

Ghana – Social Security Schemes for Health

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Accra

March 2007

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Abbreviations:

Act 650	National Health Insurance Act 2003
AGM	Annual General Meeting
CHAG	Christian Health Association of Ghana
DA	District Assembly
DANIDA HSSO	DANIDA Health Sector Support Office
DCE	District Chief Executive
DWMHIS	District Wide Mutual Health Insurance Scheme
GHS	Ghana Health Service
GTZ	German Technical Co-operation
L.I.	Legislative Instrument 1809
MHO	Mutual Health Organization
NHIC	National Health Insurance Council
NHIF	National Health Insurance Fund
NHIL	National Health Insurance Levy
NHIS	National Health Insurance Scheme
PHRplus	Partnership for Health Reform Plus – USAID funded
RCC	Regional Co-ordinating Council
SSNIT	Social Security and National Investment Trust

Some basic facts and figures about Ghana



Ghana is located in West Africa near the equator and on the Greenwich meridian. It is bounded on the north and north west by Burkina Faso, on the east by Togo, on the south by the Atlantic Ocean, and on the west by the Ivory Coast.

Ghana's total area is 238,537 sq. km (92,100 sq. miles). The terrain is composed of plains and scrubland, rain forest and savannah. Ghana has a tropical climate but reaches the Sahel zone in the North.

Throughout the year, the climate in Accra is humid and hot with only slight variations in temperature between day and

night. The rainy seasons are from May to June and from September to November. Dry season is from December to April, but there may be occasional showers throughout the whole time of the year. The maximum daytime temperature in March is about 32-35 C, the lowest in August ranges from 24-28 C.

Ghana has a population of about 20.5 million at the end of 2006 as estimated from the 2000 Population and Housing Census. Its capital city is Accra. Other cities are Kumasi, Tema, Tamale and Sekondi-Takoradi. There are ten regions, i.e. the Northern, Upper West, Upper East, Volta, Ashanti, Western, Eastern, Central, Brong - Ahafo and Greater Accra Regions. Each region is sub-divided into distinct metropolitan, municipal and district assemblies, governed by a District Assembly (DA) and an administration headed by the District Chief Executive (DCE). The total number of the assemblies is 138, up from 110 in the year 2000.

The population growth is estimated at 2.0% annually. Life expectancy at birth is calculated at 57.2 years.

The official language of Ghana is English and is widely understood and spoken with a distinct Ghanaian accent. Akan with its dialects Twi, Fanti, Akwapim, Akim remains the most important lingua franca and is understood by more than 70% of the people. Other languages include Ga, Ewe, Dagbani, Hausa to name only some.

The currency is the Ghanaian Cedi (GHC) with an exchange rate of approximately 12,000.00 Cedi / 1.00 Euro as of middle of March 2007.2

The Worldbank mentions for 2005 a GNI in current US\$ of 10.5 billions and GNI per capita according to the Atlas method of 450.00 current US\$.

Statutory Social Security Scheme

After more than 10 years of discussing and testing different approaches to reduce the burden of user fees and of the so-called “Cash and Carry System” through the use of various alternative types of health service payment methods³ the “National Health Insurance Act (Act 650)” was passed by the Ghanaian Parliament in 2003. This act introduces a national compulsory social health insurance scheme covering all persons resident in Ghana, being them formal sector employees, civil servants, self-employed persons, farmers, housewives, students, children, pensioners, aged or any other person generally.

It became fully legally effective with the entry into force of the accompanying Legislative Instrument (L.I. 1809) on 4th November 2004.

This is “an Act to secure the provision of basic healthcare 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 healthcare providers operating under health insurance schemes; to establish a National Health Insurance Fund that will provide subsidy to licensed district mutual health insurance schemes; to impose a health insurance levy to provide for purposes connected with these.”⁴

It is the legal framework for the implementation of the national health insurance through:

The **National Health Insurance Council (NHIC)** as the regulatory body and

- **District Wide Mutual Health Insurance Schemes (DWMHIS)**,
- Voluntary not for profit mutual health organizations (**MHO**), and
- Private for profit health insurance companies,

which are the bodies enlisting members and providing benefits, that is access to health care and payment of such services rendered to their members.

The basic structures of the national health insurance council and a preferred district wide mutual health insurance can be drawn as shown below:

