NATIONAL HEALTH INSURANCE POLICY FRAMEWORK FOR GHANA

REVISED VERSION

MINISTRY OF HEALTH
AUGUST 2004

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FOREWORD

This review has been inspired by the changes that occurred in the development process of Health Insurance after the passage of Act 650 in October 2003. Further work has been done in respect of the legislative instrument; a more detailed benefit package for health care providers have also been developed; and provider accreditation system has been completed. The result of all these new developments, challenge the original philosophies and some of the concepts underpinning the earlier version of this policy document.

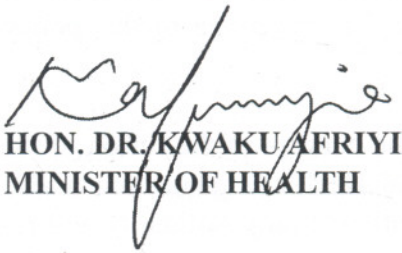
This new edition therefore brings to focus the concept of the fusion of the Social Health Insurance Scheme and Mutual Health Organisation; it also advocates for the concept of cross-subsidization, equity, solidarity and re-engineering of the health insurance system in favour of the poor and under privileged in society. In this regard, the new policy advocates the stratification of society based on ability to pay contributions. The document also describes the benefit package and issues of accreditation of providers.

Despite all these changes, the old edition still has some relevance and has served as a platform for advocacy of the concept of Health Insurance to Ghanaians. This was developed with immense contribution of a National Health Insurance team set up in early 2001 made up of the following: Dr. S. A. Akor, Mr. Ampong Darkwa, Dr. Ian Kluvitse, Mr. Joseph Kofi Adusei, Dr. Irene Agyepong, Dr. J. T. Teprey, Mr. Kwesi Eghan, Nii Ayikofi Armah and Mr. Osei Owusu.

I will like to also thank all stakeholders who participated in the discussions during the drafting of the 2002 policy framework. It is by their collective efforts that has led to the writing of this new edition. Prominent amongst them are the Civil Servants Associations, Ghana National Association of Teachers, Ghana Medical Association, The Ghana Police Service, Ghana Employers Association, Social Security and National Insurance Trust (SSNIT), The Trade Union Congress, Institute of Economic Affairs, Civil

Society Organizations and many others.

The doors of the Ministry of Health and the National Health Insurance Council are still open for suggestions for consideration for future policy review. It is the hope of Ministry of Health that Health Insurance becomes the main vehicle for health care financing in Ghana.



HON. DR. KWAKU AFRIYIE
MINISTER OF HEALTH

ACKNOWLEDGEMENT

This is to acknowledge the contribution of the following persons for the review of the policy document on the National Health Insurance Scheme; Dr. S. A. Akor (Director PPME, also Co-ordinator of the National Health Insurance Scheme), Mr. Kofi Adusei (Ministry of Health), Nana Kwasi Amo (Managing Director, Organisation and Systems Limited) and Mr. F. X. Andoh-Adjei (Special Assistant to the Minister of Health).

This review was inspired by the changes occurring in the Health Insurance sector. A National Health Insurance Act has been promulgated, and the legislative instrument is about to be completed. A design concept and a new benefit package have also been widely discussed and approved. These new development questions the original philosophies and some of the concepts underpinning the old policy document and calls for a new one.

EXECUTIVE SUMMARY

In line with the Ghana Poverty Reduction Strategy (GPRS) the government has initiated a policy to deliver accessible, affordable, and good quality health care to all Ghanaians especially the poor and most vulnerable in society.

The current out-of-pocket payment for health care at the point of service delivery popularly known as "Cash and Carry" poses a financial barrier to health care access. Indeed it is estimated that out of eighteen percent of the population who require health care at any given time, only twenty percent of them are able to access it. That is about eighty percent of people living in Ghana who need health care cannot afford to pay out-of-pocket at the point of service use. This has resulted in delays in seeking health care, non-compliance to treatment, and consequently premature death.

To address the problem of financial barrier to health care access, the government in 2001 has initiated a National Health Insurance Scheme as a humane approach to financing health care.

The aim of the health insurance scheme in Ghana is to enable the government achieve its set health goal within the context of the GPRS and the Health Sector Five Year Programme of Work, 2002-2006.

Ultimately, the vision of government in instituting a health insurance scheme in the country is to assure equitable and universal access for all residents of Ghana to an acceptable quality package of essential health care. The policy objective is "within the next five years, every resident of Ghana shall belong to a health insurance scheme that adequately covers him or her against the need to pay out-of-pocket at the point of service use in order to obtain access to a defined package of acceptable quality of health service.

