B5 | ACHIEVING A SHARED GOAL: FREE UNIVERSAL HEALTH CARE IN GHANA[1]

There has been considerable interest in the progress achieved in Ghana in sustaining its health system through innovative financing mechanisms. This chapter takes a critical look at some recent data to come to an informed conclusion.

> 'I still look at the picture of my child and feel a sense of deep sadness. If we could have afforded the hospital or the medicines would my daughter still be alive?' Samata Rabbi (50), whose youngest child Francesca died recently aged five years. The family could not afford to pay the insurance premium of GHc15 (Ghana cedis; US$10) which would have entitled her to free health care. Tamaligu community, in the Tolong-Kumbungu District of northern Ghana.

In 2008 President Atta Mills and the National Democratic Congress came to power in Ghana on a promise to deliver a truly universal health insurance scheme that reflected the contribution of all the country's citizens. The promise included guaranteed access to free health care in all public institutions, and cutting down the health insurance bureaucracy in order to 'plough' back the savings into health care services.

There can be no doubt that the introduction of Ghana's National Health Insurance Scheme (NHIS) in 2003 was a bold progressive step that recognised the detrimental impact of user fees, the limitations and low coverage of community-based health insurance (CBHI) and the fundamental role of public financing in the achievement of universal health care. The NHIS provides a comprehensive package of services, and for members of the scheme evidence suggests that access and quality of services have improved. Average outpatient visits per member per year were between 1.4 and 1.5 in 2009 against a national average of 0.81 (Ghana Ministry of Health 2010).

However, for Ghana to be held up as a success story for health insurance in a low-income country and a model for other poor countries to replicate is misleading. According to our analysis of the data available, membership of the largely tax-funded National Health Insurance Scheme could be as low as 18 per cent[2] – less than a third of the coverage suggested by Ghana's National Health Insurance Authority (NHIA) and the World Bank. Despite the introduction of the NHIA, the majority of citizens continue to pay out of pocket for their health care in the parallel 'cash-and-carry' health system,

Box B5 Overview of the health system in Ghana

The current health system in Ghana is unfair and inefficient. It doesn't have to be. The government can and should move fast to implement free health care for all citizens. Our research shows that:

- Coverage of the National Health Insurance Scheme (NHIS) has been hugely exaggerated, and could be as low as 18 per cent
- Every Ghanaian citizen pays for the NHIS through VAT, but as many as 82 per cent remain excluded
- Twice as many rich people are signed up to the NHIS as poor people. Sixty-four per cent of the rich are registered compared with just 29 per cent of the poorest
- Those excluded from the NHIS still pay user fees in the cash-and-carry system. Twenty-five years after fees for health were introduced by the World Bank, they are still excluding millions of citizens from the health care they need
- An estimated 36 per cent of health spending is wasted owing to inefficiencies and poor investment. Moving away from a health insurance administration alone could save US$83 million each year. Enough to pay for 23,000 more nurses
- Through savings, good-quality aid but primarily improved progressive taxation of Ghana's own resources, especially oil, the government could afford to increase spending on health by 200 per cent, to US$54 per capita, by 2015
- This would mean the government could deliver on its own promise to make health care free for all – not just the lucky few at the expense of the many

The shared goal of free health care for all in Ghana is within reach. Investing in the health of all citizens will lay the foundations for a healthy economy and help to achieve Ghana's goal of becoming a middle-income country.

or resort to unqualified drug peddlers and home treatment owing to lack of funds. The richest women are nearly three times more likely than the poorest to deliver at a health care facility with a skilled birth attendant.[3]

The National Health Insurance Scheme: costly and unfair

The NHIS's heavy reliance on tax funding erodes the notion that it can accurately be described as social health insurance; in reality it is more akin to a tax-funded national health care system, but one that excludes over 80 per

cent of the population. The design is flawed and unfair – every citizen pays for the NHIS but only some get to join. More than twice as many of the rich are registered compared to the poorest, and evidence suggests the non-insured are facing higher charges for their health care (Witter and Garshong 2009). Out-of-pocket payments for health are more than double the World Health Organisation (WHO) recommended rate and the risk of financial catastrophe due to ill health remains unacceptably high (World Health Organisation 2010).

The NHIS suffers from an inefficient administrative and registration system, cost escalation and high levels of abuse leading to serious questions about its sustainability. The average cost per insurance claim more than doubled between 2008 and 2009 and total expenditure on claims has increased forty-fold since the scheme first started (Ghana National Health Insurance Authority 2010). Incentives are provided for curative not preventive health and the budget for the latter is on the decline (ibid.).

Realising a vision: health care for all free at the point of use

The introduction of free health care for all pregnant women was a major step forward in 2008. In just one year of implementation 433,000 additional women had access to health care (Stewart 2009). But bolder changes are now urgently required to accelerate progress.