Diagram 1: The National Health Insurance Council and its Secretariat

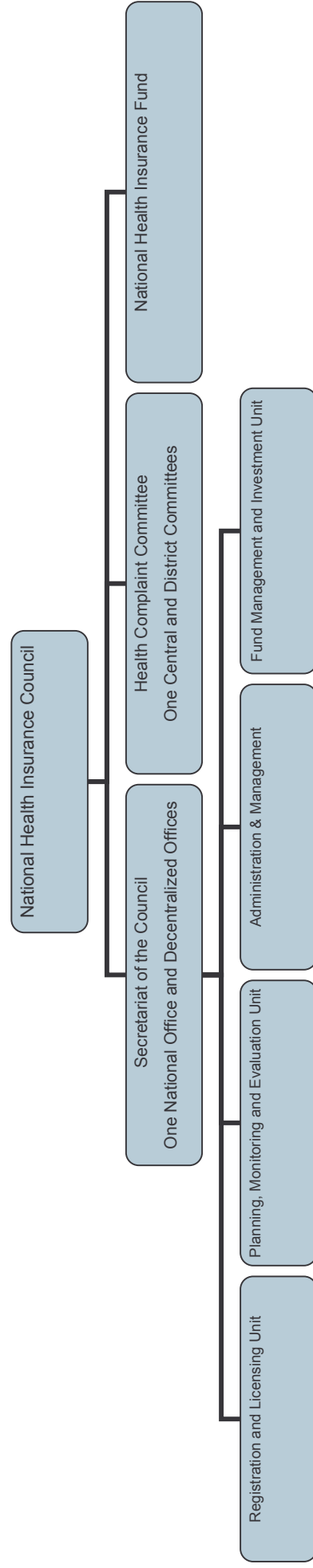
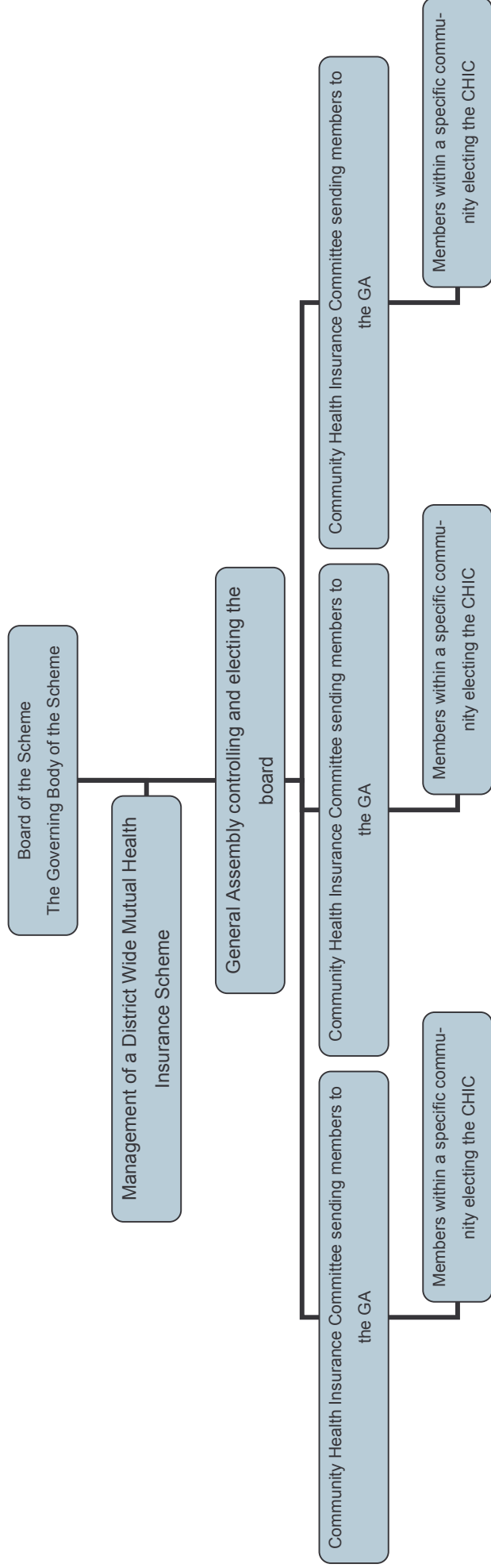


Diagram 2: District Wide Mutual Health Insurance Scheme Structure



Private not for profit MHOs usually implement a similar structure to that of the DWMHIS but may lack formalized community or otherwise locally based bodies. However, the formalized selection of representatives of local groups of people for the GA has always been part and parcel of the constitutions of MHOs. Private for profit health insurance schemes may structure themselves as they want and as the company act may permit.

The National Health Insurance Council

The NHIC is a body corporate under the Ministry of Health with the following “responsibilities:

- a) register, licence and regulate health insurance schemes;
- b) supervise the operations of health insurance schemes;
- c) grant accreditation to healthcare providers and monitor their performance;
- d) ensure that healthcare services rendered to beneficiaries of schemes by accredited healthcare providers are of good quality;
- e) determine in consultation with licensed district mutual health insurance schemes, contributions that should be made by their members;
- f) approve health identity cards for members of schemes;
- g) provide a mechanism for resolving complaints by schemes, members of schemes and healthcare providers;
- h) make proposals to the Minister [of Health, auth.] for the formulation of policies on health insurance;
- i) undertake on its own or in collaboration with other relevant bodies a sustained public education on health insurance;
- j) devise a mechanism for ensuring that the basic healthcare needs of indigents are adequately provided for;
- k) maintain a register of licensed health insurance schemes and accredited healthcare providers;
- l) manage the National Health Insurance Fund established under this Act;
- m) monitor compliance with this Act and Regulations made under it and pursue action to secure compliance; and
- n) perform any other function conferred upon it under this Act or that are ancillary to the object of the Council.”⁵

The Council is “composed of:

- a) a chairperson;
- b) a representative of the Ministry of Health not below the rank of a director;
- c) a representative of the Ghana Health Service not below the rank of a director;
- d) one representative of the Society of Private Medical and Dental Practitioners nominated by the Ghana Medical Association;
- e) one representative of the Pharmaceutical Society of Ghana;
- f) one representative each of licensed:
 - i. mutual health insurance schemes;
 - ii. private health insurance schemes;

- g) one representative of the Minister responsible for Finance not below the rank of a director;
- h) one legal practitioner with experience in health insurance nominated by the Ghana Bar Association;
- i) one representative of the National Insurance Commission;
- j) one person representing Organised Labour;
- k) two persons representing consumers one of whom shall be a woman;
- l) a representative each from
 - i. the Ministry of Local Government;
 - ii. Social Security and National Insurance Trust (SSNIT); and
- m) the Executive Secretary appointed”⁶

The Executive Secretary and the secretariat of the Council are charged with the day to day running of the national health insurance scheme by implementing the tasks spelled out in the Act.