Ghana is committed to fashioning out its own unique health insurance strategy based on the Principles of Equity, risk equalization, cross-subsidization, solidarity, quality care, efficiency in premium collection, community or subscriber ownership, partnership, reinsurance, and sustainability.

Hence the two main types of health insurance regimes shall be operational in Ghana. These are the Social-type Health Insurance Scheme made up of District Mutual Health Insurance Scheme and the Private Mutual Health Insurance Schemes and the Private Commercial Health Insurance Schemes.

The government has elected to support the development of the District Mutual Health Insurance Scheme (DMHIS) to serve as a strategy for delivering its pro-poor policy to the underprivileged segments of the society. The District Mutual Health Insurance Scheme is therefore, a fusion of the two concepts; the traditional Social Health Insurance Scheme for the formal sector workers and the traditional Mutual Health Insurance organisations for the informal sector of the society. Thus, DMHISs will incorporate members from both the formal and informal sectors. All the types of insurance models shall have governing boards to bring about best management practices, good governance and democracy.

It is compulsory for every person living in Ghana to belong to a health insurance scheme type. This is in the light of the spirit of solidarity, social responsibility, equity, and a sense of belongingness in the building of a healthy and prosperous nation.

Every person living in Ghana shall contribute according to the principle of ability to pay in order to enjoy a package of health services covering over 95% of diseases afflicting Ghanaians. There is a differential contribution level both in the formal and informal sectors of the society.

The formal sector shall contribute 2.5% of their 17.5% Social Security and National Insurance Trust (SSNIT) contribution whereas the informal sector shall contribute at least ¢72,000 per annum. The contribution levels have an inbuilt cross-subsidization mechanism whereby the rich pay more than the less privileged, adults pay on behalf of children, the healthy cover for the sick and urban dwellers pay more than the rural dwellers.

Contribution levels of the people shall be categorised based on their socio-economic stratification. The policy proposes six main types of categorization as: core poor, very poor, poor; middle income, rich, and very rich. All of these shall pay in line with their ability to pay.

The policy adopts a minimum benefit package as defined by the rules and regulations contained in the legislative instrument, which is described exhaustively at the appendix of this document.

The objectives of the minimum benefit package are; to ensure that every citizen of this country has access to a level of healthcare that provides adequate security against diseases and injury, and to promote and maintain good health. Secondly to secure the financial sustainability of the schemes through protection from excess cost burden.

All service providers within the public, private and mission sectors shall be mobilised into providing this benefit package. However, they will have to satisfy an accreditation criteria. A gatekeeper system shall be put in place as a cost control measure and to provide a mechanism for delivery of quality care to the population.

In addition to the funding of the scheme by contribution of persons working in the formal and the informal sectors of the economy, government has put in place a framework for mobilising additional funds to support the implementation of the scheme. Government has instituted by law a 2.5% National Health Insurance Levy payable on selected goods and services. Funds raised from this source shall be used to subsidize the contributions of the underprivileged segment of the society and to pay for the contributions for the core poor and other vulnerable groups.

The National Health Insurance programme shall be regulated by the National Health Insurance Council through the National Health Insurance Act 650. It shall establish units responsible for Policy Planning Monitoring and Evaluation; Registration and Licensing; Administration, Management Support and Training; and Fund Management and Investment.

With the establishment of such an organisation, it is hoped that the institutional framework and the necessary environment shall be created for the acceleration of the implementation of the National Health Insurance Scheme.

HEALTH INSURANCE POLICY FRAMEWORK FOR GHANA

Introduction

The Government through the Ghana Poverty Reduction Strategy (GPRS) has outlined its policy strategies for dealing with poverty in Ghana. A major component of the GPRS is the strategy to deliver accessible and affordable health care to all residents in Ghana especially the poor and vulnerable. The method of financing healthcare determines its accessibility and affordability. Currently, the "Cash and Carry" system of partly financing the public sector healthcare delivery poses a financial barrier in particular to the poor. As a poverty reduction strategy, Government has taken steps to put in place the framework for the establishment of health insurance in the country. The policy framework allows for the establishment of multiple health insurance schemes with a focus on the social-type known as District Mutual health Insurance to address the needs of the poor.