The government must move to implement its own aspiration and promise of a national health system free at the point of delivery for all – a service based on need and rights and not ability to pay.

Ghana is one of the few African nations within reach of achieving the Abuja commitment to allocate a minimum of 15 per cent of government resources to health. Malaria deaths for children have reduced by 50 per cent, the success rate for tuberculosis treatment is 85 per cent, and child and infant mortality are on the decline after years of stagnation (Ghana Health Service 2009).

But Ghana is off track to achieve the health Millennium Development Goals (MDGs). One quarter of the population live over 60 kilometres from a health facility where a doctor can be consulted (Salisu and Prinz 2009) and skilled birth attendance is low at only 46 per cent (Ghana Ministry of Health 2010). If current trends persist Ghana will not achieve the MDG for maternal health until 2027.

If the introduction of 'cash-and-carry' health care was stage one of health reform in Ghana, and the NHIS stage two, it is now time for stage three:

Step 1: The government must commit to a clear plan to remove the requirement of regular premium payments, abolish fees in the parallel 'cash-and-carry' system and make health care free at the point of delivery for all by 2015. A time-bound plan must also be set to reduce out-of-pocket payments as a proportion of total health expenditure to the WHO recommended rate of between 15 and 20 per cent (World Health Organisation 2010).

The change away from a premium-based health financing model means

much of the fragmented, inefficient and costly insurance architecture can be removed and many of the functions of the NHIA will no longer be required. The National Health Insurance Fund (NHIF) should be transformed into a National Health Fund to pool fragmented streams of financing for the sector. The purpose of the fund should be expanded to cover infrastructure and other capital and recurrent expenditure and be placed under the clear jurisdiction of the Ministry of Health, along with the core functions of the NHIA that remain relevant.

Step 2: At the same time a rapid expansion and improvement of government health services across the country is urgently needed to redress low and inequitable coverage and meet increased demand created by making care free. Rejuvenation of the Community-based Health Planning and Services (CHPS) strategy should form the backbone of the expansion plan and the foundation of an effective referral system. At the same time identified gaps in secondary and tertiary facilities, particularly district hospitals, should be filled. Priority should be placed on scaling up and strengthening government and Christian Health Association of Ghana (CHAG) services as the majority health care providers. While much improvement is needed the public sector performs better than the private sector at reaching the poor at scale, particularly for inpatient care.[4]

Significant advances have been made in reaching government targets for nurse training and recruitment. The government must now urgently review the reasons for poor progress in achieving the same for doctors. In 2009 Ghana had just one doctor per 11,500 people, worse than in 2007. A comprehensive review of health worker gaps across other cadres including health sector managers, pharmacists, and midwives is critical to inform a new and fully costed human resources strategy from 2012 to 2016.

The prices of medicines in Ghana are 300 to 1,500 per cent higher than international reference prices (Ghana Ministry of Health 2010). The government should use its purchasing power to negotiate lower prices, including through generic competition, while also tackling corruption, price hikes and stock shortages across the supply chain. To improve quality the government should prioritise investment in the capacity of drug regulatory authorities.

Two points are clear – business as usual is not financially viable; and, even if the government moves to a single lifetime payment, as opposed to annual premiums as is proposed, this will not contribute significant funds to the overall health budget if its goal is to increase equity and access. Our calculations suggest that financing universal health care in Ghana can be achieved from three key sources without insurance premiums:

- Inefficiencies, cost escalation, corruption and institutional conflict are costing the health sector millions of Ghana cedis each year. We calculate possible savings worth 36 per cent of total government health expenditure in 2008, or US$10 per capita.

- With projected economic growth, together with action to improve progressive taxation of Ghana's own resources, especially oil, we calculate that the government alone can mobilise a health expenditure of US$50 per capita by 2015. This figure assumes a minimum government investment in health of 15 per cent of total revenues.
- An additional US$4 per capita can be added by 2015 if improvements in the quality of aid are achieved, including that at least 50 per cent of health aid is given as sector budget support.

These sources combined mean that by 2015 Ghana could increase its per capita expenditure on health by 200 per cent from 2008 levels to at least US$54 per capita, and be well on the way to spending the US$60 per capita recommended by the WHO.

Notes

1 This chapter is drawn from the published report 'Achieving a shared goal: free universal health care in Ghana' written by Patrick Apoya and Anna Marriott and published jointly by Alliance for Reproductive Health Rights, Essential Services Platform of Ghana, ISODEC and Oxfam in 2011. Available at: www.oxfam.org.uk/resources/policy/health/achieving-shared-goal-free-healthcare-ghana.html.

2 The methodology for our calculation is based on annual NHIA income from insurance premiums and is detailed in Annex 2 of the full report from which this chapter is drawn from. To date we have had no response from the NHIA to our requests for more accurate current membership data.

3 Author's calculation based on figures presented in Garshong (2010).

4 Author's analysis of data presented in Garshong (2010).

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