It is this outfit which licenses health insurance schemes (DWMHIS, MHO, private commercial ones), accredits providers and monitors the performance of both of them.

It was also the secretariat that provided seed money for the creation of DWMHIS and still provides funds to cover for administrative expenditures and staff costs. It furthermore transfers the premiums for the exempt group (see below) to the schemes they are members of and may provide re-insurance monies for schemes which cannot pay for health care services rendered to their members without additional funding.

The National Health Insurance Fund:

The NHIF is the main means of financing healthcare expenditures through health insurance. It provides monies to the DWMHIS for special groups of members and as reinsurance when needed.

“Object of the Fund

- 77 (1) The object of the fund is to provide finance to subsidize the cost of provision of healthcare services to members of district mutual health insurance schemes licensed by the Council.
- (2) For the purpose of implementing the object, the monies from the fund shall be expended as follows:
- a) to provide subsidy as such level as the Council shall determine to district mutual health insurance schemes;
 - b) to reinsure district mutual health insurance schemes against random fluctuations on cost under conditions to be determined by the Council,
 - c) to set aside some monies from the Fund to provide for the health care cost of indigents;
 - d) to provide support to facilitate provision of access to health service;
 - e) to invest in any other facilitating programme to promote access to health service as may be determined by the Minister in consultation with the Council.

Sources of money for the Fund:

- 78 (1) The sources of money for the fund are as follows:
- a) the health insurance levy provided for under section 86;
 - b) two and one half percent of each person’s seventeen and one half percent contribution to the Social Security and Pensions Scheme Fund;
 - c) such money that may be allocated to the Fund by Parliament;
 - d) money that accrues to the Fund from investments made by the Council; and
 - e) grants, donations, gifts and any other voluntary contribution made to the Fund.”⁷

The National Health Insurance Levy mentioned is a VAT kind levy of 2.5% on selected goods and services. It is estimated to provide up to 100 million Euro annually to the NHIF. These monies are collected by the governmental VAT service and should then be transferred to the NHIF.

The contributions transferred from SSNIT, that is the pension scheme for formal sector employees, is 1/7 of the monthly contributions to SSNIT or 2.5% of the monthly value of gross wages paid to formal sector employees. These contributions are considered health insurance

premium paid by formal sector employees on a monthly base and then distributed through the NHIF to DWMHIS in lieu of personal premium payments.

Although it currently reduces the money collected by the Pension scheme, the government has assured SSNIT members that this transfer to the National Health Insurance Fund will not reduce the value of individual pensions later on.

In 2005 SSNIT transferred an amount of approximately 23 million Euro to the NHIF and in 2006 the transfer rose to approximately 34 million respectively⁸.

The National Health Insurance Scheme Benefit Package:⁹

“The healthcare services specified in this Part are the minimum healthcare benefits under the national health insurance scheme and shall be paid for by the schemes.

1. Out-patient Services

- (1) Consultations including reviews: These include both general and specialist consultations
- (2) Requested investigations including laboratory investigations, x-rays and ultrasound scanning for general and specialist out-patient services
- (3) Medication, namely prescription drugs on National Health Insurance Scheme Drugs List, traditional medicines approved by the Food and Drugs Board and prescribed by accredited medical and traditional medicine practitioners
- (4) HIV/AIDS symptomatic treatment for opportunistic infection
- (5) Out-patient / Day surgical operations including hernia repairs, incision and drainage, haemorrhoidectomy
- (6) Out-patient physiotherapy

2. In Patient Services

- (1) General and specialist in-patient care
- (2) Requested investigations including laboratory investigations, x-rays and ultrasound scanning for in-patient care
- (3) Medication, namely prescription drugs on National Health Insurance Scheme Drugs List, traditional medicines approved by the Food and Drugs Board and prescribed by accredited medical and traditional medicine practitioners, blood and blood products
- (4) Cervical and breast cancer treatment
- (5) Surgical Operations
- (6) In-Patient physiotherapy
- (7) Accommodation in general ward
- (8) Feeding (while available)

3. Oral Health Services including

- (1) Pain relief which includes incision and drainage, tooth extraction and temporary relieve
- (2) Dental restoration which includes simple amalgam fillings and temporary dressing

