program (either public or private). It is, however, not mandatory for informal sector workers, the police, or the army. The act stipulates the importance of coverage of the vulnerable population, and particularly mentions “indigents” several times (Annex 1).

## 4. Coverage of the Poor under the NHIS

### Indigents Defined under the NHIS

Indigents are defined very narrowly under the NHIS exempt group category. Estimates using the NHIS definition of indigents suggest about one-half percent of the population falls under the category of “indigents.” Given the large demographic-based exemption offered under the NHIS, the government expects that a greater percentage of the poor are being exempted from paying premiums. However, the current NHIS definition of “indigents” is not expected to capture all the poor, or even all the extreme poor (box 2).

#### Box 2 Identification of Indigents as Stipulated in the NHIS Legislative Instrument

**“Means test for indigent persons.** (1) A person shall not be classified as an indigent under a district scheme unless that person (a) is unemployed and has no visible source of income; (b) does not have a fixed place of residence according to standards determined by the scheme; (c) does not live with a person who is employed and who has a fixed place of residence; and (d) does not have any identifiable consistent support from another person.”

Source: Regulation 58, LI 1809, 2004.

### Vulnerable Defined under the NHIS

The NHIS offers exemption (from premiums) to the about 50 percent of Ghanaians who are defined as vulnerable and who include (a) children under 18 years of age (46 percent of the population), (b) the elderly above 70 years of age (3 percent of the population), (c) indigents (1.5 percent of the population), and (d) pregnant women (3 percent of the population). However, exemption is not based on economic deprivation. (One reason is the difficulty identifying the poor, since no proper identification mechanism exists.) To capture the ultravulnerable, a category of “indigents” is introduced, but it is very narrow and does not capture the poor or even the extreme poor. The legislation states that about one-half percent of the population will be covered under the category of “indigents.” Meanwhile, many poor adults (47 percent of the population is 19 to 69 years old) are left out of the protective support. In summary, the NHIS had considered capturing the vulnerable by providing exemption by demographic grouping; all but 10 to 15 percent of the poor are among the exempt category. However, the cost of such a system is that tax financing subsidizes not only the economically deprived, but the nonpoor as well.

### Targeting the Vulnerable under the NHIS

DMHISs face many challenges in identifying and in verifying exempt beneficiaries. Except for the beneficiaries of the Social Security National Insurance Trust (SSNIT), who are classified as exempt but not vulnerable, most other exempt beneficiaries are difficult to identify. DMHISs do not have updated demographic information in their districts that could be used for planning purposes. National identity cards do not exist, so DMHISs have difficulty verifying beneficiaries who claim to be under the “demographically grouped exempt” category (or even verifying whether someone is Ghanaian). Indigents are the most difficult to identify, given the definition, and DMHISs are neither skilled nor equipped to identify them. DMHISs, therefore, use their own discretion to identify this group, and many tend to ignore this category, especially since this group is small in number (per district). It is not clear whether the NHIS council is able to validate the indigents (as stipulated by law). Therefore, a significant proportion of the poor are not

necessarily covered, because they are difficult to reach. Consequently, many ineligible are exempt and many eligible may be left out of the system (box 3).

### Box 3 DMHIS Responsibilities on Coverage of Indigents under the NHIS

“(2) The conditions under subregulation (1) for ascertaining who is an indigent shall be incorporated in the registration form of a district scheme. (3) A person assigned the duty by a district scheme of registering persons for the scheme, shall elicit the information required under subregulation (1) for the classification of indigents as part of the registration process. (4) Every district scheme shall keep and publish a list of indigents in its area of operation and submit the list to the Council for validation. (5) Where the list of indigents submitted by a district scheme exceeds one-half percent of the entire membership of the scheme, the Council shall verify the list by whatever means the Council determines.”

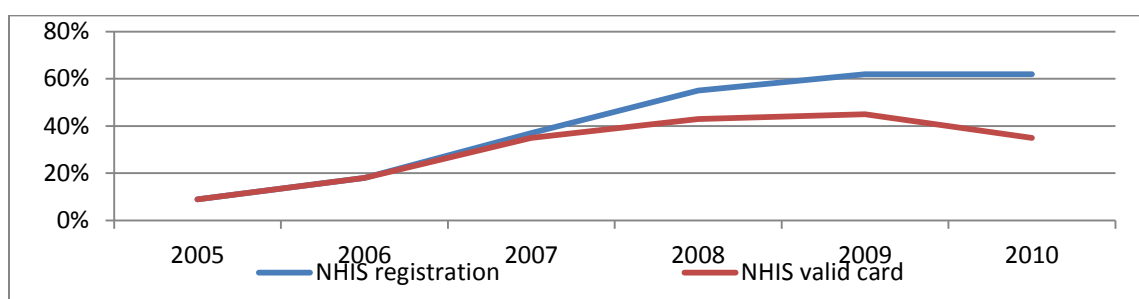
Source: Regulation 58, LI 1809, 2004.

The International Labor Organization (ILO), when invited by the Government of Ghana to assist in the development of NHIS (ILO 2005), recommended that the government adopt a community-based targeting mechanism so that *“benefits that target the poor can be delivered if the identification process is based on community involvement and that community involvement is organized by existing institutional structures. The actual delivery of benefits requires a fairly thorough supervision through local and external arrangements.”* However, the NHIS to date has been unable to adopt such a mechanism.

### Coverage and Challenges under the NHIS

According to a simulated exercise using household survey data, less than 40 percent of the population in Ghana was enrolled in the NHIS in 2008. However, according to institutional data, about 55 percent were registered and 43 percent had a valid card in 2008. As of 2010, 8.2 million people, or 35 percent of the population, were considered to have a valid NHIS card (NHIA 2011) (figure 3).

Figure 3 NHIS Valid Cardholders in Millions, 2005–10



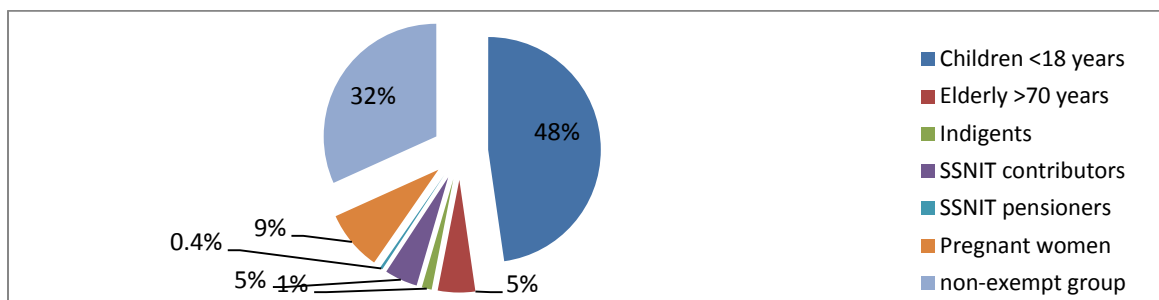
Source: NHIA 2011.

Note: Data may not be comparable because institutional information system is still not mature.

Nevertheless, in just a short period (2005–08), about 40 percent of Ghanaians were registered in the NHIS. Most (63 percent) registered were among the vulnerable. However, among the target vulnerable beneficiaries, less than half were registered; among children under 18 years old, only 40 percent had registered, and even among the small group of indigents, only one-third had registered by 2008 (author’s simulated results). Among individuals 15 to 59 years old in the

lowest consumption quintile, about one-fourth had registered (GDHS 2009). Registration seems to have tapered off, a consequence of difficulties reaching people and adverse selection (figure 4).

**Figure 4 Composition of NHIS Enrollees, 2010**



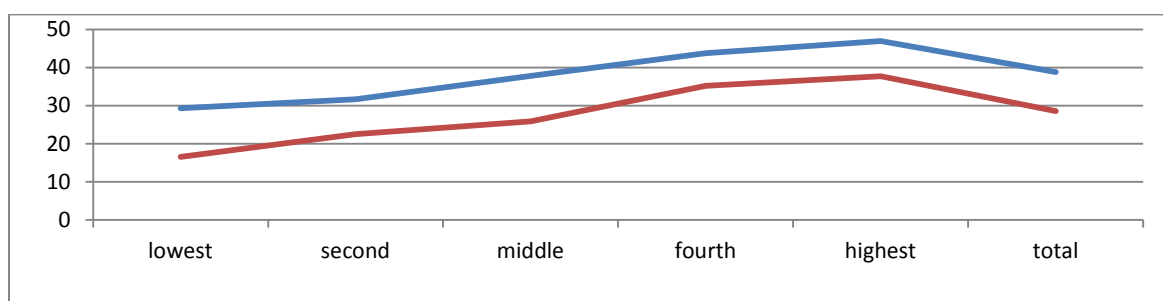
Source: NHIA 2011

As of 2010/11, the NHIS has tried to ensure that indigents covered by the NHIS are the same as those covered under the Ministry of Employment and Social Welfare's (MESW's) Livelihood Empowerment Against Poverty (LEAP) program. However, only a small proportion of eligible LEAP beneficiaries are enrolled to date in the LEAP program. Indigents could be better targeted if there was a community-based identification or means-testing mechanism in place. A common targeting approach has been introduced under the leadership of the MESW. A collaborative effort is underway between the MOH and the MESW to scale-up identification of the poor.

The NHIS is not a mandatory program for informal sector workers. Besides the low coverage of the poor under the NHIS, the other big challenge is the coverage of informal sector workers. There are signs of adverse selection, and this particularly affects informal sector workers. However, there are no signs of stigma, since the NHIS cards do not differentiate exempt from nonexempt groups, and the benefits package does not differentiate exempt from nonexempt groups. However, a significant proportion of the poor (especially the working-age group) are not covered under the demographically defined exempt groups, and this concerns the poor.

Given that exempt groups are not identified primarily on a poverty basis but on a demographic basis, a publicly financed subsidy is being offered equally to poor and nonpoor beneficiaries. Most people enrolled are, however, among the nonpoor. Therefore, benefits of public resources are mostly received by the nonpoor, and this is seen as regressive in its benefit incidence (figure 5).

**Figure 5 NHIS Enrolment by Income and Gender Differentials, 2008**



Source: Ghana Statistical Service 2009.

