Enabling transition to formalization through providing access to health care: The examples of Thailand and Ghana

Jennifer de la Rosa and Xenia Scheil-Adlung
ILO Social Security Department

I. Introduction

About 1.2 billion people in the world live in extreme poverty (less than one dollar per day). It was estimated that most of them that lack access to health services live in developing countries: 34 per cent in south Asia, 27 per cent in sub-Saharan Africa and 19 per cent in South East Asia and the Pacific. [1] Specifically, about 1.3 billion people globally are not in a position to access effective and affordable health care if needed while 170 million are forced to spend more than 40 per cent of their household income on medical treatment. [2] Catastrophic health events further plunge people into poverty as a result of the associated high costs. [3] This link, if left unattended, can lead to vicious cycles of poverty and ill health. Improving the health status of the poor is crucial for generating income, increasing productivity and wealth.

People working in the informal economy are of particular concern due to their characteristics. Informal economy refers to economic activities falling outside the scope of government regulations and laws, including those on labour protection and social security. Informal enterprises tend to operate with low levels of capital, skills and technology and limited access to markets; they provide low and unstable incomes and poor working conditions. [4] Social health protection is seen as a means to reach out to the informal economy to address the various health and financial risks they are exposed to.

Based on the core values of equity, solidarity and social justice, the ILO defines social health protection as a series of public and publicly organized and mandated private measures against social distress, loss of productivity, loss of earnings due to the inability to work or the cost of treatment that is caused by ill health and financed through government revenues, contributions or premiums. Achieving universal social health protection coverage, defined as effective access to affordable quality health care and financial protection in case of sickness, is a central objective for the ILO. [5] Such is the use of health-financing mechanisms in the form of: (1) tax-based health protection (e.g. national health service and social assistance approaches like vouchers and cash benefits); (2) national health insurance, social health insurance, community-based insurance and micro-insurance; and (3) private health insurance.

[1] UNDP: Human Development Report, 1997.

[2] WHO (2004b), p. 2.

[3] "World Health Statistics 2007", at www.who.int/hdp/database , 25 Sep. 2007.

[4] "ILO technical note on the extension of social security to the informal economy in Thailand", 2004, p. 1.

[5] "Social health protection: An ILO strategy towards universal access to health care", 2007, p. 3.

The inclusion of the informal economy in social health protection schemes remains to be a challenge. Some of the reasons include the invariable contact between the government and the informal economy which has implications on the records the government has on the informal economy worker; the determination of the informal economy workers' income is problematic as compared to the formal economy where workers' salaries and wages are documented; the informal workers' occupations is wide ranging thereby making it difficult to provide certain types of benefits; and the absence of relevant information about target groups within the informal economy makes it difficult to design schemes for specific occupations and industries.

This paper presents the country experiences of Thailand and Ghana in improving access to health care for the workers in the informal economy and their families. The evaluation of the financing mechanism experience of these two countries and the lessons that can be gathered from their experiences to craft recommendations are the focus of this paper.

II. Health financing mechanisms to reach the informal economy

The ILO supports the use of pluralistic financing mechanisms as a strategy to achieve universal coverage within a realistic time frame. The different social health protection and financing mechanisms used globally to reach the informal sector include schemes such as tax-based insurance, social health insurance, micro-insurance, community-based schemes and private-for-profit and not-for-profit insurance. Each scheme, however, has its advantages and disadvantages. Except for the private-for-profit insurance that is not pertinent to the informal sector, the table below provides an overview of these schemes.

Table 1. Overview of advantages and disadvantages of financing mechanisms for social health protection for the informal economy

Health financing mechanism	Advantages	Disadvantages	Country
Tax-based [a]	Pools risks for the whole population	Risk of unstable funding and often under funding due to competing public expenditure	Thailand – UC/30 baht scheme Malaysia Singapore
- Financed by government revenues and taxes, members include all citizens	Potential for administrative efficiency and cost control	Inefficient due to lack of incentives and effective public supervision	
Examples			
■ National health service – Delivery of services publicly organized	Redistributes between high and low risk, and high and low income groups in the covered population		
■ Conditional cash transfer (CCT) and vouchers – public programmes that provide cash to the needy for verifiable changes in behaviour (Blomquist, 2004) [b]	Provide support to the poor May promote human capital development	Compliance costs Problems associated with cash transfers	Mexico – PROGRESA/Oportunidades Brazil – PETI Columbia – FA Jamaica – PATH