4. Eye care services including

- (1) Refraction

- (2) Visual fields
 - (3) A – Scan
 - (4) Keratometry
 - (5) Cataract removal
 - (6) Eye lid surgery
5. Maternity Care including
- (1) Antenatal care
 - (2) Deliveries, namely normal and assisted
 - (3) Caesarean section
 - (4) Postnatal care
6. Emergencies
- (1) Medical emergencies
 - (2) surgical emergencies including brain surgery due to accidents
 - (3) paediatric emergencies
 - (4) obstetric and gynaecological emergencies including Caesarean sections
 - (5) Road traffic accidents
 - (6) industrial and workplace accidents
 - (7) dialysis for acute renal failure
7. Accessing services under the health insurance system
- (1) The first point of attendance, except in cases of emergency, shall be a primary health care facility, which includes Community based health planning and Services (CHPS), health centres, district hospitals, polyclinics or sub-metro hospitals, quasi public hospitals, private hospitals, clinics and maternity homes
 - (2) In localities where the only health facility is a Regional Hospital, the general patient department shall be considered a primary healthcare facility
 - (3) All health care services provided in these facilities shall be paid for by the District Mutual Health Insurance Schemes (DMHIS)
 - (4) In cases where the services are not available, all referred cases other than those in the exclusion list shall be paid for by the DMHIS
 - (5) Emergencies shall be attended to at any health facility

Exclusion List

- 1 The healthcare services specified in this Part of the this schedule are not covered under the minimum benefits available under the National Health Insurance Scheme.
- 2 Health Insurance schemes may decide to offer any of these as additional benefits to their members

Excluded are the healthcare services that fall under any of these groups:

- (a) Rehabilitation other than physiotherapy
- (b) Appliances and prostheses including optical aid, hearing aids, orthopaedic aids, dentures
- (c) Cosmetic surgeries and aesthetic treatment
- (d) HIV retroviral drugs
- (e) Assisted reproduction e.g. artificial insemination and gynaecological hormone replacement therapy
- (f) Echocardiography
- (g) Photography
- (h) Angiography
- (i) Orthoptics
- (j) Dialysis for chronic renal failure
- (k) Heart and brain surgery other than those resulting from accidents
- (l) Cancer treatment other than cervical and breast cancer
- (m) Organ transplantation
- (n) All drugs that are not listed on the NHIS drugs list
- (o) Diagnosis and treatment abroad
- (p) Medical examinations for purposes of visa applications, educational, institutional, driving license
- (q) VIP ward (accommodation)
- (r) Mortuary services

Free Public Health Services

The following healthcare services are free:

- (a) Immunization
- (b) Family planning
- (c) In-patient and out-patient treatment of mental illnesses
- (d) Treatment of Tuberculosis, Onchocerciasis, Buruli Ulcer, Trachoma and
- (e) Confirmatory HIV test on AIDS patients

It should further be mentioned that the Ministry of Health is offering free antenatal care with up to 4 visits for all pregnant and is supporting supervised deliveries in selected regions.

However, there have been constant complaints by health care providers that the monies due for these services do not reach them either in time or at all.

It is estimated that the benefits as spelled out in the L.I. cover for 90% of all health care services provided to ill people.

The current form of payment of these services is itemized "fee for service" although other payment methods including capitation or DRG could be used in the future.

District Wide Mutual Health Insurance Schemes:

This is the preferred type of health insurance scheme of the act. One DWMHIS is to be established in each district, municipal or metropolitan assembly area. In case of metropolitan areas with large numbers of inhabitants, sub-metro health insurance schemes may be created instead of only one central scheme.

Every DWMHIS is to be registered with the Registrar General as “Company limited by Guarantee” and is as such an independent economic and legal entity. After having passed this registration the DWMHIS has to apply for a license from the National Health Insurance Council before it is allowed to start providing benefits to its members.

At the end of 2006 there are 139 such DWMHIS in place providing benefits to their members while in some nine newly created districts the preparations are ongoing to also install a DWMHIS.

The majority of DWMHIS was created in 2004 and 2005 while some 20 changed from already existing MHO status to DWMHIS status with the support of the Ministry of Health, the NHIC, District, Municipal and Metropolitan Assemblies, the Ghana Health Service and development partners like the DANIDA HSSO, USAID and GTZ.

139 schemes provided benefit services in 2006.

Structure of the DWMHIS

It is an autonomous body constituted by:

- The General Assembly (Act 650 (54))
- The Board of Directors / Trustees (L.I. 1809 (11))
- The Scheme Management Team
- Community Health Insurance Committees from which delegates will be elected to represent the members at the General Assembly.

General Assembly and Board are responsible for the direction of policies of the scheme and for the appointment of employees.

To ensure the representation of important social groups within the board, it is usually structured as follows:

- One representative of the local council of churches
- One representative of the Muslim community
- One representative of the traditional authorities, i.e. of the local chiefs and gates
- At least one representative of women groups
- One representative of the District Assembly
- The District Planning Officer
- The District Director of Health Services
- An officer of the District Department of Social Welfare

- One representative from the department of Community Development
- One representative of the local banking institutions
- The Scheme manager being the secretary to the board¹⁰

The Scheme Management Team furthermore shall consist of the scheme manager, an information systems manager, a claims manager, a public relations officer and an accountant. They are there to run the day to day operations of the scheme, while scheme manager and board are requested to keep the members of the scheme always informed about the financial as well as service delivery situation.

It is hoped that the members of the community health insurance committees would provide for the necessary transmission to the communities.