Financing health care has gone through a chequered history in Ghana. Immediately after independence health care provided to the people was "free" in public health facilities. This meant that there was no direct out-of-pocket payment at the point of consumption of health care in public health facilities. Financing of health in the public sector was, therefore, entirely through tax revenue. The sustainability of this form of financing became questionable as the economy began to show signs of decline and there were competing demands on the same source. What is important to note was that the general tax revenue did not allow for a percentage earmarked for health as we now have in the case of a percentage of VAT funds earmarked for education.

This situation continued until 1985 when the Government introduced the user fees for all medical conditions except certain specified communicable diseases. The free health care policy was badly implemented in that although communicable diseases were supposed to have been exempted, in practice nobody enjoyed this facility. Also, a guideline for implementation was not provided and no conscious system was designed to prevent possible financial leakages. In the ensuing years the standard of health care provision fell drastically. There was acute shortage of essential drugs in all public health facilities. Most importantly, the introduction of the user fees resulted in the first observed decline in utilization of health services in the country.

[1]Ghana Living Standard Survey, 2000

In spite of this, the government went ahead to institute full cost recovery for drugs as a way of generating revenue to address the shortage of drugs. The payment mechanism put in place was termed "Cash and Carry". The implementation of the "Cash and Carry" compounded the utilization problem by creating a financial barrier to health care access especially for the poor. It is estimated that out of the eighteen percent of the population who require health care at any given time, only twenty percent of them are able to access it. Implying that about eighty percent of Ghanaians who need health care cannot afford it.

The Government noting the problems associated with the "Cash and Carry" system has initiated action to replace this out-of-pocket payment for health care at the point of service. The implementation of the programme to replace the "Cash and Carry" would be in phases. This approach takes cognizance of the fact that uptake of health insurance is dependent on various factors including level of confidence, perceived quality of care, willingness of individuals to subscribe to it and the attractiveness of the benefit package. Thus, the implementation of the health insurance would be a gradual process.

Context of Health Insurance

Healthcare financing may be done through a number of options either singularly or a combination. These options may be classified broadly into the following;

i. Direct out-of-pocket payment at the point of service and personal health account,
ii. Risk pooling or sharing through tax revenue and health insurance.

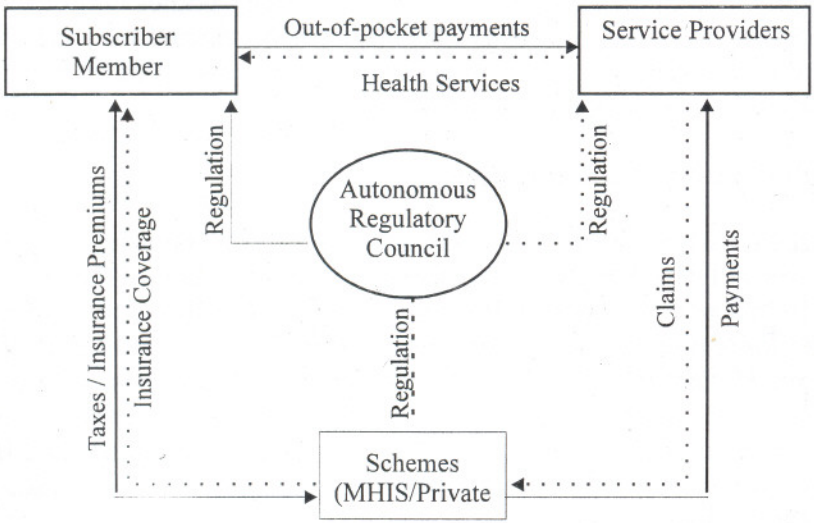
Thus, Health Insurance is one of several methods that the government is adopting to finance health care in the country. Currently, 80% of health financing in the public health sector is through tax revenue and donor funds. The 20% is from internally generated funds through the "Cash and Carry" System. As indicated earlier, health Insurance is to replace the "Cash and Carry" system of payment of health services consumed. This means that tax revenue would continue to form part of the overall health sector financing strategy for a long time to come. It is note worthy that health insurance does not abolish cost recovery but it does replace direct out-of-pockets payment at the point of service use.

The aim of the health insurance is to enable the government achieve its set health goal within the context of the GPRS and the health sector's Five-Year Programme of Work, 2002 - 2006 .

It is to spread the risks of incurring health care costs over a group of subscribers. The more the subscribers, the more likelihood of available funds to support members when they require health care. The point to note here is that individuals still make payment for services consumed but in a more humane manner as they do not have to carry the burden of health care alone. This underscores the policy of making it compulsory among others for every resident in Ghana to belong to a health insurance scheme of his/her choice.