Health financing mechanism	Advantages	Disadvantages	Country
Mandatory Social Health Insurance [a]	Generates stable revenues Often strong support from the population	Poor are excluded unless subsidized by government	Ghana – NHIS Philippines – PHIC Viet Nam – SHI Republic of Korea – NHI Kenya – NSHIF
– Funded through payroll taxes, membership is mandatory and coverage is legally defined	Provides access to a broad package of services	Payroll contributions can reduce competitiveness and lead to higher unemployment	
– Subsidies for the poor are usually provided and service delivery is often through the private sector/contracting	Involvement of social partners	Complex to manage; governance and accountability can be problematic	
The organization is through an independent fund. The national health insurance is a variation of this category	Redistributes between high and low risk, and high and low income groups in the covered population	Can lead to cost escalation unless effective contracting mechanisms are in place	
Micro-insurance and community-based schemes [a]	Can reach out to the informal sector	Poor may be excluded unless subsidized	Bangladesh – Grameen Bank India – SEWA United Republic of Tanzania – community health fund for small-scale tea farmers
These are funded through premiums and the membership is voluntary. Service delivery is often through the private sector/contracting. These are usually small scale or in the community	Can reach the close-to-poor segments of the population Strong social control limits and abuse and fraud and contributes to confidence in the scheme	May be financially vulnerable if not supported by national subsidies Coverage usually remains a small percentage of the population	
		Strong incentive to adverse selection (people who believe they have a greater chance of qualifying for benefits are more particularly motivated to join a scheme than others)	
		May be associated with lack of professionalism in governance and administration	
	Provide support to the poor	There are extensive and compliance costs	
	May promote human capital development	Problems associated with cash transfers	

Sources: [a] Social Health Protections: An ILO strategy towards universal access to health care, 2007. [b] http://info.worldbank.org/tools/docs/library/70042/spring 2004/pdf/eng/blomquist.pdf

Given the various schemes, clearly, there is a need to balance their advantages and disadvantages. The ILO suggests that improving and connecting the approaches through the development of a coverage plan can prevail over the differences. The conduct of evaluation studies can identify which mechanisms are appropriate for specific segments of the population in a given country to achieve the purpose of increasing sufficient and

sustainable revenues in an equitable manner for the provision of adequate benefit packages and financial protection for the whole population. [6]

III. The experience of Thailand and Ghana

Global experience and evidence show that there is no sole and right model for providing social health protection. The ILO strategy on rationalizing the use of pluralistic finance mechanisms proposes the extension of existing means of funding health care rather than creating new structures to achieve universal access. Such were demonstrated by Thailand and Ghana in their utilization of various schemes to improve their population's access to health care.

Thailand

Thailand is a developing country located in the Southeast Asia. It was primarily agrarian but later developed into becoming largely industrial. It had one of the fastest growing economies in the region in the mid-80s to the mid-1990s with an average growth rate of 8.4 per cent. Its economy suffered during the 1997 economic crisis that plunged its GDP growth rate to -10 per cent and that resulted into an economic slowdown. It however was able to recover and by 2003 to 2004, its growth rate increased to more than 6 per cent per year. Demographic data shows a decline in population growth rate and an improvement in life expectancy. Infant mortality rate (IMR) in Thailand has improved since the 1990s when the estimated IMR was logged at 26/1,000 live births. [7] IMR is one of the leading indicators of child health and general development in countries. As for health expenditures, Thailand spent 3.5 per cent of its GDP on health in 2004 of which 64.7 per cent is the general government health expenditure (GGHE) and the rest private expenditure (35.3 per cent). Out of the GGHE, about 10 per cent was spent on social security for health. Out-of-pocket expenditure accounts for 28.7 per cent of the total health spending on health and this may be a reflection of the country's improved social health protection coverage. This figure is low compared OOP spending found in low-income countries in Africa and Asia, which ranges from 50–80 per cent of total health expenditure. [8] In terms of access deficit data, such is vital when developing and advocating strategies for universal coverage, given the close link between access to health services and lack of coverage in social health protection. [9] Thailand has a very low access deficit in terms of skilled attended births. It has only a percentage of the live births not attended by skilled health personnel at a given period of time (table 2).

[6] "Social health protection: An ILO strategy towards universal access to health care", 2007, p. 34.

[7] "Trends in infant mortality in the SEA region, by country, 1960–99", at www.searo.who.int/EN/Section1243/Section1382/Section1386/Section1898_9256.htm , 25 Sep. 2007.

[8] "Social health protection: An ILO strategy towards universal access to health care", 2007, p. 7.

[9] "Social health protection: An ILO strategy towards universal access to health care", 2007, p. 19.