Eligibility for membership

- It is compulsory for every person resident in Ghana to become a member of either one of the three health insurance schemes. However, MHOs and private commercial companies have the right to reject applications for membership while the DWMHIS has to accept any resident applying for membership, provided he is willing to pay the fees and premium as anybody else.
- To cover children under 18 years of age under the NHIS both parents have to be legal members of a DWMHIS.
- Formal sector employees (SSNIT contributors), pensioners under the social security pension fund (SSNIT), and persons aged above 70 should register with the DWMHIS to receive benefits without paying premiums – however, they have to pay a registration fee for themselves and their children, while their spouses will have to pay premium and registration fee provided they are not SSNIT contributors themselves.

The premiums for these groups of people, usually called exempt group, are covered by the NHIL and transfer payments from SSNIT provided that they register with a DWMHIS. In case they register with either a MHO or a private commercial health insurance the governmental subsidies will not be paid on their behalf and they will have to pay all premiums and administrative fees themselves.

- In case both parents or a confirmed single parent register with a DWMHIS all their children under 18 years of age are to benefit fully after having paid the registration fees only. Children under 18 years of age are also considered to be members of the exempt group and their premiums are also provided for by the NHIF.
- Indigents and their families are to be identified by each DWMHIS by nation wide criteria spelt out in the L.I. and to be enrolled without any payments be it premiums or administrative fees. To identify indigents the L.I. spells out a means test shown below.
- To receive benefits everybody else, that are all persons above 18 years of age, being from

the informal sector have to register with a scheme by paying registration fees and premiums. Their children under 18, of course, are covered under the same conditions as mentioned above, provided they register with a DWMHIS.

Means Test for Indigent Persons

- “A person shall not be classified as an indigent under a district scheme unless that person
 - is unemployed and has no visible source of income
 - does not have a fixed place of residence according to standards determined by the scheme
 - does not live with a person who is employed and who has a fixed place of residence, and
 - does not have any identifiable consistent support from another person
- However, if more than 0.5% of the members of a DWMHIS are registered as indigents, there will be an independent inquiry into their eligibility.”¹¹

Contributions / Funding

- The amount of premium transferred from the NHIF to the DWMHIS for each fully registered member of the exempt groups has changed over the years. The 2005 rate was calculated at ₵80,000.00 (about €7.00) per person, while in 2006 an average of ₵100,000.00 (€8.50) seems to have been transferred. Another increase to about ₵120,000.00 (€10.00 Euro) is expected in 2007. Support to administrative and staff costs have come additionally.
- For persons from the informal sector the NHIC has suggested that they should pay premiums according to estimated income levels. These suggested premiums range from approx. €6,00 to €40.00 per adult and year, i.e. a family premium of not less than €12,00 and not more than €80.00.
- A registration fee of approx. €1.50 to €2.00 is charged for each person either of the informal sector or the exempt group. Indigents, however, are free.
- Only some DWMHIS in the metropolitan areas of Accra, Kumasi and Sekondi/Takoradi have implemented a stratified premium of €6.00 to €40.00.
- Most schemes have chosen to ask for a flat rate premium that is adjusted annually by the General Assembly of the schemes. In 2006 the majority of schemes charged €6.00 plus registration fees per person from the informal sector. A family registration including the average number of 3 children under 18 would then result in an annual health insurance family payment of about €22.00.

This sum has changed to about €10 for a grown up while the registration remained rather constant. Thus the family payment may now reach €26.00 to €30.00 creating a problem

for those who could hardly pay the former sum.

Performance of DWMHIS in 2006

2006 has seen a considerable increase in the number of registered members of DWMHIS. Through their implementing agencies, i.e. the DWMHIS, the national health insurance scheme has reached more than 6 million people from all over Ghana. 4 million of them could access healthcare services in 2006 without bothering to pay upfront or at all. The remaining ones are either still in the primary waiting period of up to six months or may not have received their ID card yet due to technical difficulties.

According to information provided by various DWMHIS to the “Network of Mutual Health Organizations of Ghana” and to information provided by the Ghana Health Service for 2006, the rate of visits to healthcare providers per person and year has increased considerably for insured as well as non-insured persons although insured persons access healthcare services considerably more often than their non-insured fellows.

Data from schemes show that the average number of visits of members per head and year ranges between 1.00 and 3.10 with the average closing in on 2 visits per head and year. The national average is estimated at approximately 0.5 visits.¹²

Brong Ahafo and Eastern Region seem to be still ahead of other regions when it comes to the ratio of insured persons compared to the population. This may be because they had started to create district oriented MHO earlier than other regions, but the gap is narrowing. With support from DANIDA HSSO for training and basic equipment and USAID support for training the three northern regions and the Ashanti region followed, while in the remaining regions the majority of DWMHIS only started in 2004 and 2005 respectively. Their schemes however also received training support from DANIDA through 2006.

Support was also provided by the ILO’s “The Ghana Social Trust pre-Pilot Project”¹³ to help in the considerations of financial sustainability of the scheme and in relation to the identification of indigents and people who cannot pay the amount of €6.00 fully.

Last but not least the support from the Ghana Health Service and the Faith Based Healthcare Providers (to name the Christian Health Association of Ghana as their national association) has to be fully acknowledged. Without their initial and continuous initiatives and support the idea of health insurance would not be nearly as vibrant as it currently is. The GHS Regional Health Insurance Co-ordinators have provided immense continuous support to the schemes and provide for regular meetings where scheme representatives and service providers can discuss and solve problems and complaints related to the quality, quantity and costs of healthcare services provided.