Ultimately, access to health care is made easier for those who really need it. Nonetheless, access is a function of location of providers of services, cost of care and ability to pay, quality of care and socio-cultural aspects of service provision. Financial barrier to health care is dependent on the payment mechanism that is put in place at the time of use of service. Out of pocket payment at the time of use reinforces non-access to health care. Prepayment schemes minimize or remove the financial barrier to accessing health care. That is access to health care becomes independent of the individuals ability to pay out of pocket at the time of illness. Direct out of pocket payment is regressive in that a higher proportion of income of the poor and lower income groups go into health care. Moreover, people are expected to pay for services consumed at the time of illness when in fact they are actually non-productive during the period.

Fig 1. Finance and Service Delivery System



5 Wagner, R (2004) Risk Equalisation within the Ghana National Health Insurance, Discussion Paper No. 6, ILO, Geneva

The Vision, Goal and Objectives

The vision

Ultimately, the vision of government in instituting health insurance schemes in the country is to assure equitable universal access for all residents of Ghana to an acceptable quality of a package of essential health services without out of pocket payment being required at point of service use. This way, everyone will be protected from the problems that are associated with having to find money at the time of illness before needed services can be provided.

The Goal

Health Insurance will replace out of pocket payments by providing a specified minimum healthcare benefit package at the point of service use.

Policy Objective

Within the next five years, every resident of Ghana shall belong to a health insurance scheme that adequately covers him or her against the need to pay out-of-pocket at point of service use in order to obtain access to a defined package of acceptable quality health services.

Specifically, within the next five years, the necessary bodies will be created, awareness raising and consensus building will be carried out, the needed legislation passed and the enabling environment developed to ensure the realization of the policy goal of government.

Principles underlying the Design

As indicated earlier, about 70% of Ghanaians are in the non-formal sector of the economy. There are two main problems with this sector. The first is the difficulty that may be encountered in collecting contributions. This means that traditional mechanisms for organising communal contributions need to be examined and factored into the design of the schemes. The second problem, which is a critical one, is that most people, at least 40%, live below the poverty line and may not be able to afford high premiums. The health insurance scheme has been designed with the aim to offer healthcare access to the poor and vulnerable in society.

[2] Adapted from Cichon, M et al (1999) Modelling in Health Care Finance, A Compendium of Quantitative Techniques for Health Care Financing, ILO, Geneva.

Thus, the design would take into account the following principles;

- Equity
- Risk equalization
- Cross-subsidization
- Solidarity
- Quality care
- Efficiency in premium collection and claims administration
- Community or subscriber ownership
- Partnership
- Reinsurance
- Sustainability

Equity implies that everybody has access to the minimum benefit package irrespective of peoples' socio-economic background. This means that everybody should have the opportunity to join a health insurance scheme. So health insurance should be at the door-step of every resident in Ghana. Also, health insurance should be available all the time so that subscribers are not denied access to health care when they need it.

Risk-equalisation: The scheme should ensure that disease burden and mortality patterns serve as one of the basis for allocating financial resources to geographical areas of the country. The cost of care varies depending on the disease burden in the geographical areas. Moreover, disease burden correlates positively with poverty. Thus, the higher the poverty level the heavier the disease burden. A formula for risk-equalistion shall be developed to make up the cost difference based on the minimum contribution levels.

Cross-subsidisation: The design of the scheme should be such that contribution is based on ability to pay. In this case the rich will pay more while the poor pay less . Also, it must ensure that all persons contribute and not only have those with the risk of falling ill join the scheme. Thus, the rich will cross-subsidise the poor and vulnerable, the healthy will cross-subsidise the sick and the economically active adults will cross-subsidise the children.

[3] Ghana Living Standard Survey

Quality of Care: The main tenet of quality care is value for money. When clients perceive health services used as value for the money their propensity to utilize health care increases. Perceived quality of care is also linked to health care access as poor quality of care is a barrier to access. Thus, when everything remains constant, people are more likely to use health care that they perceive to be good than one perceived to be bad.

Solidarity is a desired virtue in social health insurance. The purpose of health insurance in Ghana is to remove financial barrier to health care access which ultimately will impact on the health status of the population. It is important to note that our individual health status are interlinked especially when dealing with communicable diseases which are the main causes of morbidity in this country. To be free of such diseases one has to help his or her neighbour who happens to have been afflicted with a communicable disease in order to get rid of these diseases in most cases. The vulnerable groups are the poor, children and the elderly. These groups need the support of the rest of the population in terms of health care access.