Table 2. Background statistics, Thailand

Statistics	2000	2005	2006
Population, total (millions) [a]	61.4	64.2	64.7
Population growth (annual %) [a]	1.0	0.8	0.8
Life expectancy at birth, total (years) [a]	69.5	70.9	
Mortality rate, infant (per 1 000 live births) [a]	19.0	18.0	
GNI per capita, Atlas method (current US$) [a]	1 990.0	2 720.0	2 990.0
GDP (current US$) (billion) [a]	122.7	176.2	206.2
Total expenditure on health as a % of GDP (2004) [b]		3.5	
General government expenditure on health as % of total expenditure on health (2004) [b]		64.7	
Private expenditure on health as % of total expenditure on health (2004) [b]		35.3	
Social security expenditure on health as % of general government expenditure on health (2003, 2004) [d], [b]		32.0 [d] 10.2 [b]	
Out-of-pocket expenditure as % of private expenditure on health (2004) [b]		74.7	
Out-of-pocket as a % of total expenditure on health [c]		28.7	
Estimated access deficit (skilled attended birth) (%) [c]		1.0	

Sources: [a] World Development Indicators Database, April 2007; [b] www.who.int/whosis/whostat2007_6healthsystems_nha.pdf; [c] Social health protection: An ILO strategy towards universal access to health care, 2007; [d] http://www.who.int/whr/2006/annex/annex2.xls

A key feature in Thailand's socio-economic picture is its informal economy. It provides employment and income for the great majority of Thailand's working population. Of the estimated total workforce of 34 million, 20 million are part of the informal economy. Included in this group that lacks any formal social security are agricultural workers, homeworkers, casual construction workers, side street and market vendors, entertainment venue workers, domestic staff and other types of self-employed workers. [10]

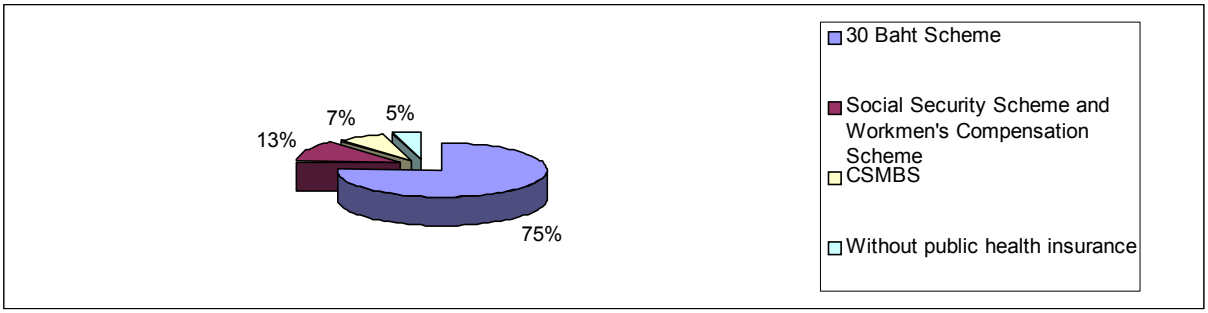
Overview of financing health protection in Thailand

Prior to the introduction of the Universal Health Care Scheme (UC), Thailand had a number of health financing schemes, namely the medical welfare, civil servants medical benefits scheme, social security scheme and the health card. Inefficiencies were prominent in almost all schemes for varying reasons including adverse selection, moral hazard and allocative inefficiency. Changes were made in the different schemes to expand coverage, however 30 per cent was still uninsured. [11] In 2001, the Thai government introduced the UC or the "30 baht scheme". This merged the publicly financed programmes–medical welfare scheme and the Voluntary Health Card Scheme. UC beneficiaries are those who do not belong to the Social Security Health Insurance scheme or SSO scheme (for private formal sector employees) or the Civil Servants' Medical Benefit Scheme (CSMBS) (for government, retirees and their dependents). It covers about 75 per cent of the population (figure 1). The UC's implementation was a political milestone in the country's effort to achieve full coverage of the population.

[10] "ILO technical note on the extension of social security to the informal economy in Thailand", 2004, p. 1.

[11] P. Hanvoravongchai and W. Hsiao: quoted in "Social health insurance for developing nations", World Bank, p. 145.

Figure 1. Thailand's public health insurance schemes coverage, 2004



Source: Hughes and Lethongdee, Universal coverage in the land of smiles: Lessons from Thailand's 30 baht reforms, Health Affairs 26, No. 4 (2007), p. 1001.

Specifically, finance for the UC comes from general tax revenue with minimal co-payment of 30 baht. CSMBS is also funded from general taxes while SSO scheme is financed through equally shared contributions from the insured (1.5 per cent of the salary); the employer and the government. The UC and the SSO are both compulsory schemes (table 3). For the SSO, all companies are compelled unless they can provide evidence that they can offer their employees better medical benefits from another scheme. As for Thailand's budget for health, in 2004, the ILO and the Thailand International Health Policy Programme undertook a budgeting exercise to produce a health budget model based on the modelling philosophy of the ILO's social budgeting models. It provided pragmatic "if then" projections and allowed the effects of changes in the health delivery and financing system to the overall national health expenditure and government's budgetary balance to be documented. [12]

Table 3. Summary of financing health protection in Thailand

Characteristics	Social security scheme	CSMBS	UC/30 baht scheme
Membership	Private employees	Government employees, public sector workers and their dependents that includes parents, spouses and children	Self employed and those not covered by CSMBS and SSS
Type	Compulsory	Fringe benefit	Compulsory
Financing			
Source	Contributions by employees, employers and the Government of 1.5 per cent of payroll each (reduced to 1 per cent since 2004)	General taxes	General taxes
Authority	Social Security Office	Ministry of Finance	National Health Security Office (NHSO)
Provider payment mechanism	Capitation (testing diagnostic related group payments for inpatient care)	Fee for service (testing diagnostic related group payments for inpatient care)	Global budget and capitation

[12] "Social health protection: An ILO strategy towards universal access to health care", 2007.