### **Enrolment of Vulnerable under the NHIS**

The definition of “indigents” needs to be reconsidered, as provided under LI 1809, 2004. First, the definition may not be capturing the poor or even the extreme poor. Second, the definition is not an easy one for the DMHISs to use to identify “indigents,” and doing so has been a challenge. As a short-term solution, the NHIS has proposed that the LEAP definition be applied. However, the number of people enrolled in the LEAP has been low and therefore does not help the NHIS solve its problem. There is also a definitional challenge, that is, whether the two definitions—one provided in LI 1809, 2004, and one provided by the MESW for LEAP<sup>2</sup>—are synonymous. Does the LI definition need to be refined to be identical to the LEAP definition, or should another definition be applied for indigents to be exempted under the NHIS? This definitional challenge between the two programs has been addressed somewhat by the recently approved NHIS Act, 2012, where indigents were more broadly redefined as:

*“[C]ategories of differently-abled persons determined by the Minister responsible for Social Welfare using a means test prescribed by the Minister in consultation with the Minister responsible for Social Welfare and the Minister responsible for Local Government”, and “a person classified by the Minister responsible for Social Welfare as an indigent.” (NHIS Act 2012).*

The wording is not very explicit (it could have specified the extreme poor, or the bottom 20 percent of the population, for example). The revised LI, which is awaited, should specifically describe (a) “who are indigents” to be covered under the NHIS, and hopefully this is defined as the economically deprived; and (b) the mechanisms to identify indigents. This will also determine resource needs for coverage of the poor. Once the refined definition is prescribed, and the common targeting approach scaled up, it may create better traction for coverage of the poor under the NHIS. However, this may take time, since the scaling up of the common targeting approach will take a few years.

<sup>2</sup> Eligibility is based on poverty and on having a household member who is an orphan or a vulnerable child (with emphasis on children affected by AIDS and children with severe disabilities), persons with severe disabilities, and the extremely poor above age 65 (<http://www.issa.int/Observatory/Country-Profiles/Regions/Africa/Ghana/Reforms/Livelihood-Empowerment-Against-Poverty-Programme>).



The common targeting approach using (proxy means test) community-based identification of the poor was introduced under the lead of the MESW but will need to be scaled up (efforts that are supported by World Bank projects [World Bank 2010] and other development partners). Going forward, the NHIS should adopt this mechanism to identify the poor. There seems to be buy-in on this by the MOH, which proposed supporting some of the MESW's costs to scale-up the identification of the poor. However, scaling up will take time and, meanwhile, the NHIS has other options to consider, such as geographic targeting. It is well known that a significant proportion of the poor live in Northern areas, and that could be their starting point.

Policy changes are being considered regarding inclusion of the poor as a specific exempt beneficiary group. This discussion is being led by the MOH. Once the MOH has defined the "indigents" to be exempt under the NHIS, further discussions will be required on whether exemption provided under the demographic definition (all children under 18 years of age, all elderly over 70 years of age) should continue to apply, since there is an overlap between the two groups. Furthermore, discussions will be required with the Ministry of Finance and Economic Planning since the ministry is supposed to provide financial commitment for coverage of "indigents" under the exempt group (because it might be more than one-half percent of the total population and will have an administrative budget to identify newly defined indigent groups). If the "demographically defined exempt" are replaced by the "economically defined exempt," then it is possible that additional funds will be required for this group, but this must be estimated. The MOH could apply a phased approach, with a commitment to provide exemption and enroll all "newly defined indigents" under the NHIS.

## **5. The Benefits Package**

The larger benefits package is comprehensive but fragmented between those financed under the MOH (preventive and promotive in nature) and those financed under the NHIS (curative in nature). All beneficiaries are eligible to receive free care for those services financed under the MOH, which is responsible for public health goods and services. For example, immunization vaccines and services are covered by the MOH budgetary financing. HIV/AIDS treatment is financed mainly by external partners (for example, the Global Fund), but provision is the responsibility of the MOH. Other services, such as family planning, are covered under the NHIS, but family planning commodities and some other services and drugs must be financed out-of-pocket.<sup>3</sup> Services and goods financed under the MOH are available to all Ghanaians, regardless of income or insurance status.

The basic benefits package (BBP) under the NHIS is comprehensive and is the same for all beneficiary groups, both exempt and paying. The BBP is primarily curative in nature and covers outpatient and inpatient services and drugs. It has an official benefits package and an official medicines list, and exclusion lists for both services and drugs. Rules regulating access to the BBP are publicized, including on the websites, but publicizing in rural and remote areas could be improved. The BBP does not, however, include preventive and promotive care, which is under the responsibility of the MOH. The poor mostly suffer from communicable diseases, and need basic, child, and reproductive care. Most of the services they need are offered through MOH

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<sup>3</sup> The NHIS excludes the following services: cancer, except cervical and breast cancer; dialysis for chronic renal failure; heart and brain surgeries, and others; services covered under government vertical programs (immunization, family planning, and so forth); and drugs not on the NHIS drugs list.

financing and are provided through public health facilities. Among curative care, their needs are relatively lower cost. Although more details on NHIS claims are not available at this time for analysis, it is assumed, that the BBP mostly benefits the nonpoor (Annex 2).

During preparation of the NHIS program (prior to 2005), a task force was set up to develop a BBP. The task force developed an exclusion package, based on scientific discussions; however, the final BBP adopted by the NHIS did not incorporate the task force's recommendations. International Labour Organization (ILO 2009) estimates had already warned the NHIS of the unaffordability of such a comprehensive BBP. No fiscal impact or budget considerations were contemplated when the BBP package was initially defined. The BPP has not been revisited since the NHIS was introduced in 2005, and there seems to be little political support to refine the BBP.

## **6. Provider Payment Mechanism**

### **Network of Health Providers**

The NHIS has a network of accredited public, mission, and private providers. Providers must be NHIS accredited before they join the network. Initially, all public facilities were provided blanket accreditation, and therefore quality and standards vary. This may change in the coming years. Mission and for-profit private facilities must go through an accreditation process, and several are already accredited. Several are not accredited because they did not qualify or are on a waiting list. Missions were especially included among the network, given that they had a partnership arrangement with the MOH, and because they are in rural and remote areas, where public sector facilities may be limited. They therefore have the potential to cater services to areas where the poor reside.

All beneficiary groups (exempt and paying) are eligible to access services among any of these accredited providers; however, the poor are less likely to be able to access the same quality of care as the nonpoor, given that they live in less developed regions and outside the main urban areas, where the better-quality services are likely to be offered. The unregistered beneficiaries are charged for services and drugs at these facilities, even though they may be public facilities. Many adult poor are not among the exempt group and are less likely to have registered with the NHIS. If they are not insured, there is no way to get free care unless they go to a mission facility, given the latter's mandate to offer a social welfare program.

### **Provider Payment Mechanisms**

Because of low service use prior to 2005, the NHIS provider payment mechanism was designed with incentives to motivate service use and service provision. Ghana has a fee-for-service system, and the NHIS-accredited providers are reimbursed for services provided (inpatient and outpatient care) and for drugs prescribed to the NHIS beneficiaries. It has a price list for services under its payment mechanisms and fee-for-service for drugs. The Ghana diagnostic-related grouping (GDRG) is applied to all services—outpatient and inpatient care in both clinics and hospitals. A significant number of codes—546—are used under the GDRG. This is extensive.

Unlike the classic diagnosis-related grouping, as applied in many Organisation for Economic Co-operation and Development (OECD) countries, the Ghana system de-bundles drugs, so service

and drug claims are separated. The GDRG also uses multiple rates, separated for public and private providers. Because public sector employees receive salaries through budgets, the GDRG rates are lower (because the GDRG excludes the salary portion, which is not the situation for the private sector). GDRG rates for a particular service may differ by type of facility—tertiary compared to secondary hospitals, or hospitals compared to clinics.

Several challenges are noted in the current payment mechanism. These include:

- The GDRG system has a tendency to lead to supplier-induced demand. Patients can be referred for additional tests, more expensive drugs, or for additional services. The fragmented larger benefits package and the different financing mechanism (one budgetary and one reimbursement) create an incentive among providers to push for curative over preventive care.
- Gatekeeping is not effective given the low quality of care provided at most clinics, especially in rural areas. Therefore, the NHIS is likely to pay for an outpatient GDRG at the hospital rather than clinic rate, or for an inpatient GDRG rather than an outpatient GDRG.
- The GDRG system causes medical cost inflation because of tariff creeping. Tariff creeping means that providers have an incentive to shift to a GDRG that offers a higher tariff; for example, more cases are reported as complicated malaria rather than normal malaria.
- The GDRG system, with the nonexistence of copayments or deductibles, has a tendency to lead to moral hazard. The government had intentionally introduced a fee-for-service mechanism with no copayments in order to encourage service use, since service use was low to begin with. However, the government had not considered the unintended use of services and the rising costs of care. Options have been recommended including that the NHIS consider copayments for the nonpoor beneficiaries, but there is little appetite in the current political environment to once again open doors on “cash and carry.”

Additional concerns include (a) difficulty in administration, because all primary health care consultations also have ex-post GDRG reimbursements; (b) a diagnosis may not be related to drugs prescribed, because they are not bundled together; and (c) there is little fraud control, and anecdotal evidence shows cases of more expensive drugs being prescribed for a simple treatment.

It is important to monitor the developments in health care and to estimate medical cost inflation, and to have a good database that allows analysis by GDRGs, by providers and GDRGs, and by prices and providers and GDRGs. This information is also necessary for the calculation of the overall consumption of health care.

Some efforts are underway to improve efficiency of the payment mechanism, and these are listed below.

The NHIS is piloting a capitation model to cover primary health care services, and this could result in efficiency gains. It is expected that this could help address more fundamental problems in the service delivery system, such as lack of focus on prevention, poorly coordinated care, and inadequate management of chronic diseases, as well as efforts to improve quality of primary health care services.

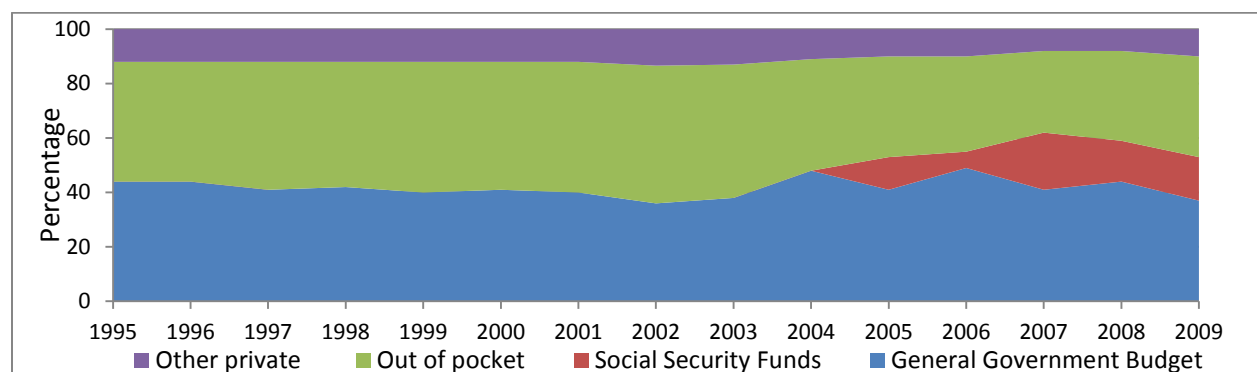
The NHIS has an opportunity to indirectly influence drug prices in the market. The NHIS has its own medicines list that includes those from the essential drug list (of the MOH), and some additional medicines. Most of them are generics or branded generics. In the earlier stages of the NHIS, providers are reimbursed for whatever drug charges are claimed; however, recently prices have been standardized. These prices are determined from market surveys, whereby mid-retail prices (median) are selected for each drug to be reimbursed. Price reviews occur approximately every two years. The NHIS could set parameters following MOH drug price mark-up policies, and NHIS price standards could help influence market prices.