Performance of DWMHIS in 2006:

Region	Population	Legal members	Members with ID cards benefiting
Ashanti	3,924,425	1,171,972	691,220
Brong Ahafo	1,968,205	1,153,177	924,985
Central	1,687,311	484,374	180,977
Eastern	2,274,453	746,799	632,327
Gt. Accra	3,576,312	624,289	436,164
Northern	1,790,417	553,514	325,956
Upper East	963,448	227,317	157,416
Upper West	581,866	172,680	104,026
Volta	1,636,462	330,489	218,395
Western	2,042,340	552,548	302,350
	20,445,239	6,017,159	3,973,816

Source: National Health Insurance Council Secretariat, March 2007

Region	Members from the In-formal sector fully paid	SSNIT	Pensioners	Under 18	Aged: 70 and above	Indigents	Members / population
Ashanti	22.2%	11.4%	2.9%	53.5%	8.8%	1.3%	29.9%
Brong Ahafo	34.1%	5.8%	0.4%	51.2%	6.3%	2.1%	58.6%
Central	13.4%	15.5%	1.8%	58.2%	9.3%	1.8%	28.7%
Eastern	25.1%	10.6%	1.2%	52.6%	9.1%	1.5%	32.8%
Gt. Accra	26.2%	26.3%	1.7%	37.1%	6.2%	2.5%	17.5%
Northern	16.1%	16.3%	3.7%	47.7%	11.2%	5.0%	30.9%
Upper East	20.3%	11.7%	2.6%	43.1%	13.9%	8.4%	23.6%
Upper West	21.2%	10.2%	1.1%	48.4%	15.8%	3.3%	29.7%
Volta	13.6%	10.9%	1.8%	53.1%	17.6%	3.0%	20.2%
Western	21.9%	14.0%	0.9%	57.2%	5.2%	0.7%	27.1%
Average	23.4%	12.7%	1.8%	50.9%	8.9%	2.3%	29.4%

Source: National Health Insurance Council Secretariat, March 2007, own calculations

Unfortunately, there is currently no distinctive reporting which children under 18 years of age belong to which parents. Thus information is not readily available about the aggregate rate of informal sector or indigent membership.

Not for Profit Mutual Health Organizations

Until the passing of Act 650 all not for profit insurance schemes in Ghana could have been defined as mutual health organizations. They were fully owned by their members, which annually elected or confirmed a board to oversee the day to day running of the scheme.

Two major types of schemes competed for members. Type 1 can be described as oriented towards a local, clearly defined community or group of people be it inhabitants of the same village or traditional area, migrants from the same area of origin, women and children only, members of a co-operative union of producers or members of credit unions. Within this group of insurance schemes we also have to mention associations of professionals (like the civil servants associations) providing services only to a clearly defined group of persons or school schemes, that provided primary health care services for its student and teacher population.¹⁴ Type 2 of MHOs can be described as oriented towards a larger geographical area, that is either the target area of an hospital or the area of a district. These were the predecessors of the DWMHIS.

Both types of MHOs provided support mainly for “low risk - high cost” conditions or catastrophic expenses, i.e. hospital admissions or referral to regional and teaching hospitals. OPD treatment was hardly covered at all, although some MHOs provided some support in case of exceptional high OPD costs incurred by one of their members.

As the Act requests that all health insurance schemes, whether DWMHIS, not-for-profit MHOs or private for profit ones have to provide at least the minimum benefit package shown above, many of the type 1 schemes stopped providing benefits to members. Some of them became community units within a larger DWMHIS while others supported their members to become full members of DWMHIS by subsidizing the premium and fee payments.

Others, mainly the three Civil Servants Associations Health Insurance Schemes of Upper West, Ashanti and Eastern Region understand their current benefit package as an add-on benefit to the minimum benefit package their members receive as members of a DWMHIS. They may add coverage for children up to the age of 25 provided that they are still pursuing education or formal training. They may also offer partial contributions for excluded treatments, but usually do not provide full cost coverage.

To provide this additional benefit CSAs usually request the payment of a monthly contribution of about €0.8 per civil servant. They are currently running in problems as the former solution that these premiums were deducted at source, that is by the national accounts departments, was stopped by the department about a year ago. They are now trying to find ways to collect these premiums on their own, incurring higher cost than before.

Four school health insurance schemes continue to provide OPD healthcare services at the school compound during school terms as before. They are as before financed through PTA dues.

It is not yet clear on whether these insurance schemes will receive a full license due to the fact that they do not provide the complete minimum benefit package as prescribed in the Act.

Type 2 schemes mostly changed their status from not for profit MHO to DWMHIS and provide the full benefit package by now.

Contracting

Act 650 provides that “in determining the tariffs to be paid to health care facilities and the schemes, the Council shall consult the facilities and the schemes.”¹⁵

A memorandum of understanding between providers and NHIC concerning services provided and prices charged was agreed upon in 2004. It provided the basis for contracts between schemes and facilities.

As the DWMHIS and the MHOs are independent companies they usually sign separate contracts with each facility where their members may access services. These contracts state the kind of services provided by the facility: OPD, admission, laboratory, x-ray, prescription drugs, etc., and the prices that the service provider will charge and the scheme will pay for. As the schemes are district bound their contracts are mostly with the facilities in their respective districts but may also be concluded with facilities in the neighboring districts. Contracts with referral hospitals at regional and national level have also been signed.