Characteristics	Social security scheme	CSMBS	UC/30 baht scheme
Benefits	Comprehensive package with: – outpatient and inpatient services in public and private facilities; – maternity benefits – immunization and health education – with cash benefits	Comprehensive package with: – outpatient services in public facilities; – inpatient services in public and private facilities (emergency cases only); – maternity benefits – annual physical check-up benefits	Comprehensive package with: – outpatient and inpatient services in public and private facilities; – maternity benefits – immunization and health education
Access to a provider	Through a contracted hospital or its network; with registration requirement	Member is free to choose a provider	Through a contracted hospital or its network; with registration requirement

As for access to health services, CSMBS members can choose their own provider, however, for UC and SSO, access is done through a contracted hospital or network. Access, through UC, commences with the registration of eligible persons with a network responsible for providing primary care to its registrants. There are designated district based network of providers composed of health centers, district hospitals and co-operating provincial hospitals. Members obtain free insurance cards and pay a co-payment (user fee) of 30 baht for each outpatient visit or hospital admission. A hospital is paid a capitation fee for each person registered. As a cost containment mechanism, the capitation fee is used to deliver a comprehensive benefit package except for few identified expensive cases for which a "special payment" schedule is applied. Personal preventive and health promotion services are included in the benefit package. Drugs on prescription are free of charge.

The National Health Security Office (NHSO) is the national purchaser and the hospital (contracted unit for primary care – CUP), the main contractor of health services. This describes the purchaser–provider split model. As a contractor the hospital should have at least a capacity of 100 beds. Apart from being a unit for beneficiary registration, it also serves as a gatekeeper of patients and cases. These hospitals are also allowed to subcontract services to smaller and more cost-effective providers such as polyclinics.

Is Thailand achieving its objectives?

Though not documented, the implicit health policy objective of Thailand is to improve the health status of the population through the promotion of pro-health policies, the provision of effective public health services and the ensuring of access to curative health care of adequate quality or all. [13] To provide universal coverage is key to achieving the implicit policy. This thrust through the UC thereby benefits the informal economy left out in the SSO and CSMBS schemes. Based on the concluded conference on Extending Social Health Insurance to Informal Economy Workers jointly organized by the GTZ, ILO, WHO and ADB, it was presented that as of 2006, Thailand's overall health insurance coverage is 97.8 per cent. From this, 75.3 per cent is UC's coverage and 22.5 per cent for SSO and CSMBS. It was also documented that from 2002–05, the outpatient utilization and hospitalization admission rates increased annually by 4.3 per cent and 2.2 per cent

[13] Quoted in "ILO technical note to Government: Financing universal health-care in Thailand" p. 7.

respectively. The NHSO's data also showed that the poor could access essential services more than the rich. [14]

What can we learn from the Thailand experience?

The experience shows that, for a developing country access to basic health care for all Thai people, including those in the informal economy, is attainable. Some of the lessons that can be drawn from the experience are the following: [15, 16]

- coordinated pluralistic health financings mechanisms can achieve universal access to health services in a realistic time frame;
- health-care financing and service delivery should be carefully prepared and designed prior to implementation;
- it is key to establish:
  - effective knowledge management mechanisms and sufficient long-term investment in human resources (capacity building and research) for system development and management;
  - effective decision-making mechanisms involving government ministries and taking into account voices of social partners, the poor and others;
  - effective policy communication such as the use of mass media;
  - strong political support and commitment;
- good governance and provision of resources for change;
- attainment of increased government spending on health;
- attainment of increase in fiscal space for sustainability such as the introduction of additional source of funding: proportion of taxes for tobacco and alcohol was earmarked to safeguard resources for health for poor members of the population during fiscal challenges;
- ensuring good governance including decision-making mechanisms, developing capacity building and communication policies towards the insured are a prerequisite of success.

Ghana

Located in West Africa, Ghana is a low-income agrarian nation endowed with natural resources. Ghana has twice the per capita output of the poorer countries in West Africa.

[14] P. Jongudosmsuk: quoted in "Managing rapid increase of health-care coverage in Thailand: What lessons can we learn?", Conference on Extending Social Health Insurance to Informal Economy Workers, October 2006.

[15] ibid.

[16] "Social health protection: An ILO strategy towards universal access to health care", 2007, p. 55.