## 7. Sustainable Financing for NHIS

### Sources of Financing for Health

Ghana has a complex system of multiple financing for the health care delivery system. Prior to 2005, primary financing came from general revenue and from household out-of-pocket expenditures. In 2000, total health expenditures were 4.9 percent of GDP, of which the public sector contributed 41 percent and the private sector 59 percent. Household out-of-pocket expenditures were 47 percent of total health expenditure, an increase in household out-of-pocket expenditures compared to 1995 (Saleh 2012) (figure 6).

**Figure 6 Source of Financing for the Health Sector, 1995–09**

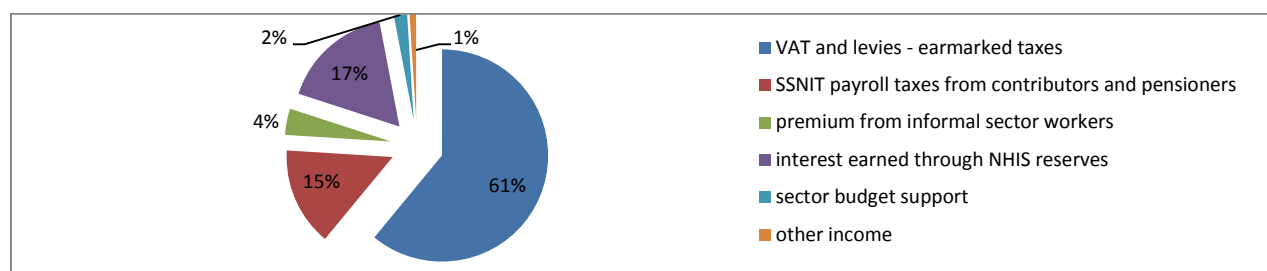


*Sources:* World Bank staff using simulated data based on National Health Accounts data from the WHO National Health Accounts database, [http://apps.who.int/nha/database/StandardReport.aspx?ID=REP\\_WEB\\_MINI\\_TEMPLATE\\_WEB\\_VERSION&COUNTRYKEY=84639](http://apps.who.int/nha/database/StandardReport.aspx?ID=REP_WEB_MINI_TEMPLATE_WEB_VERSION&COUNTRYKEY=84639); the rebased (that is, the old base year used for compiling the constant price estimates has been replaced with a new and more recent base year) GDP from the International Monetary Fund; and data from the Ministry of Finance and Economic Planning.

Overall, public financing (government general budget and social security funds) for health has grown and has been diversified since the launch of the NHIS in 2005. For the health sector, the treasury provides general revenue to the MOH, to the autonomous bodies such as the publicly financed tertiary hospitals, and to the NHIF. The public sector contributions increased to 53 percent of total health expenditures in 2009, having peaked at 62 percent in 2007. In 2009, 16 percent of the total health financing came from the NHIF (or 30 percent of total public resources in health).

Initial funds provided under the NHIF came from the Fund for Heavily Indebted Poor countries (HIPC)<sup>4</sup> and were earmarked as general revenue. Subsequently, the NHIF was financed through mixed contributions from (a) general revenues; (b) earmarked taxes, such as, sales taxes, the value-added tax and levies (2.5 percentage points), which funds most of those who are exempt; (c) payroll taxes (the Social Security National Insurance Tax, SSNIT), at 2.5 percentage points, which covers most of the SSNIT contributors and pensioners and offers cross-subsidy; (d) voluntary premiums, which cover most informal sector workers; (e) interest earned through the reserves; and (f) grants, donors, and other voluntary contributions. Most of the NHIF funds come from earmarked taxes (61 percent in 2009) followed by payroll tax contributions from contributors and pensioners (15 percent in 2009). Premium contributions that come from informal sector workers are collected by DMHISs but are small (4 percent in 2009). Premiums, which are rated geographically but are not actuarially estimated, are considered to be low, given the comprehensive BBP (figure 7, and Annex 3).

**Figure 7 Sources of Financing for the NHIS in 2009, Percent**



Source: NHIA 2010.

The earmarking of funds for health has boosted the morale of the MOH, but for the Ministry of Finance and Economic Planning (and the International Monetary Fund) this is not a positive move, because they do not support earmarking for any sector. The MOH is glad to have a parliamentary commitment to earmark funding for health. For the MOH, earmarking has brought about significant stability in financing, especially of the nonsalary recurrent budgets for health. Prior to this, budgets fluctuated on an annual basis, and there was no reliable source of health funds. The reserve fund under the NHIS, and the fact that it is a multiyear fund and not subject to the annual budgetary cycle, has made the availability of funds more reliable.

### **Funds Flow and Predictability**

The NHIS receives funds from the treasury. However, despite creation of the NHIF, which should maintain their funds, they continue to rely on the Treasury, which disburses funds to the NHIF in installments, thereby maintaining control over when and how much to release to the NHIF at any given time. One reason for this slow disbursement could be the Treasury's low revenue collection, thus creating resource constraints. This however, leaves the NHIF dependent on when and how much to reimburse providers at a time. Nevertheless, compared to the MOH, the NHIF has more predictable financing and, given earmarked funds, it is less vulnerable. Spending above budget estimates by the NHIS may not require legislative approval, since the

<sup>4</sup> As a response to the economic crisis, the World Bank and the International Monetary Fund introduced a poverty fund for the HIPC's in 1996.

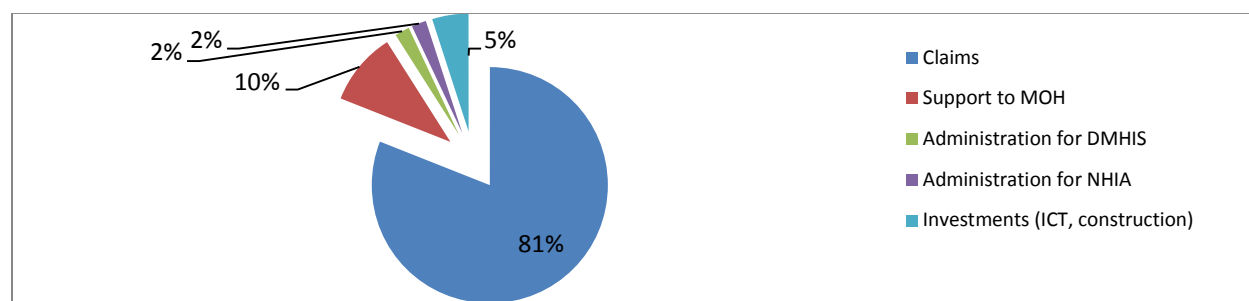
funds are earmarked for the NHIS and a reserve fund is maintained. However, no proper rules have been established on how much to keep in reserve. In the earlier stages of the NHIS, there has been little cost containment. The NHIS has strong political support and expects government to ensure its sustainability. However, given the NHIS's recent experience of rising claims costs and stabilizing revenue, they are increasingly considering cost-containment avenues.

The NHIF provides DMHISs an amount (of premium) for the enrolment of the exempt groups, including the vulnerable and the beneficiaries of the SSNIT. The NHIS also provides resources for DMHISs administrative costs.

### Where are NHIS Funds Spent?

Most NHIS funds go to reimbursing claims to providers (this amount grew from 73 percent in 2008 to 81 percent in 2009). In addition, the National Health Insurance Act stipulates that NHIF funds can also be used for “*investment in any other facilitating programme to promote access to health service determined by MOH in consultation with the Council* (Act 2003, Section 77).” The NHIS therefore can also pay for expenses incurred by the MOH/Ghana Health Service (GHS) for activities, such as, vaccines, training, and health facility refurbishment. This commitment varies from year to year and is negotiable, but has averaged slightly more than 10 percent of NHIS expenses (14 percent in 2008 and 10 percent in 2009). However, it blurs the rule of separation of providers and payers. Administrative fees are reasonable at about 4 percent, and investments (for example, strengthening information and communication technology, construction, and others) were about 5 percent in 2009. Spending patterns cannot be disaggregated by whom it covers (the poor versus the nonpoor). This type of information will be critical to understanding whom the NHIS caters to and how the funds are used (figure 8).

**Figure 8 Expenses Incurred by the NHIS in 2009, Percent**



Source: NHIA 2010.

About 55 percent of claims reimbursed were for drugs in 2009. Periodically (every two to three years), providers have an opportunity to negotiate claims rates with the NHIS. There is a tendency among providers to demand higher rates. The private sector pharmacy lobby is strong; drug prices are negotiated frequently, and the NHIS estimates rates from market median prices. Since 2005, however, some drug retail prices have increased, in some cases to three to five times above international reference pricing.

## **Reliability of Reimbursements to Providers**

Provider payment is ex post. Providers provide services with the expectation that they will be paid, but often reimbursement is delayed, sometimes for up to six months (Saleh 2012). There are no controls or ceilings set on total spending among providers. Arrears are therefore common between the NHIS and providers. The NHIS then agrees on a payment schedule.

Consequently, providers have had to make purchases on credit, such as for drugs, and pay for them when reimbursement is received from the NHIS. Sometimes providers face a challenge in purchasing drugs on credit from the private sector, since the private sector is not willing to advance additional credit.

There is a system for provider complaints, but statistics about complaints are not transparent. The NHIS has had to respond to redress complaints, often negotiating with providers to receive reimbursements in installments.

The NHIS through its central claims processing department has initiated electronic claims processing starting with larger hospitals. The NHIS has also discussed providing reimbursements of at least 40 percent to providers upon receiving the claims, and reimbursing the rest upon validation of the claims. In addition, a capitation modality is being piloted for primary health care centers, which would allow them to prepay providers for an agreed population and service package. Plans are also underway to improve administrative efficiencies in claims management at the service provider level, at DMHISs, and at the central level.