The NHIC is currently preparing for a new tariff that will replace the 2004 agreement and will then be the basis for future contracts between DWMHIS and accredited providers.

Challenges

Poverty Reduction

Although understood and planned as major means to improve accessibility of healthcare services especially for the poor and vulnerable, the experience of the first years has not really shown that those persons become members of schemes in big numbers.

The means test for indigents covers almost nobody in Ghana, as with the exception of very few persons, almost everybody has some support from irregular income or relatives.

Many people may be excluded as they do not qualify as indigents, but do not earn enough to pay the registration fees and premiums for themselves and their family members.

Increasing flat rates asked for by DWMHIS outside the metropolitan areas exclude even more people from becoming members of health insurance schemes.

It will be necessary to explore other ways to define indigents or to provide support to very poor people at least. Some schemes have started to include all relevant social groups in their district (i.e. traditional chiefs, welfare officers, teachers, assembly members, church communities, community health insurance committee members and others) in the decision making process on who should be considered indigent and be treated as such.

However, this may not solve the problem of priority given to health insurance by poor families. We have realized that there are families with similar annual incomes that become insurance members while others say they cannot afford it. Schemes have not yet found always successful ways to deal with this problem as it seems to be a Ghanaian social trait not to blame somebody for bad decisions, that is having other priorities than prepare for healthcare expenditures in time.

Equity

As mentioned above only few schemes implement the graduated premium system that allows to assess the premium of a prospective member according to his or her income. Flat rates usually support better off persons, while worse off persons loose. A discussion about flat rates versus graduated premiums will have to be initiated so that members and the general public may understand the problem as one, that seems to lead to ever increasing flat rates, reducing the chances of poor people to join, while not solving the problem of equity. The main source of funding, i.e. the National Health Insurance Levy, does not really support improved equity as is the case with all indirect taxes.

Increased Usage and fraudulent use of services:

There are widespread rumors and some confirmed cases that members of schemes fraudulently access healthcare services. Fraudulent use includes impersonation, visits to multiple healthcare services for the same case even within the same day, or showing up with symp-

toms of somebody else only to hand over the prescription drugs to that usually uninsured person. Helping out uninsured relatives seems to be a widespread activity, for which nobody can be blamed really, or so they say.

NHIC, schemes, providers and other stakeholders are trying to find solutions to this problem. Some hope that better claims management, i.e. computerized and centralized claims management, will reveal fraudulent use, others think that only social control and an understanding of ownership among the members of a scheme may lead to a reduction of this type of fraud.

Provider hazard

There are reports and rumors that providers or their staff ask for illegal payments from insured persons. Other reports show an increase in the number of drugs and services prescribed or of possibly medically unnecessary referrals to specialist treatment. The request for revisits has increased even for cases of simple malaria.

Ownership of Schemes

Before Act 650 the creation of an MHO usually was an answer to the felt need of many people to improve accessibility to healthcare services. Most of the scheme members understood themselves as the owners of the scheme, being responsible for its sustainability, exerting at least some control over members using up too many resources.

They may also have voluntarily started activities to curb preventable diseases, especially malaria through environmental measures.

Although legally owned by its members and non-partisan in principle, the relationship between the DWMHIS and its members seems to be different from those of MHOs.

Many may see it as a purely governmental or political institution that does not deserve respect, but should provide as often as wished for.

Politics

Although non-partisan in principle health insurance in Ghana has always been a political issue. This has resulted either in undue pressure on boards and managements to follow and implement political party decisions or in objections to become members.

Conclusion

Ghana has put in motion an impressive national health insurance scheme. It has drawn from the experience of many community based and owned insurance experience.

The law makers have tried, and to a large extent successfully, to put these experiences in a legal framework.

The number of people after just two years of being in place is higher than expected or even hoped for at the beginning.

However, challenges remain and it would be interesting and useful to compare the experiences made with experiences made in other countries under different conditions.