However, Ghana is greatly dependent on international financial and technical assistance. It has an increasing income per capita and is above average in sub-Saharan Africa. Data shows a decreasing population growth rate and an improving life expectancy. Ghana's infant mortality rate (IMR) is lower than the IMR for sub-Saharan Africa (2004–05) which is 100/1,000 live births. [17] As for health expenditures, Ghana's total expenditure on health as a per cent of GDP in 2004 amounts to 6.7. Of this, 42.2 per cent accrues to the general government expenditure on health and 57.8 per cent for private expenditure. OOP as a per cent of total expenditure for health is 68.2 per cent. As for the access deficit in terms of skilled attended births, skilled health professionals are not able to attend to about half of the live births (53 per cent) at a given period of time. Access deficit to staff at the national level amounts to 66 per cent. This means that for every 100 population, 66 Ghanaians are not able to access a health professional.

Table 4. Background statistics, Ghana

Statistics	2000	2005	2006
Population, total (millions) [(a)]	19.9	22.1	22.5
Population growth (annual %) [(a)]	2.2	2.0	1.9
Life expectancy at birth, total (years) [(a)]	56.7	57.5	..
Mortality rate, infant (per 1,000 live births) [(a)]	68.0	68.0	..
GNI per capita, Atlas method (current US$) [(a)]	320	450	520
GDP (current US$) (billion) [(a)]	5	10.7	12.9
Total expenditure on health as a % of GDP (2004) [(b)]		6.7	
General government expenditure on health as % of total expenditure on health (2004) [(b)]		42.2	
Private expenditure on health as % of total expenditure on health (2004) [(b)]		57.8	
Out-of-pocket expenditure as % of private expenditure on health (2004) [(b)]		78.2	
Out-of-pocket expenditure as % of total expenditure on health [(c)]		68.2	
Estimated access deficit (skilled attended birth) (%)		53.0	
Estimated staff-related national access deficit (% of population)		66.0	

Sources: [(a)] World Development Indicators Database, April 2007, [(b)] www.who.int/whosis/whostat2007_6healthsystems_nha.pdf; [(c)] Social health protection: An ILO strategy towards universal access to health care, 2007.

The percentage of the population living below the national poverty line (39.5 per cent) [18] and the percentage of the population living on less than $2 per day and $1 per day (75 per cent and 45.1 per cent respectively) [19] reflect the most vulnerable members of the Ghanaian society needing social health protection. In addition, the informal employment represents over 90 per cent of total employment in Ghana. This sector comprises, among others, different types of vendors, farmers, small workshop/factory workers and agricultural labourers.

[17] Quoted in "IMR for sub-Saharan Africa", *The Little Data Book on Africa*, World Bank, 2006.

[18] CIA (1999 estimate), 2006.

[19] World Bank, 2006.

Overview of financing health protection in Ghana

The National Health Service in Ghana was introduced in 1957, a model that was based on the British system. Entitlement to free health care and services from publicly owned facilities were afforded to everyone but this entitlement, however, proved to be unsustainable as the country's economic performance declined. In 1985, co-payments were introduced to prevent the disintegration of the publicly funded services followed by the "cash and carry system" in 1992. The employment of user fees generally limited access, served as a disincentive to the utilization of health-care facilities and excluded the poorest. The voluntary mutual health insurance organizations (MHO)/community-based health insurance schemes (CBHI) were established in the early 1990s with the help of international donors and agencies to provide access and financial protection to those not covered by formal schemes and those affected by the implementation of user charges. After almost a decade, the MHOs/CBHIs proliferated and covered the larger sections of the population.

The dissatisfaction with the "cash and carry" financing system drove political parties in Ghana to pursue reforms. This came in the form of the National Health Insurance System (NHIS), which was passed by the Ghanaian Parliament in 2003 and operationalized in November 2004. The purpose of the policy is "to secure the provision of basic health-care services to persons resident in the country through mutual and private health insurance schemes; to put in place a body to register, license and regulate health insurance schemes and to accredit and monitor health-care providers operating under health insurance schemes; to establish a National Health Insurance Fund (NHIF) that will provide subsidy to licensed DHIMS; to impose a health insurance levy to provide for purposes connected with these". [20]

The NHIS is a decentralized national health insurance system that employs a district model. It includes various health schemes namely, the district mutual health insurance schemes (DMHIS) (district-based and state sponsored), private commercial health insurance schemes (private for profit schemes) and the private mutual health insurance schemes (community-based non-profit schemes). The NHIS policy called for the establishment of two national institutions namely the National Health Insurance Council (NHIC) and the NHIF. The NHIC, with the Ministry of Health, defines the national minimum benefit package, accredits medical providers in the health insurance system, approves and oversees the operations of the DMHIS, voluntary not-for-profit MHO and private insurers, and determines the premiums required. The DMHIS, MHO and private insurers are responsible for enrolment of residents, collection of premiums, payment of bills and negotiation with providers/provision of benefits.