Given delayed claims reimbursements from the NHIS to providers, anecdotal evidence suggests that cream skimming is probably happening, and differential prices are probably being charged for services and drugs for the uninsured. Anecdotal evidence suggests that patients (insured and uninsured) have had to pay under the table (informal payments) in kind, and this could affect the poor adversely. Drug stock-outs are evident, but the situation has improved. Often, drugs prescribed are not on the NHIS essential drugs list, so patients have had to pay out-of-pocket for them. However, so far, there is no evidence of insured patients being turned away by providers. However, drug expenses could adversely affect the uninsured poor. The appeals procedure for grievance redress is not developed for beneficiaries, and access of claimants to genuinely independent agencies (for example, strong and independent courts, political autonomy and effective ombudsman) is not clear.

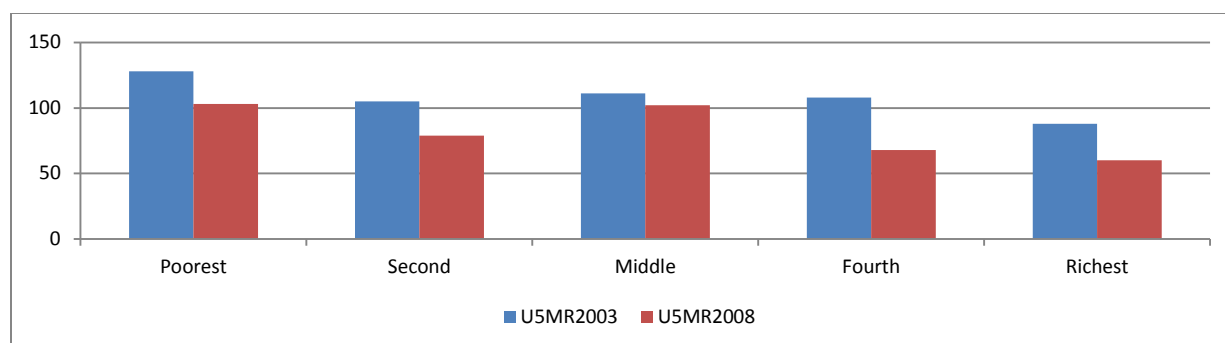
## **8. Health Outputs**

### **Health Outcomes**

Overall health outcomes, for example, under-five mortality rates for all consumption quintiles, improved in Ghana between 2003 and 2008. Nevertheless, given the slow improvement (1994–2003), Ghana may not meet Millennium Development Goal targets by 2015 (figure 9). However, more recently, there have been improvements in health outputs. This section discusses some of health output achievements and the remaining challenges in the health delivery system. Since the NHIS was introduced in 2005, the improvements realized since then suggest they are directly related to the universal health coverage program. However, this is not an impact assessment,

since the NHIS program was still in its infancy in 2008, and is still scaling up and introducing reforms.

**Figure 9 Ghana: Under-five Mortality Rate over Time and by Consumption Profile, 2003 and 2008**



Source: Ghana Statistical Service 2004, 2009.

## Health Service Use

Overall, health service use has increased in Ghana, among all economic groups, including the poor, who are well represented. More poor in 2008 used health services for maternal and child health care than in 2003 (GDHS 2009). The increased use of health services is attributed to the fact that GDP per capita has been steadily rising, and there has been an increase in access (geographic and financial) to health facilities and services (box 4).

### Box 4 Initiatives Undertaken to Improve Access to Health Services

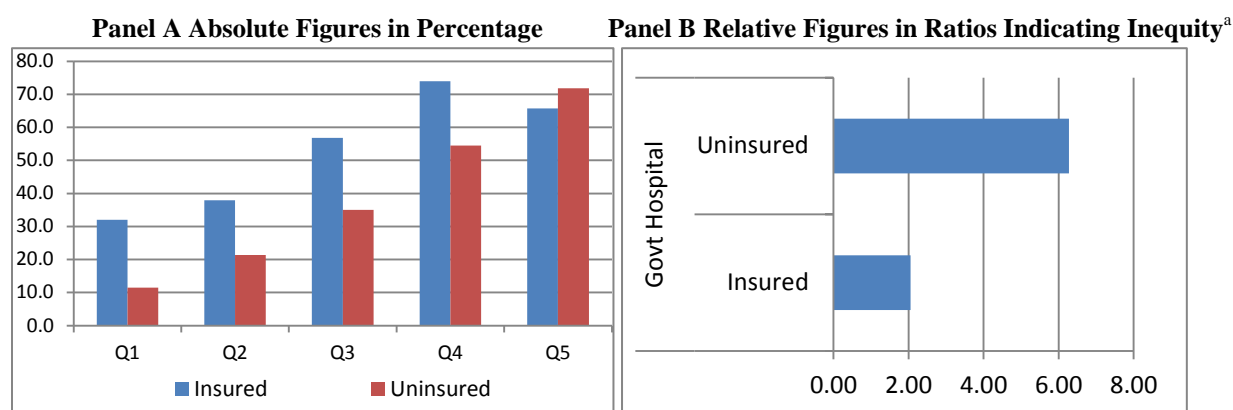
- The Community-based Health Planning and Services (CHPS) initiative was adopted nationwide in 1999. The purpose of this program, which is jointly administered by the central and local governments, is as follows: “CHPS is a national health policy initiative that aims to reduce barriers to geographical access to health care. With an initial focus on deprived and remote areas of rural districts, CHPS endeavors to transform the primary health care system by shifting to a program of mobile community-based care provided by a resident nurse, as opposed to conventional facility-based and ‘outreach’ services.” (Nyonator et al. 2005)
- The 2006 partnership agreement between the public sector and the Christian Health Association of Ghana (CHAG) also improved access to health services in rural and remote areas.
- The community-based health initiative and, later, introduction of the NHIS, also helped in providing financial protection required against illness costs.
- The NHIS decision to include within its provider network both the public and private sectors also increased access to providers reimbursed by the NHIS, and improved affordable access to services for NHIS beneficiaries.
- Finally, the rising public sector expenditures in health, and the autonomy in use of internally generated funds (for example, user fees, reimbursements from insurance) to decentralized levels helped improve certain supply-side aspects and perceptions of quality of care, such as through improved access to drugs, and for some consumers, it provided access to subsidized or free drugs (especially for those enrolled under the NHIS).



Although, inequity was still high, there were signs it was starting to decline by 2008; beneficiaries in the highest consumption quintile were three times more likely to use public facilities compared to beneficiaries in the lowest consumption quintile (compared to four times more likely in 2003). Reasons for this include (a) access to public sector facilities, especially in rural areas, and (b) households perceived that the quality of public sector health services had improved.

The insured seem to use health services more frequently among all consumption quintiles compared to the uninsured. The poor who were enrolled in the NHIS were more likely to use public facilities than the poor who were not enrolled (figure 10, panel A). In addition, among the insured, there was a lower (consumption) inequity gap in the use of health facilities compared to the uninsured; that is, the insured nonpoor were twice as likely to use public health facilities for delivery compared to the insured poor, whereas, the uninsured nonpoor were six times more likely to use public health facilities than the uninsured poor (figure 10, panel B). Although free maternal care was offered to all residents, regardless of their economic grouping, the low enrolment into the NHIS is suggestive of the newness of the program in 2008, and of fewer beneficiaries being informed of this benefit. The low service use is also evidence of the burden of nonmedical expenses on the poor (for example, transport).

**Figure 10 Institutional Delivery at Facilities among Insured Compared to Uninsured, 2008**

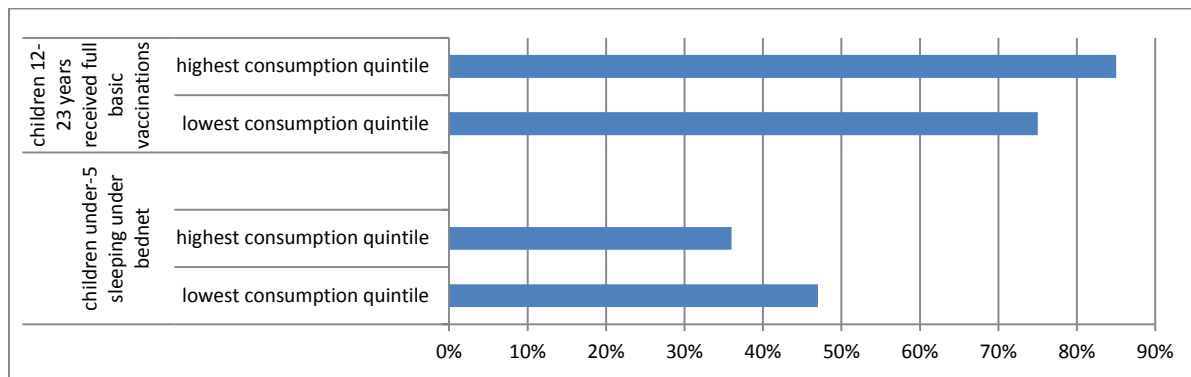


*Source:* Ghana Statistical Service 2009.

*Note:* a: The ratio is calculated as follows: percent of beneficiaries using health facilities at the highest consumption quintile over beneficiaries using health facilities at the lowest consumption quintile. The higher numbers indicate more favorable use by the nonpoor.

In Ghana, several preventive health care programs, financed under government budgets and by external financing, and programs administered predominantly by the public sector facilities, have been propoor, and have shown lower inequities in coverage among consumption quintiles. For example, more children among the lowest compared to highest consumption quintiles slept under a bed net in 2008, and there was no significant difference in immunization coverage between the lowest and highest consumption quintiles (figure 11).

**Figure 11 Coverage of Preventive Health Care by Consumption Quintile, 2008**



Source: Ghana Statistical Service 2009.

However, the situation for curative health care has shown wider equity gaps in service use. The poor are more likely to go to a facility closer to their community settings, but also to go to a facility that may be of lower quality. For example, among children under five years of age with fever, fewer among the lower consumption quintile sought treatment from a provider (40 percent among the lowest quintile compared to 80 percent among the highest quintiles in 2008). Among those who sought care, the lowest consumption quintile received a lower quality of care. Curative care nonsalary recurrent costs are financed in the public sector primarily by the NHIS (for the insured) and by household out-of-pocket (for the uninsured). The private sector relies on the NHIS reimbursement and household out-of-pocket payment for salary and nonsalary recurrent costs.

### Provision of Health Services

The public sector is the predominant supplier of health care in Ghana, followed by the private sector; a quarter of physicians and a third of nurses belong to the nonpublic sector. The missions are important players in the health sector, since they are predominantly in rural and remote areas, although, in reality, they do not cover more poor than the public sector (Coulombe and Wodon 2012).