Appendix 1: Ghana Data Profile

Ghana Data Profile	2000	2004	2005
People			
Population, total	19.9 million	21.7 million	22.1 million
Population growth (annual %)	2.2	2.1	2.0
Poverty headcount ratio at national poverty line (% of population)	..	..	..
Life expectancy at birth, total (years)	56.7	57.2	..
Fertility rate, total (births per woman)	4.6	4.2	..
Mortality rate, infant (per 1,000 live births)	68.0	68.0	..
Mortality rate, under-5 (per 1,000)	112.0	112.0	..
Births attended by skilled health staff (% of total)	..	..	..
Malnutrition prevalence, weight for age (% of children under 5)	..	..	..
Immunization, measles (% of children ages 12-23 months)	84.0	83.0	..
Prevalence of HIV, total (% of population ages 15-49)	..	..	2.3
Primary completion rate, total (% of relevant age group)	..	65.4	72.1
School enrolment, primary (% gross)	80.5	81.4	88.4
School enrolment, secondary (% gross)	37.4	41.8	43.6
School enrolment, tertiary (% gross)	2.8	3.1	..
Ratio of girls to boys in primary and secondary education (%)	89.4	90.6	92.6
Literacy rate, adult total (% of people ages 15 and above)	..	57.9	..
Environment			
Surface area (sq. km)	238.5 thousand	238.5 thousand	238.5 thousand
Forest area (sq. km)	60,940.0	..	55,170.0
Agricultural land (% of land area)	63.5	..	..
CO2 emissions (metric tons per capita)	0.3	..	..
Improved water source (% of population with access)	..	75.0	..
Improved sanitation facilities, urban (% of urban population with access)	..	27.0	..
Energy use (kg of oil equivalent per capita)	397.0	..	..
Energy imports, net (% of energy use)	25.4	..	..
Electric power consumption (kWh per capita)	305.8	..	..
Economy			
GNI, Atlas method (current US\$)	6.5 billion	8.2 billion	10.0 billion
GNI per capita, Atlas method (current US\$)	330.0	380.0	450.0
GDP (current US\$)	5.0 billion	8.9 billion	10.7 billion
GDP growth (annual %)	3.7	5.8	5.8
Inflation, GDP deflator (annual %)	27.2	14.1	14.8
Agriculture, value added (% of GDP)	36.0	37.9	38.8
Industry, value added (% of GDP)	25.4	24.7	24.6
Services, etc., value added (% of GDP)	38.6	37.4	36.6
Exports of goods and services (% of GDP)	49.0	34.5	30.4
Imports of goods and services (% of GDP)	67.5	54.4	49.5
Gross capital formation (% of GDP)	24.0	27.9	29.6
Revenue, excluding grants (% of GDP)	..	36.5	..
Cash surplus/deficit (% of GDP)	..	-2.9	..
States and markets			
Time required to start a business (days)	..	85.0	81.0
Market capitalization of listed companies (% of GDP)	10.1	29.8	12.9
Military expenditure (% of GDP)	1.0	0.8	0.7
Fixed line and mobile phone subscribers (per 1,000 people)	17.2	92.7	..
Internet users (per 1,000 people)	1.5	17.0	..
Roads, paved (% of total roads)	..	..	..
High-technology exports (% of manufactured exports)	1.9	..	..
Global links			
Merchandise trade (% of GDP)	93.3	74.0	71.2
Net barter terms of trade (2000 = 100)	100.0	123.4	..
Foreign direct investment, net inflows (BoP, current US\$)	166.0 million	139.3 million	..
Long-term debt (DOD, current US\$)	5.3 billion	5.9 billion	..
Present value of debt (% of GNI)	..	32.3	..
Total debt service (% of exports of goods, services and income)	15.6	6.6	..
Official development assistance and official aid (current US\$)	600.4 million	1.4 billion	..
Workers' remittances and compensation of employees, received (US\$)	32.0 million	82.0 million	..
Source: World Development Indicators database, April 2006			

The reports mentioned under endnotes 3, 13, and 14: Atim et. al are added in a zip file to this report.

An electronic copy of the Act 650 and the LI were already provided before to Mr. Leger.

¹ Source: www.ghanadistricts.com/home/?_id=27

² Source: www.ghanatoday.com

³ C.f.:

Atim, Chris et al: Technical Report No. 50: An External Evaluation of the Nkoranza Community Financing Health Insurance Scheme, Ghana, Bethesda, MD., (PHR – Partnership for Health Reform), 2000

Atim, Chris et. al. : A Survey of Health Financing Schemes in Ghana, Bethesda, MD. (PHRplus – Partners for Health Reform), 2001

Anie, Dr. Sylvia J. et al: Mutual Health Organizations: Working Paper: A Quality Information Survey in Ghana, Bethesda, MD. (PHRplus), 2001

⁴ National Health Insurance Act, 2003 (ACT 650), Accra (Assembly Press) 2003: 5

⁵ ACT 650: 2(2), p. 6

⁶ ACT 650: 3(1), pp. 6,7

⁷ ACT 650: p. 26

⁸ Daily Graphic of 20 March 07, p.48: that is ₵272.3 billion in 2005 and ₵409.7 billion in 2006

⁹ L.I. 1809: National Health Insurance Regulations, 2004: pp. 47-50

¹⁰ This sample was taken from the Constitution of the Asikuma Odoben Brakwa District Mutual Health Insurance Scheme. Similar provisions can be found in almost all constitutions of DWMHIS.

¹¹ L.I. 1809: p. 26 f.

¹² Data was provided by Asikuma Odoben Brakwa HIS, Pru HIS, Berekum HIS, Bole HIS, Gonja West HIS, the Eastern Regional Health Insurance Support Office Koforidua, the Brong Ahafo and Greater Accra Regional Health Directorates of the GHS

¹³ ILO: Improving Social Protection for the Poor: Health Insurance in Ghana. The Ghana Social Trust pre-Pilot Project. Final Report, Geneva 2005

¹⁴ see 3 above

see also: Sabi, W.K.: Mandatory Community-based Health Insurance Schemes in Ghana: Prospects and Challenges. Cape Town (MPH thesis, School of Public Health and Family Medicine), 2005

Asafo-Adjei, Veronica: Social Security Systems for the Excluded Majority: the Extension of Health Insurance to the Informal Sector in Ghana. Bochum (Ruhr University, Master Thesis), 2004

Atim, C., P. Apoya & W. Sabi: Initial Lessons from the Passage and Implementation of Ghana's NHIS Law (Act 650). Manila (Conference on "Extending Social Health Insurance to Informal Economy Workers"), 2006

¹⁵ LI 1809 (37): p. 18