Funding for the National Health Insurance Scheme is largely obtained from three sources: (1) 2.5 per cent value added tax (VAT) on goods and services, a health levy with some exclusions; (2) 2.5 per cent from payroll tax imposed on the formal sector employees to support the social security and pensions scheme; (3) an annual premium of 72,000 cedis for adult members of working age (formal sector employees who contribute to the social security do not have to pay the annual premium). In addition, there are also transfers from the state budget apportioned to the fund by the parliament, returns on investments made by the NHIC and contributions to the fund (e.g. grants, donations and other sources). Support from international donors and agencies help subsidize the health insurance premiums of selected indigents or those who cannot afford the full amount of the premium, mostly comprising of pregnant women and mothers with young children.

[20] "Ghana National Health Insurance System Act (L.1.1809)", 2003, p. 1.

An adult family member pays 72,000 cedis for premium to access a comprehensive benefit package for inpatient and outpatient care. For a family of five, the total cost amounts to 144,000 cedis. Children under 18 years old, those above 70 years old, indigents and pensioners are exempted from paying the premiums. The formal sector members are also excluded because 2.5 per cent of their salaries go the NHIF via the social security and pension scheme. The minimum benefit package covers most diseases in Ghana. Additional benefits may vary depending on the scheme but are most often dependent on the premiums. Provider payment is done through fee for service following an agreed upon tariff structure.

Accessing services through the health insurance system is initially through the primary health-care facility (health centres, district hospitals, polyclinics, private hospitals, clinics, maternity clinics, quasi public hospitals). The general patient department of a sole regional hospital in the area is also considered a primary health-care facility. The health services provided by these facilities as well as the referred cases (apart from those found in the exclusion list) are paid for by the DMHIS. Emergency cases are dealt with in any health facility.

Table 5. Summary of the Ghana's National Health Insurance System

	Source of funds	Premium	Benefits covered	Form of payment	Exclusions
National Health Insurance System (NHIS)	2.5 per cent VAT, health levy 2.5 per cent payroll tax from formal sector or the social security and pensions scheme funds Annual premium	72,000 cedis per adult family member 144,000 cedis per family of five	Comprehensive for inpatient, outpatient care, oral health services, eye-care services, maternity care and emergencies An exclusion list was made available for health-care services not covered under the minimum benefits under the NHIS	Fee for service	Children under 18 years of age Those above 70 years old Indigents Formal sector workers Pensioners

Mutual health organizations that existed before the NHIS, like the Nkoranza MHO, will have to adjust to the NHIS benefit package and the premium (72,000 cedis) as their minimum.

The health-financing schemes in Ghana were developed in close collaboration with international agencies. The ILO, known for its long-standing record of technical cooperation in the field of social protection, has established years of cooperation with the Government of Ghana. Policy and technical advice on various aspects regarding social security reform and the NHIS, including the determination of the financial feasibility of extending coverage to the poor are some of the activities that ILO extended to support the Government of Ghana. Specifically, the ILO has been providing broad advice on institutional structures, medium-term financing and implementation and supported the development of the health budget model that is currently being developed in more detail. It provides for medium-term projections of health expenditure and serves as a tool for policy planning. ILO likewise developed the conceptual framework for the Ghana Social Trust. This project aimed to support the development of a pluralistic health-care financing system and the extension of social protection benefits to excluded members of society especially those in the informal sector. A subsidization mechanism for the poor was developed to ensure that the general and financial governance mechanisms of the DMHIS are adequate to ensure their viability.

Is Ghana achieving its objectives?

Overall, the policy objective is to pool risks, reduce individual burden and to achieve better utilization rates. [21] The government of Ghana aims to incorporate 50–60 per cent of the residents into NHIS in the next five–ten years. Policy, systems and organizational interventions have been implemented to reach this five–ten year target, however, much needs to be done to attain the overall goal. Some of the accomplishments to facilitate access to health care include the development of the DMHIS. Majority of the DMHIS were formed in 2004 and 2005. Others have changed from existing MHOs to DMHIS and by the end of 2006,139 DMHIS were operational and were providing services. [22] As for coverage, 47 per cent of the national population has registered as of June 2007. Of this, more than half is exempted (63.7 per cent). Twenty per cent is from the informal sector and 9.6 per cent from the formal sector (table 6).

Table 6. Summary of the NIHS operational status, June 2007 [23]

Variable	Percentage
Registered to national population	47.0
Membership to national population	39.4
NHIS ID cards issued to national population	32.1

Variable	Percentage	Variable	Percentage
Children under 18 years to national population	20.4	Children under 18 years to total registered	9.5
SSNIT contributors to national population	4.5	SSNIT contributors to total registered	9.6
Indigent to national population	0.9	Indigent to total registered	1.9
Informal to national population	9.5	Informal to total registered	20.2
Exempt to total national population	29.9	Exempt to total registered	63.7

Source: National Health Insurance Secretariat, 2007.