Challenges faced in health service delivery that affect their functioning capabilities include (a) geographically inequitable distribution and access to health centers and clinics; (b) limited access to adequate health personnel, especially at lower-level facilities; and (c) limited access to other amenities such as basic laboratories, basic equipment (for example, filled oxygen cylinders), ambulances, and drugs. Access to basic health care (CHPS and health centers and clinics) is inequitable across the country, with fewer providers in rural and remote areas and in the Northern region of Ghana. Further, many district hospitals are inappropriately equipped to manage referrals (Saleh 2012).

### Improve Health Service Access for the Poor

The poor compared to the nonpoor in Ghana are not benefiting from the subsidized and publicly financed NHIS. Nor is the program reaching poor and underserved areas. Mechanisms need to improve the provision of health care.

All NHIS beneficiaries, including the poor, have access to the same basic benefits package; however, there are regional and/or rural-urban differences in availability of health services. All NHIS-accredited services are equally available to all NHIS beneficiaries, regardless of the source of payment of their premium (that is, exempt or nonexempt). This is true for all levels of services. However, the quality of services offered may vary considerably among both regions and urban/rural areas.

Providers prefer to stay in urban and larger metropolitan areas, and to serve in hospitals over clinics, given the larger remunerations they can earn through salary, reimbursements, and user fees. They are more likely to prefer to serve the higher-income groups, given the potential for better earnings from the more expensive treatments provided, either because of a higher level of care required, or because of potential earnings. The gatekeeping process is not effective, and reports show that patients are bypassing clinics and using outpatient services at hospitals. Improved gatekeeping would also lead to lower expenditures for both the health delivery system and households. Further effort is required on the supply side to improve access to and quality of services, especially at the clinic and district hospital level.

A 2009 consumer satisfaction survey (NDPC 2009) revealed that NHIS beneficiaries were satisfied with public services after implementation of the NHIS, because services and drugs are available to them at no formal costs, no copayments or deductibles, and no reimbursement ceilings. Although quality of services has improved over time, it still remains poor, and further effort is required on that front (Saleh 2012).

## **9. Benefit Incidence Analysis**

Health financing in Ghana is seen to be proportional to income; although earmarked and payroll tax financing are progressive, out-of-pocket spending is regressive. The data, however, are from 2005/06 and are concurrent with the introduction of the NHIS. More recent household data are needed to show whether the situation has changed since the NHIS was introduced.

Benefit incidence in Ghana is seen as regressive. More public monies are spent for hospitals and curative care than for primary and cost-effective care; both hospitals and curative care cater predominantly to the health needs of the nonpoor. Also, more of the nonpoor receive subsidies for registering with the NHIS than the poor, and more of the nonpoor use public facilities than the poor. In addition, public monies do not appear to be allocated equitably; the Northern region has a significant proportion of the poor, and the worst health outcomes, but this region also receives the lowest public expenditures for health per capita (Couttolenc 2012). There is no equalization fund or equity-based allocation formula for using central government resources (box 5).

However, there is a multiplicative effect of insurance on the poor: the insured poor are better off than the uninsured poor. This finding suggests that NHIS has a progressive effect when the poor are insured. Unfortunately, the proportion of insured poor over insured nonpoor is small.

### **Box 5 Key Messages on Health Coverage of the Poor**

- Overall benefit incidence is mixed, although mostly regressive (that is, public spending benefits the nonpoor).
- More poor than nonpoor are ill, but fewer poor use health services when ill.
- When the poor use services they go primarily to public facilities. Although the poor are more likely to use lower-level public health facilities (health posts and clinics), at higher levels of care (hospitals) for both outpatient and inpatient care, the poor are less likely to use public facilities. Overall, the nonpoor are more likely to use public facilities. Government expenditures on health favor the nonpoor.
- When the poor use health services, they are less likely to receive the same quality of care as the nonpoor.
- However, when the poor are enrolled in the NHIS, they are more likely to go to health facilities, and so the NHIS is likely to be progressive in its benefits if it can enroll the poor.

*Sources:* Saleh 2012; World Bank 2012.

## **10. Next Steps: Improve Efficiency of the NHIS**

Universal health coverage cannot be achieved if special attention is not given to marginalized groups including the poor, informal sector workers, and underserved areas. In addition to improving enrolment of the poor, it is critical to address those other groups that are left out, such as the informal sector workers. Coverage of informal sector workers is a challenge faced by health insurance programs globally. Innovative solutions need to be found to attract informal sector workers into the NHIS. In addition, rules to reduce adverse selection need to be considered, such as a penalty for not renewing enrolment and a waiting period for coverage of preexisting conditions.

The fact that the NHIS is not mandatory for informal sector workers is an added challenge. Informal sector workers are a significant proportion of the population, and could add to its revenue base, but given adverse selection, their enrolment is limited. It might be beneficial for the MOH to reconsider the pros and cons of making the NHIS mandatory for all Ghanaians.

Although the BBP is comprehensive, it is unaffordable, since premium rates are not actuarially based. Claims are increasing, although the revenue base remains stable. The political economy environment does not make it easy to further discuss the rationalization of the benefits package. Nor does it make it easy to discuss copayments or deductibles for the nonpoor to reduce moral hazard. Further discussions will also be required to reconsider progressive premium rates based on actuarial estimates. Already discussions and testing are underway on provider payment mechanisms and on options for a more efficient claims management. These are important discussions that will help increase NHIS efficiency.

The NHIS offers a comprehensive BBP with an exclusion list of services and drugs. The NHIS is focused on curative care. Coverage of preventive care and public health care is, however, a concern. The incentives created through the provider payment are for providers to focus on curative over preventive care. The provider payment system, with differential rates, also creates incentives among providers to see patients in hospitals over clinics. More cost-effective interventions and incentives for personal health promotion and prevention need to be included.

Monitoring and evaluation in the NHIS remains weak. Not much information is available on the epidemiology of diseases for which services are used, or on who uses the services (except for

from household surveys). Annual reports concentrate on enrolment and financials. The enrolment information as reported by routine monitoring and evaluation, was unreliable, and therefore had to be validated through household surveys (which cannot be done frequently). Plans are underway to strengthen reporting of beneficiary enrolment, and also of claims management. Although epidemiological data have been collected in registers at the service-delivery level, little is done to analyze the data. Household surveys to capture household expenditures in health will be critical to better understand the benefits of the program across consumption quintiles. These will be important next steps.

To remain sustainable, the NHIS may need additional resources, some of which could be obtained through increasing the enrolment of paying members (informal sector workers), through an additional injection of general revenue taxes (for coverage of the poor), and through efficiency gains.

Overall, registration has somewhat tapered off at 40 percent of the population. Further, huge (direct and indirect) challenges are faced in targeting and in identification of beneficiary groups, in administering the program, in inefficiency of reimbursements, in reporting and monitoring, in controlling rising costs, and in other areas.

## **11. Policy Implications: NHIS Compared to NHS**

An ongoing and spirited debate in Ghana has questioned the value of the NHIS over a previously functioning national health system (NHS). While this is not the main theme of this paper, a perspective in the context of the paper's topic "integrating the poor into a universal health coverage program" will be helpful. Universal health coverage can be achieved through various means: an NHS, the NHIS, or some hybrid model. There is no one solution. Ghana in 2005 decided to move from the NHS to the NHIS, with mixed results. In this section, we examine the situation in Ghana to understand why this decision was made and what the pros and cons are of the NHIS compared to the NHS.

Ghana has gone through various health models; pre-1985, under the NHS, it offered free health care at public health facilities to the entire population. Between 1985 and 2005, under the NHS, user fees were imposed in public health facilities. User fees continued from 2005 to date in public health facilities; however, with the introduction of the NHIS, fees are reimbursed by the NHIS for the insured, while the uninsured pay them out-of-pocket. In essence, the insured get free care at point of service.

Just before the NHIS was introduced in 2005, the NHS under the cash and carry system (LI 1313, 1985) led to some adverse effects, such as reduced health service use and reduced quality of health care. Health outcomes were starting to deteriorate, which led to increased out-of-pocket spending on health. As a result of this development, the poor were left out, since they could not afford to pay for services—either official user fees or unofficial under-the-table payments. Nonmedical expenses were an additional cost burden to them. The section below analyzes the situation, including listing pre-2005 NHS concerns and the government's response leading to the delivery of the NHIS. It also discusses the achievements and challenges under the NHIS.

First, a pre-2005 concern was that public spending on health fluctuated annually and deterred the sector from consistent performance (44 percent in 1995 to 36 percent in 2002 of total health spending). The government, committed to respond to this concern, earmarked taxes for health, so that politics and changing programmatic priorities would not adversely affect the sector. Additional funds were marked for health from value-added taxes and levies. These taxes are progressive (a higher proportion is contributed by the nonpoor) in Ghana. This contribution brought in an additional 18 percent to public health spending by 2009. Further, employer and employee contributions were also tapped (SSNIT), although given that the formal sector is small, their contributions added only 5 percent to public health spending (2009). Informal sector contributions were even lower; they added only 1 percent to public health spending (2009). Overall, the social security fund increased to 16 percent of total health spending (or 30 percent of public health spending) in 2009.

These additional contributions helped to increase overall public health share, which immediately increased and then peaked at 62 percent of total health spending in 2007, but has since settled at about 53 percent of total health spending in 2009. This increase in, and retention of, public health share has been seen internationally as a remarkable achievement. However, given the small proportion of labor working in the formal sector and a significant proportion in the informal sector, payroll taxes and premium collections have been very low (the rates are not actuarially estimated) and have not added significantly to public health spending (table 2). If contributions other than general taxes were not significant, then the question is: “*Why all the fuss to have an NHIS; why not add the earmarked taxes to the current NHS?*” The sections below analyze this question.

**Table 2 Sources of Financing under Ghana’s NHS and NHIS, 2000–09**

Source of Financing	ACTUAL NHS (2000)	ACTUAL NHIS (2009)	Hypothetical – Could be in NHS?
Public health expenditure as share of GDP	2.00%	2.58% (additional one-third for social security fund)	
Public health expenditure as share of THE	41%	53% (includes social security fund)	50%
MOH expenditure as share of THE	41%	37%	37%
Social security fund for health as share of THE	None	16%	13%
General taxes	100%	70% of public health share	Yes
Earmarked taxes (VAT and levies)	None	18% of public health share (2009) OR (61% of NHIS financing)	Yes
Payroll taxes	None	4.5% of public health share (2009) OR (15% of NHIS financing)	No
Interest earned	None	5% of public health share (2009) OR (17% of NHIS financing)	Yes
Out-of-pocket as share of THE	47%	37%	
Reserve fund	None	Multiple year use	Yes

*Note:* GDP = gross domestic product. MOH = Ministry of Health. NHIS = National Health Insurance Scheme. NHS = National Health System. THE = total health expenditure. VAT = value-added tax.

Second, many Ghanaians believe that the public sector suffers from a culture of limited accountability. This is seen in the auditing culture, the expenditure reporting culture, and the

monitoring and evaluation culture. For example, audits are often delayed, internal audits are not compulsory, and budgets are released but expenditures are not necessarily accounted for or monitored. The perception was that it would be difficult to change institutional culture, unless some drastic steps are taken; a third-party agency separating payers from providers could help build a change mechanism and stronger accountability. However, NHS could have also resulted in improved accountability; for example, the payer-provider split could be structured between district assemblies/payers and providers (GHS, missions, and for-profit).

Third, a pre-2005 concern was the need to expand access to health facilities. Human resources had, however, been a challenge, since attrition was high and retention low, especially in rural and remote areas. The government at that time had also started considering working with the private sector. The MOH, therefore, adopted policies and programs to engage the nonpublic sector in this partnership. Initial public-private partnerships were developed with missions whose mandate to serve the poor had led to their increased presence in rural and remote areas. However, given budget fluctuations, it was often a challenge for the MOH to fulfill its contractual obligations with missions, subsequently not helping them meet their objective to improve access to services. Using public monies to engage the private sector in meeting national objectives could help “kill two birds with one stone,” that is, use monies both more efficiently and more effectively. Pre-2005, public-private partnerships already existed, but a more reliable source of funds could ensure retention of this partnership between the MOH and the private sector.

Fourth, there were low health service use, poor performance, and poor quality of health care. In Ghana, the budget preparation and release process has been historical and incremental. It does not create an incentive for improved performance, productivity, and accountability. Changing budget processes and procedures is out of the hands of the sectors since it is the responsibility of the Ministry of Finance and Economic Planning. Incentive structures could be set up within the budgetary process, but the sector decided to use a provider payment mechanism to get appropriate reactions and create incentives to help increase health service use (table 3).

**Table 3 Accountability Mechanisms that could be set up in the NHS and NHIS**

Structural Changes	ACTUAL NHIS, 2009	Hypothetical – Could be in NHS?
Accountability mechanisms	Separation of payer and provider Contractual agreements between NHIS/payer and providers (GHS, mission, for-profit)	Separation of payer and provider Contractual agreements between district assemblies/payers and providers (GHS, mission, for-profit)
	Ex-post reimbursement based on outputs	Output/performance-based budgeting and releases
	Mandatory reporting, and reimbursement based on reporting	Fund releases based on reporting
Expanding access to services	Accreditation and contractual agreements between payer and provider to serve certain areas, certain beneficiaries Can do selective contracting	Public-private partnership policies required that would agree to use public monies to pay for private provision of services District assemblies could do selective contracting

Fifth, although the above challenges could be addressed within an NHS, the discussion on demand-side financing suggested to the government the possibility of a more targeted protection of the vulnerable. Money would follow beneficiaries, and not the other way around. It would

build the health care system where population demands were, and given appropriate emphasis on the vulnerable, health systems would be strengthened as much in areas where the vulnerable lived, and for services that the vulnerable most needed.

### **What has Demand-side Financing Achieved and has it Resulted in the Government Meeting Program Objectives and Targets?**

As a consequence of the NHIS, findings show (a) more reliable financing, given that the NHIS pools risks and can have multiyear reserve funds; it has been able to assure a more reliable earmarked financing, and a more progressive source of financing since it is mostly from general taxes and progressive earmarked taxes; (b) a concerted effort to target the vulnerable and the poor and to finance their health care; (c) an effort to streamline service standards (through accreditation) and to develop accountability of providers, given that they are contracted and reimbursed based on service provision, or are accountable to provide data on service provision; and (d) there is an increased network of providers, since there is a mechanism to purchase services from public and private providers, because in Ghana, significant accredited providers are from among the nonpublic sector, which has helped improve access to services. It also has an opportunity to motivate provider and consumer behaviors through provider payment mechanisms that are output-based, and to set pricing controls (Schieber and others 2012).

However, it is not only the NHIS that has led to these positive results in the health sector. The positive findings in the public health program are also a result of the developments undertaken by the MOH and GHS. Better access to drugs at the facility level is a combined effort of the MOH's policy on decentralized procurement, retention, and use of internally generated funds (out-of-pocket payment), and reimbursements by the NHIS to the health facility level (in most cases). A better network of providers, especially missions, is also a combined effort of MOH agreements with the Christian Health Association of Ghana (CHAG) and the NHIS reimbursing CHAG.

Positive results include the following:

- The out-of-pocket share of total health spending has declined. The health financing situation in Ghana suggests that out-of-pocket spending remained significant before 2005 (ranging between 44 percent and 51 percent of total health spending between 1995 and 2002). The out-of-pocket spending share has, however, declined to about 37 percent of total health spending in 2009.
- Health service use by the insured (of all economic backgrounds) has been significantly better than health service use of the uninsured (of all economic backgrounds). It is clear that if free health care is offered, it will lead to improved utilization among all economic groups. Health service use has increased for all economic groups; the insured are using health services more than the uninsured. This is also seen among the nonpoor (who can afford care). However, there are implications here of moral hazard and supplier-induced demand.

A more recent household survey does not exist to corroborate the effect of the NHIS on household financial protection.



However, some adverse post-NHIS effects include the following:

- Many people, including the poor, do not have access to the NHIS; according to a household survey (GDHS 2009), population registered under the NHIS was skewed toward the nonpoor.
- Many people, including the poor, do not have access to affordable health care, which is reflected in their low service use. According to a household survey (GDHS 2009), the population using health services was skewed toward the nonpoor and those insured. Many poor (and the insured poor) continued to have low use relative to the nonpoor. Besides all the benefits offered under the NHIS, coverage remains stagnant at close to 40 percent of the population.

Then there are those poor whom this program has missed, either because of mistargeting or adverse selection, which is a major concern, because those uninsured poor are still suffering and still have low health service use and poor health outcomes. Under the current system, the uninsured, regardless of their economic status, are expected to pay out-of-pocket. This is a bigger worry for Ghana.

The questions that remain unanswered and need critical attention are: How long will it take the government to scale-up the common targeting approach to identify the economically deprived from the program? How long will the NHIS take to ensure that all the economically deprived populations are counted under the “vulnerable” category, are registered, and have access to quality and affordable health care? Will there be sufficient funds and risk pooling, and administrative support to meet the 2015 Millennium Development Goal targets? Should Ghana return to the NHS?

If the disparity in coverage is not addressed with some urgency, Ghana is likely to continue to underperform in health outcomes.

## Annex 1 Ghana National Health Insurance Act and Emphasis on Indigents

**The National Health Insurance Act mentions “indigents” in six sections under part 1, as follows:**

**Part 1, Section 2 – Object and functions of the Authority.** (j) devise a mechanism for ensuring that the basic health care needs of the indigents are adequately provided for.

**Part 1, Section 38 – Indigent members.** A district mutual health insurance scheme, shall on the basis of the means test, identify and keep a list of members registered with it who are indigents; The list shall be submitted to the Authority at the time determined by the Council; The Council shall, in consultation with the managers of district mutual health insurance schemes, determine the method to secure the provision of the minimum health care benefits to indigents; The Minister responsible for Finance shall, in consultation with the Council, determine at least six months in advance the Budget for the support of indigents.

**Part 1, Section 66 – Termination or suspension of membership.** A district mutual health insurance scheme shall not suspend the membership of an indigent without the scheme first informing the Council within the period directed by the Council.

**Part 1, Section 77 – Object of the Fund (National Health Insurance Fund).** To set aside some monies from the Fund to provide for the Health care cost of indigents.

**Part 1, Section 79 – Formula for disbursement from the Fund.** The Council shall in the disbursement of moneys from the Fund make specific provision annually towards the health needs of indigents and prescribe the method for distributing the monies involved.

**Part 1, Section 103 – Regulations.** Prescribe the means test for indigents

**The National Health Insurance Legislation states:**

**Regulation 58 – Means test for indigent persons.** (1) A person shall not be classified as an indigent under a district scheme unless that person (a) is unemployed and has no visible source of income; (b) does not have a fixed place of residence according to standards determined by the scheme; (c) does not live with a person who is employed and who has a fixed place of residence; and (d) does not have any identifiable consistent support from another person. (2) The conditions under subregulation (1) for ascertaining who is an indigent shall be incorporated in the registration form of a district scheme. (3) A person assigned the duty by a district scheme of registering persons for the scheme, shall elicit the information required under the subregulation (1) for the classification of indigents as part of the registration process. (4) Every district scheme shall keep and publish a list of indigents in its area of operation and submit the list to the Council for validation. (5) Where the list of indigents submitted by a district scheme exceeds one-half percent of the entire membership of the scheme, the Council shall verify the list by whatever means the Council determines. (6) Any member of a district scheme who is dissatisfied with the classification of a person as an indigent under the scheme may first complain to the scheme and after that if the member is still not satisfied, to the District Health Complaint Committee. (7) The District Health Complaint Committee shall investigate any complaint about the classification of a person as an indigent.

**Sources:** Ghana National Health Insurance Act (Act 650, 2003); Ghana National Health Insurance Legislation (LI 1809, 2004).