Nevertheless, the situation also reflects that while the scheme is mandatory, enforcement is lacking. The deficiencies in administrative capacity severely impacts on the performance of the scheme thereby causing delays in enrolments, slow payments to providers and inadequate understanding of scheme by providers and insured.

What can we learn from the Ghana experience?

Since the implementation of the NHIS policy, some of the lessons can that can be appreciated include the following:

– The strong political commitment of government with the support of development partners towards pro-poor policies. This could be described by the Ministry of Health's vital role in supporting the development and implementation of the MHO. The current government was likewise key in eliminating the "cash and carry" system and in replacing it with health insurance. More recently this type of commitment also

[21] ILO: "Improving social protection for the poor: Health insurance in Ghana", Ghana Social Trust Pre-Pilot Project final report, 2005.

[22] A. Grüb: "Ghana – Social security schemes for health." p. 16.

[23] "Draft Strategic Plan of the National Health Insurance Secretariat", Aug. 2007, p. 35.

yielded the current form of the Ghana Health Insurance System. For the provision of technical and financial assistance, collaboration with international agencies and donors was, in the same token, essential.

– The approval of the NHIF in 2005 (77 per cent accounts for the national health insurance levy and 23 per cent from the Social Security and National Insurance Trust accounts) showed the commitment to mobilize funds for health care.

– Enforcement of legislation and development of staff capacity are important components for success during the implementation phase.

IV. Comparison of Thailand and Ghana

The table shows that, even if Thailand and Ghana are both developing countries and have considerable proportions of their population belonging to the informal economy, they have diverse characteristics. Though Thailand is almost three times more populous than Ghana, health outcomes in terms of life expectancy, infant mortality rate and access deficit are better. The economic performance of Thailand seems to be more promising. It, too, has a lower out-of-pocket expenditure which points to a functional health financing system thus providing financial protection to its constituents.

Table 7. Statistics of Thailand and Ghana

Statistics	Thailand	Ghana
Category	Developing	Developing
Informal economy	Approx. 59 per cent of the estimated total workforce	Over 90 per cent of total employment
Population, total (millions) (2006) [a]	64.7	22.5
Population density	Approx. 117 persons/km^2 (Thailand) Approx 5,111 persons/km^2 (Bangkok)	Approximately 79 persons/km^2 (Ghana)
Population growth (annual %) (2006) [a]	0.8	1.9
Life expectancy at birth, total (years) (2005) [a]	70.9	57.5
Mortality rate, infant (per 1,000 live births) (2005) [a]	18.0	68.0
GNI per capita, Atlas method (current US$) (2006) [a]	2 990.0	520.0
GDP (current US$) (billion) (2006) [a]	206.2	12.9
Total expenditure on health as a % of GDP (2004) [b]	3.5	6.7
General government expenditure on health as % of total expenditure on health (2004) [b]	64.7	42.2
Out-of-pocket as a % of total expenditure on health [c]	28.7	68.2
Social security expenditure on health as a % of general government expenditure on health [b] (2004)	10.2	
Estimated access deficit (skilled attended birth) (%) [c]	1.0	53.0

Sources: [a] World Development Indicators Database, April 2007; [b] www.who.int/whosis/whostat2007_6healthsystems_nha.pdf [c] Social health protection: An ILO strategy towards universal access to health care, 2007; [d] http://www.who.int/whr/2006/annex/annex2.xls

Political will and commitment were seen as necessary and common to both countries in the initiation and implementation of their health financing policies. As for their systems, both were geared towards improving coverage or attaining universal coverage, crafting a comprehensive benefit package and improving access to health services to reach those not formally covered or those in the informal economy. Thailand seemed to have had more experience with pluralism and formal health financing schemes (medical welfare, civil servants medical benefits scheme, social security scheme and the health card) compared to

Ghana. Their years of health financing experience possibly helped them pursue and operationalize their goal of universal coverage. Ghana's health financing experience, on the other hand, was diverse and limited. Financing schemes went from publicly funded provision of free health services to the utilization user fees. Though voluntary mutual health insurance was initiated, this only came in the early 1990s and the experiences varied from one scheme to the other.

V. Conclusion and next steps

The experience of the two countries shows that countries can successfully invest in affordable social health protection for the informal economy. Though they may have common health financing goals, their experiences varied due to their social, economic, historical and cultural contexts. This proves that replication of experiences are hardly possible. However, the lessons that these countries have obtained in terms of the process, the involvement and roles of key stakeholders and the policy content could be useful for other countries when choosing and designing health-care financing mechanisms to achieve universal coverage.

Another key conclusion the use of coordinated pluralistic financing mechanisms rather than one single scheme is important for achieving universal coverage and access to affordable health services. In addition, since targeting workers in the informal economy create enforcement challenges, related coverage plans need to be developed. The necessity to increase public funds, invest in good governance and create public awareness are important challenges to be anticipated. Likewise, strengthening national capacities for sustainable social health protection are prerequisites for success.