## Annex 2 Ghana National Health Insurance Scheme: Basic Benefits Package Exclusions

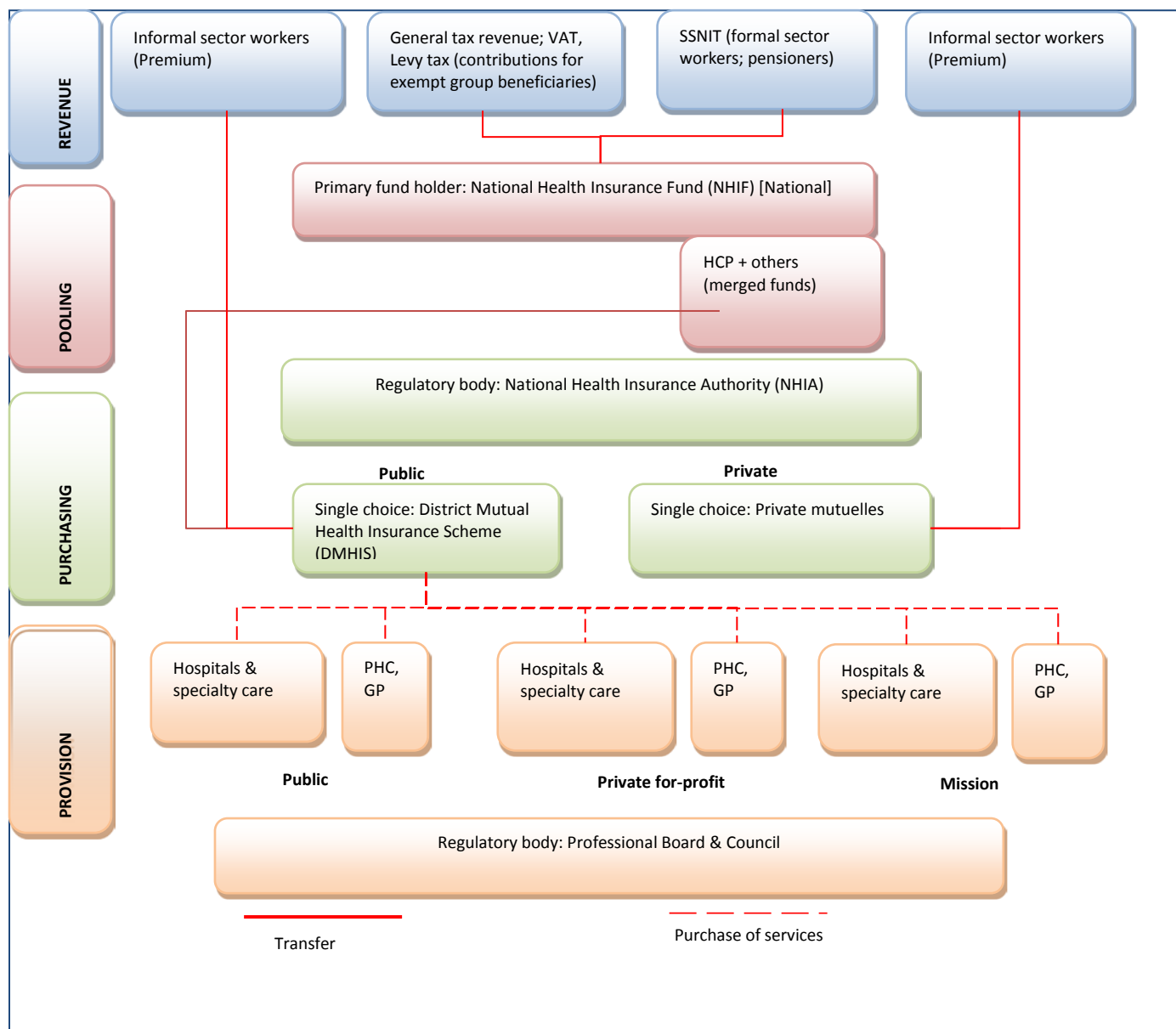
### **The following health procedures are excluded from the National Health Insurance Scheme Benefits List:**

Appliances and prostheses including optical aids, heart aids, orthopedic aids, dentures  
Cosmetic surgeries and aesthetic treatment  
HIV retroviral drugs  
Assisted reproduction (for example, artificial insemination) and gynecological hormone replacement therapy  
Echocardiography  
Photography  
Angiography  
Dialysis for chronic renal failure  
Organ transplants  
All drugs not on the NHIS list  
Heart and brain surgery other than those resulting from accidents  
Cancer treatment other than breast and cervical  
Mortuary services  
Diagnosis and treatment abroad  
Medical examinations for purposes other than treatment in accredited health facilities (for example, visa application, education, institutional, driver's license, and so forth)  
VIP ward (accommodations).

*Source:* LI 1809, 2004 Schedule II Part 2 (Regulation 20): Exclusion List.

*Notes:* LI 1809, 2004 Schedule II Part 1 (Regulation 19(1) provides the minimum healthcare benefits.  
[http://www.nhis.gov.gh/\\_Uploads/dbsAttachedFiles/LI18091.pdf](http://www.nhis.gov.gh/_Uploads/dbsAttachedFiles/LI18091.pdf).

### Annex 3 Ghana National Health Insurance Scheme: Fund Flow Diagram



## Annex 4 Spider Web

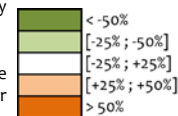
### I. Outcomes comparisons: Ghana and Lower Middle Income Countries



#### Note on interpretation:

In this plot 'higher' is 'worse' – since these indicators are positive measures of mortality / morbidity. Life expectancy is converted to be an inverse measure.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

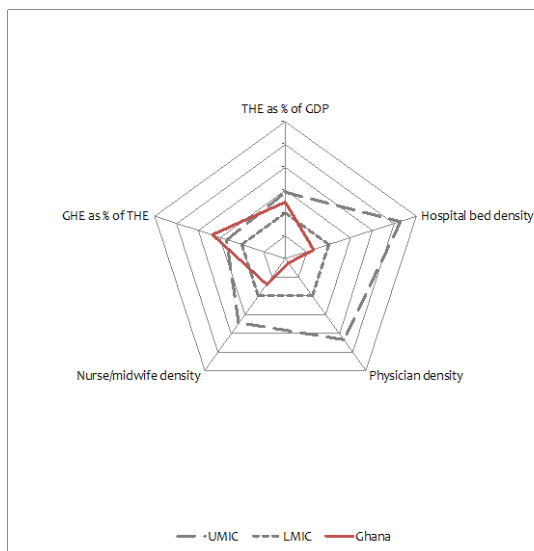


The table below summarizes outcome comparisons with the average lower middle income country (LMIC).

Country Data	Ghana	LMIC	% Diff.
GNI pc (2000 USD)	252.1	592.4	-57.5%
IMR	50.0	50.3	-0.7%
U5MR	74.4	69.4	7.1%
Stunting	28.6	29.7	-3.7%
MMR	350.0	260.0	34.6%
Adult Mortality	254.8	244.1	4.4%
100-Life Expectancy	36.2	34.6	4.5%
Neonatal Mortality	28.0	29.1	-3.8%
CD mortality	61.0	47.0	29.8%

IMR: Infant mortality rate (2010). U5MR: Under-5 mortality rate (2010). Stunting: prevalence of low height-for-age among children under 5 (2010). MMR: Maternal mortality rate (2010) per 100 000 live births. Adult mortality: Adult mortality rate per 1000 male adults (2010). [100-(life expectancy)]: Life expectancy at birth (2010) subtracted from maximum of 100. Neonatal mortality: Neonatal mortality per 1000 living births. CD as cause of death: Communicable diseases as cause of death (% total). All data from World Bank's World Development Indicators. Income averages for stunting calculated by Bank staff and are unweighted.

### II. Inputs comparisons Ghana and Lower Middle Income Countries

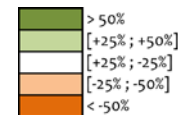


#### Note on interpretation:

This plot shows indicators which measure spending on health or the number of health workers per population.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

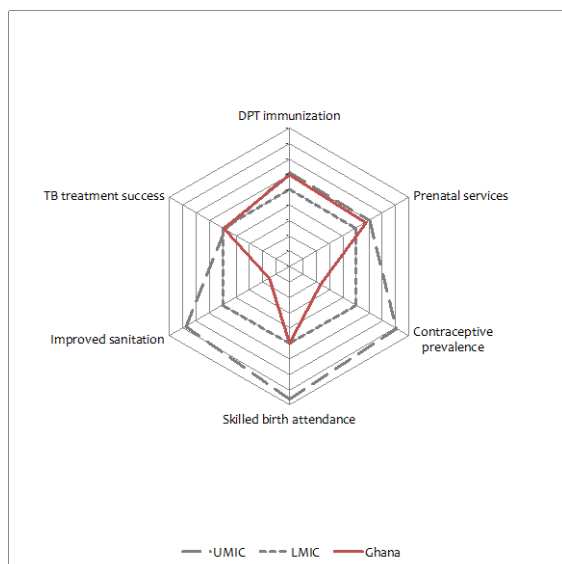
The table below summarizes inputs comparisons with the average lower middle income country (LMIC).



Country Data	Ghana	LMIC	% Diff.
GNI pc (2000 USD)	252.1	592.4	-57.5%
THE %GDP	5.2	4.2	23.2%
Hosp. bed density	0.9	1.4	-35.3%
Phys. density	0.1	0.8	-89.0%
Nur./midwife dens.	1.0	1.5	-30.8%
GHE %THE	67.4	40.2	67.7%

THE as % of GDP: Health expenditure, total (% of GDP) (2010). Hospital bed density: Hospital beds per 1,000 people (latest available year). Physician density: Physicians per 1,000 people (latest available year). Nurse/midwife density: Nurses and midwives per 1,000 people (latest available year). GHE as % of THE/10: Public health expenditure (% of total expenditure on health) (2010). All data from World Bank's World Development Indicators.

### III. Coverage comparisons Ghana and Lower Middle Income Countries

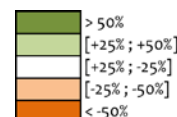


#### Note on interpretation:

In this plot 'higher' is 'better' – since these indicators are positive measures. In this case, all are percent of the population receiving or having access to a certain health related service.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

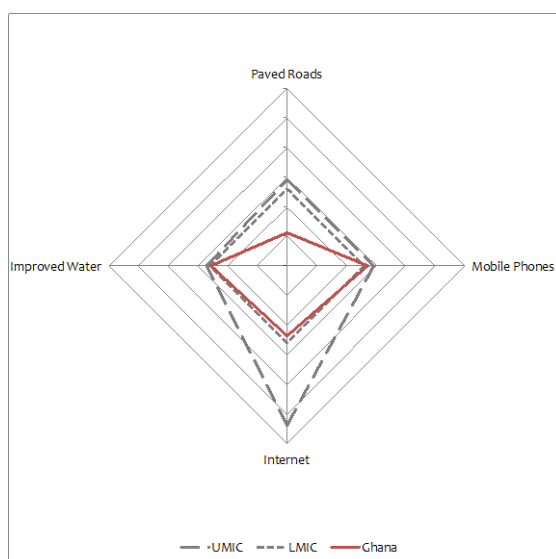
The table below summarizes coverage comparisons with the average lower middle income country (LMIC).



Country Data	Ghana	LMIC	% Diff.
GNI pc (2000 USD)	252.1	592.4	-57.5%
DPT	94.0	78.7	19.4%
Prenatal	90.1	78.1	15.3%
Contraceptive	23.5	50.1	-53.1%
Skilled birth	57.1	56.9	0.3%
Sanitation	14.0	47.0	-70.2%
TB success	87.0	88.0	-1.1%

DPT immunization: % of children aged 12-23 months with DPT immunization (2010). Prenatal services: % of pregnant women receiving prenatal care (latest available year). Contraceptive prevalence: % of women ages 15-49 using contraception (latest available year). Skilled birth attendance: % of all births attended by skilled health staff (latest available year). Improved sanitation: % of population with access to improved sanitation facilities (2010). TB treatment success: Tuberculosis treatment success rate (% of registered cases). All data from World Bank's World Development Indicators.

### IV. Infrastructure comparisons Ghana and Lower Middle Income Countries

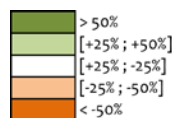


#### Note on interpretation:

In this plot 'higher' is 'better' – since these indicators are positive measures of provision of certain good / service, and a measure of urban development.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

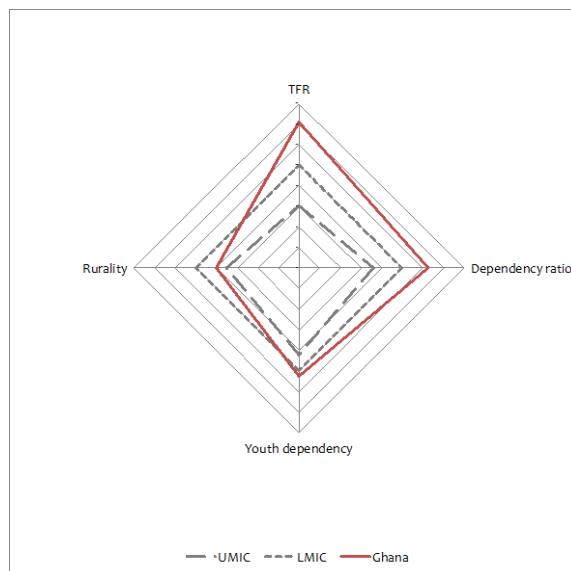
The table below summarizes infrastructure comparisons with the average lower middle income country (LMIC).



Country Data	Ghana	LMIC	% Diff.
GNI pc (2000 USD)	252.1	592.4	-57.5%
Paved roads	12.6	49.5	-74.6%
Mobile phones	84.8	79.3	7.0%
Internet	14.1	16.0	-12.0%
Water	86.0	87.3	-1.4%

Paved roads: % of total roads paved (most recent). Internet users: users per 100 people (2010, with some estimates from prior years). Mobile phone users: mobile cellular subscriptions per 100 people (2010). Access to improved water: % of population with access to improved water source (2010). All data from World Bank's World Development Indicators.

## V. Demography comparisons Ghana and Lower Middle Income Countries

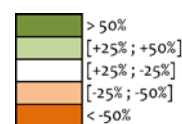


### Note on interpretation:

Indicators here measure births per woman, the extent of rurality, and the number of dependents.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

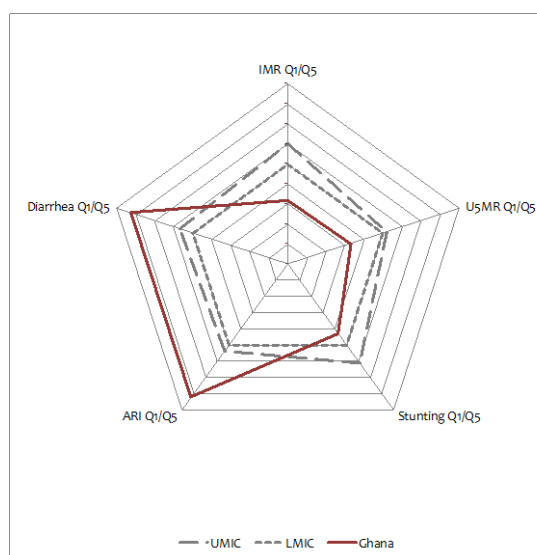
The table below summarizes demographic indicators comparisons with the average lower middle income country (LMIC).



Country Data	Ghana	LMIC	% Diff.
GNI pc (2000 USD)	252.1	592.4	-57.5%
TFR	4.2	2.9	42.3%
Dependency (Total)	73.6	58.8	25.2%
Youth share	91.0	86.7	5.0%
Rural pop.	48.5	60.6	-19.9%

TFR: total fertility rate (births per woman), 2009. Dependency ratio: % of working-age population (2010) aged less than 15 or more than 64. Youth dependency: % of working-age population (2010) aged less than 15. Rurality: % of total population in rural areas (2010). All data from World Bank's World Development Indicators.

## VI. Inequality comparisons Ghana and Lower Middle Income Countries

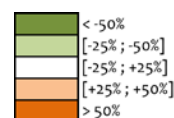


### Note on interpretation:

In this plot 'higher' is 'inequal' and indicators here measure inequalities in selected health outcomes by taking the ratio of prevalence between Q1 and Q5.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

The table below summarizes inequality indicators comparisons with the average lower middle income country (LMIC).



Country Data	Ghana	LMIC	% Diff.
GNI pc (2000 USD)	252.1	592.4	-57.5%
IMR Q1/Q5	1.3	2.0	-36.3%
U5MR Q1/Q5	1.7	2.6	-33.8%
Stunting Q1/Q5	2.3	2.7	-14.1%
ARI Q1/Q5	2.1	1.3	64.5%
Diarrhea Q1/Q5	2.5	1.5	65.4%

All indicators measure the ratio of prevalence between the poorest (in Q1, the first wealth distribution quintile) and the richest (in Q5, the fifth wealth distribution quintile). The data (latest data available) are taken from HNPstats (<http://data.worldbank.org/data-catalog/HNPquintile>).

## References

- Agyepong, Irene Akua, and Sam Adjei. 2008. "Public Social Policy Development and Implementation: A Case Study of the Ghana National Health Insurance Scheme." *Health Policy and Planning* 23 (2): 150–160.
- Coulombe, Harold, and Quentin Wodon. 2012. "Mapping Religious Health Assets: Are Faith-Inspired Facilities Located in Poor Areas." World Bank, Washington, DC.
- Couttolenc, Bernard. 2012. "Decentralization and Governance in the Ghana Health Sector." A World Bank Study, World Bank, Washington, DC.
- Ghana National Health Insurance Act. Act 650, 2003.  
[http://www.nhis.gov.gh/\\_Uploads/dbsAttachedFiles/Act650original2.pdf](http://www.nhis.gov.gh/_Uploads/dbsAttachedFiles/Act650original2.pdf).
- Ghana National Health Insurance Act. 2012.
- Ghana Hospital Fees Regulations. Legislative Instrument 1313, 1985.
- Ghana National Health Insurance Regulation 58, Legislative Instrument 1809, 2004.  
[http://www.nhis.gov.gh/\\_Uploads/dbsAttachedFiles/LI18091.pdf](http://www.nhis.gov.gh/_Uploads/dbsAttachedFiles/LI18091.pdf).
- Ghana Statistical Service. 2004. Ghana Demographic and Health Survey 2003.  
<http://www.measuredhs.com/pubs/pdf/FR152/FR152.pdf>.
- . 2009. Ghana Demographic and Health Survey 2008.  
[http://www.measuredhs.com/pubs/pdf/FR221/FR221\[13Aug2012\].pdf](http://www.measuredhs.com/pubs/pdf/FR221/FR221[13Aug2012].pdf).
- ILO (International Labour Organization). 2005. "Improving Social Protection for the Poor: Health Insurance in Ghana." The Ghana Social Trust Pre-Pilot Project, Final Report, in collaboration with Global Social Trust, March.
- . 2009. "Ghana Financial Analysis of the National Public Health Budget and Projections of Reform Options, 2008–2018." Social Security Department, International Labour Organization, Geneva.
- IMF (International Monetary Fund). 2011. "Ghana: 2011 Article IV Consultation." International Monetary Fund, Washington, DC.
- McIntyre, Diane, Bertha Garshong, Gemini Mtei, Filip Meheus, Michael Thiede, James Akazili, Mariam Ally, Moses Aikins, Jo-Ann Mulligan, Jane Goudge. 2008. "Beyond Fragmentation and towards Universal Coverage: Insights from Ghana, South Africa and the United Republic of Tanzania." *Bulletin of the World Health Organization* 86 (11) (November): 817–908. <http://www.who.int/bulletin/volumes/86/11/08-053413/en/index.html>.
- NDPC (National Development Planning Commission). 2009. "2008 Citizen's Assessment of the National Health Insurance Scheme: Towards a Sustainable Health Care Financing Arrangement that Protects the Poor." Republic of Ghana, Accra.  
<http://www.ndpc.gov.gh/GPRS/Citizens%20Assessment%20of%20NHIS%202008.pdf>.
- NHIA (National Health Insurance Authority). 2010. "Annual Report." Accra, Ghana.  
<http://www.nhis.gov.gh>.



- . 2011. Unpublished Actuarial data. Accra, Ghana.
- Nyonator, Frank K., J. Koku Awoonor-Williams, James F. Phillips, Tanya C. Jones, and Robert A. Miller. 2005. “The Ghana Community-based Health Planning and Services Initiative for Scaling Up Service Delivery Innovation.” *Health Policy and Planning* 20 (1): 25–34.
- Saleh, Karima. 2012. “The Health Sector in Ghana: A Comprehensive Assessment.” Directions in Development, World Bank, Washington, DC.
- Schieber, George, Cheryl Cashin, Karima Saleh, and Rouselle Lavado. 2012. “Health Financing in Ghana.” Directions in Development, World Bank, Washington, DC.
- USAID (United States Agency for International Development). 2005. “An Evaluation of the Effects of the National Health Insurance Scheme in Ghana.” United States Agency for International Development, Washington, DC.
- Wahab, Hassan. 2008. “Universal Healthcare Coverage. Assessing the Implementation of Ghana’s NHIS Law.” Paper Prepared for the Workshop in Political Theory and Policy Analysis Mini-Conference, Indiana University, Bloomington, April 26–28.
- World Bank. 2011a. “Republic of Ghana: Joint Review of Public Expenditure and Financial Management.” World Bank, Washington, DC.
- . 2011. “Republic of Ghana: Tackling Poverty from Northern Ghana.” Africa Region, World Bank, Washington, DC.
- . 2012. “Health Equity and Financial Protection Report – Ghana.” Washington, DC: World Bank. Unpublished.





The World Bank supports the efforts of countries to share prosperity by transitioning toward universal health coverage (UHC) with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, the quality of the instruments and institutions countries establish to implement UHC are essential to its success. Countries will face a variety of challenges during the implementation phase as they strive to expand health coverage. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Studies Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the nuts and bolts of 27 programs in 25 countries that have expanded coverage from the bottom up, starting with the poor and vulnerable. The protocol consists of 300 questions designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following:

- Manage the benefits package
- Manage processes to include the poor and vulnerable
- Nudge efficiency reforms to the provision of care
- Address new challenges in primary care
- Tweak financing mechanisms to align the incentives of different stakeholders in the health sector

The UNICO Studies Series aims to provide UHC implementers with an expanded toolbox. The protocol, case studies and technical papers are being published as part of the Series. A comparative analysis of the case studies will be available in 2013.



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