In achieving universal coverage in social health protection, ILO's strategy is to rationalize the use of pluralistic financing mechanisms. Different mechanisms simultaneously exist in a country, however, they are largely uncoordinated which leaves some groups or sub-groups of the population covered, uncovered or partly covered. In order to bridge this problem, the ILO suggests that countries develop strategies towards universal coverage by following these steps: [24]

(1) assessing the national coverage gap;

(2) developing a national coverage plan;

(3) strengthening national capacities.

Documentation of existing financing mechanisms in a given country and determination of the coverage gap are needed to assess the deficit in terms of the population's access to health services. This can be done through the conduct of national surveys with regional analysis of the formal legal coverage of each financing scheme. The next step is to develop a national coverage plan by taking stock of the advantages and disadvantages of all financing mechanisms that need to be addressed in the coverage plan. Linkages among the financing mechanisms should be developed to reduce limitations, create synergies and increase the extension of social health protection. The plan should also include the funds available for social health protection, policies for improving health financing mechanisms, well designed and adequate benefit packages, and mechanisms to achieve institutional and administrative efficiency. The last step concerns the need to strengthen national administrative and technical capacities through training; upgrading capacities in designing, implementing and monitoring; and knowledge development to achieve sustainable social health protection.

[24] "Social health protection: An ILO strategy towards universal access to health care", 2007.

References

Blomquist, J. (2004). "Cash transfers", retrieved 23 September 2007 from http://info.worldbank.org/tools/docs/library/70042/spring%202004/pdf/eng/blomquist.pdf

Central Intelligence Agency (CIA). (2006). "The world factbook: Ghana", from https://www.cia.gov/library/publications/

Grüb, A. (2007). "Ghana – Social security schemes for health", Accra, GNeMHO (unpublished).

Hanvoravongchai, P. and Hsiao, W. (2007). "Thailand: Achieving universal coverage with social health insurance. Social health insurance for developing nations", Washington DC, World Bank.

International Labour Organization (ILO) (2002). Resolution concerning decent work and the informal economy, International Labour Conference, 90th Session, Geneva, ILO.

—. (2002). "Decent work and the informal economy", International Labour Conference, 90th Session, Geneva, ILO.

—. (2004). Thailand social security priority and needs survey, Geneva, ILO.

—. (2004). ILO technical note on the extension of social security to the informal economy in Thailand, Geneva, ILO.

—. (2005). "Improving social protection for the poor: Health insurance in Ghana", The Ghana Social Trust Pre-Pilot Project Final Report, Geneva, ILO.

—. (2007). "Social health protection: An ILO strategy towards universal access to health care", Issues in social protection, Discussion Paper 19, Geneva, ILO.

Jongudosmuk, P. (2006). "Managing rapid increase of health-care coverage in Thailand: What lessons can we learn?", Conference on Extending Social Health Insurance to Informal Economy Workers. Manila, Philippines.

National Health Insurance Council Secretariat (2007). Draft Strategic Plan, Ghana

Ramachandra, S. and Hsiao, W. (2007). "Social health insurance for developing nations", Ghana: Initiating social health insurance, Washington DC, World Bank.

Scheil-Adlung, X. (2006). "Social security issues for workers in the informal economy", Conference on Extending Social Health Insurance to Informal Economy Workers, Manila, Philippines.

The Parliament of Ghana (2003). National Health Insurance System Act L.1.1809

United Nations Development Programme (UNDP) (1997). "Human development to eradicate poverty", Human Development Report 1997, New York, UNDP.

van Ginneken, W. (2004). "Extending social security: Policies for developing countries", ESS – Extension of Social Security Paper No. 13, Geneva, ILO.

WHO South-East Asia Regional Office. "Trends in infant mortality in the SEA region, by country, 1960–99", retrieved 25 September 2007 from www.searo.who.int/EN/Section382/Section1386/Section1891_9256.htm

World Bank (2006). *The Little Data Book on Africa*, retrieved 25 September 2007 from http://siteresources.worldbank.org/INTSTATINAFR/Resources/little_data_ebook.pdf.

—. (2006). *World Development Indicators 2006*, Washington DC, World Bank.

—. (2007). *World Development Indicators*, retrieved 20 September 2007 from http://web.worldbank.org/WSITE/EXTERNAL/DATASTATISICS/0,,contentMDK:20535285~menuPK:1192694~pagePK:64133150~piPK:64133175~theSitePK:239419,00.html

World Health Organization (WHO) (2004b). "Regional overview of social health insurance in South-East Asia", SEA-HSD-274 Regional Office for South-East Asia, New Delhi.

—. (2007). *World Health Statistics 2007*, retrieved 25 September 2007 from www.who.int/whosis/shostat2007_6heathsystems_nha.pdf