Efficiency in the collection of contributions and claims administration: there are two issues relating to efficiency; the demand or purchasing side efficiency and supply side efficiency. In the case of the former, collection of contributions is vital for building a sustainable fund for the social-type health insurance schemes in the country. The problem in our circumstance is that most of the potential contributors are in the informal sector of the economy where formal systems of collection of contributions do not exist. Consequently, the NHIS shall adopt existing informal traditional systems of community contributions. In the case of the latter, the issue is about how fast the system would be able to reimburse service providers since they depend very much on internally generated funding to complement government regular budget. Government budget releases often delays and therefore the internally generated fund is used to fill the gap by serving as a revolving fund.

Community or subscriber ownership is vital to ensure community participation. In the past community participation has eluded health care planning and delivery. Efforts have been made as part of the Primary Health Care strategy to encourage and sustain community participation without much success. Community ownership of the scheme is expected to promote community participation and thereby bring to bear the client perspective of quality of care on the delivery process.

Partnership with government is key to the sustainability of the scheme based on the fact that being a pro-poor scheme government will be required to provide Central funds to bridge the gap that may result from the expected contribution level and the actual contribution as well as outright payment of contribution on behalf of the poor, children under 18 years and the aged.

Reinsurance as a principle is at the centre of the operations of any type of insurance. This is especially so in health insurance where schemes may run into the risk of under funding due to unforeseen catastrophic events such as epidemics and natural disasters. Should such events occur, central fund needs to be set aside to recapitalize schemes.

Sustainability is essentially about how well the schemes are managed especially in the area of risk management and fraud control. Thus, the NHIP shall develop the human resource capacity and systems and policies that will ensure sustainability of all the schemes in the country.

Types of Health Insurance Schemes

The following types of insurance schemes shall be considered operational in Ghana;

- Social-type Health Insurance Schemes
  - District Mutual Health Insurance Schemes
  - Private Mutual health Insurance Schemes
- Private Commercial Health Insurance Schemes

All the types of health insurance shall have governing boards which shall be responsible for the direction of policies of the scheme. They shall be registered under the Companies Code, Act 1973 as either limited by guarantee or liability. There is no restriction on the number and type of scheme that one can join.

District Mutual Health Insurance Scheme

The District Mutual Health Insurance Scheme (DMHIS) is a fusion of two concepts; the traditional *Social Health Insurance Scheme* for formal sector workers and the traditional Mutual Health Organizations for the informal sector with a district focus.

Thus, the DMHIs will incorporate members from both the formal and informal sectors of the economy. It is a decentralized system with ownership belonging to the members who have made their required contributions. It is social in character because it is not-for-profit. At the end of the year surpluses made will be ploughed back into the scheme to reduce contribution levels or increase the benefit package. Thus, every district is to establish a health insurance scheme to enable residents in that district register as members. The DMHIS has been designed to ensure transparency, build subscriber confidence and in particular bring health insurance to the door steps of residents. However, it will be in partnership with government in that the DMHIS will receive subsidy from government in the form of risk-equalisation and reinsurance for catastrophic events.

Private Mutual Health Insurance Scheme

Any group of persons in Ghana may establish and operate a Private Mutual Health Insurance Scheme which shall not necessarily have a district focus. It may either be community-based or occupational or faith-based. It is also social in character but this type will not receive subsidy from government.

Private Commercial Health Insurance Scheme

Private Commercial Health Insurance refers to health insurance that is operated for profit based on market principles. Premiums are based on the calculated risks of particular groups and individuals who subscribe to it. Thus, those with higher risks pay more. Commonly the ownership of the Private Commercial Health Insurance Scheme resides with a company and shareholders and stocks of the company can be traded on the market just like the stocks of the producers of any other goods and services.

The Private Commercial Health Insurance Companies will play the role of offering the minimum benefit package and supplementary insurance plans as an add-on for those who so desire and can afford to pay.

Structure of District Mutual health Insurance Scheme

The structure of the DMHIS shall be such that each of them will have a District Health Insurance Assembly (DHIA) comprising of a chairman or secretaries of the Community Health Insurance committee of the various communities in the district. The DHIA will provide the general policy direction of the scheme operations, put in place a constitution and appoint Board of Directors for the Scheme.

The Board of Directors shall be responsible for the enforcement of the constitution, approval of budget, render operational and financial accounts to the DHIA and appointing management staff for the scheme.

Each defined community or electoral area (in the case of the metropolis) shall have a health insurance committee comprising a chairman, secretary, publicity coordinator, contribution collector and one other member. They will initiate the identification of the core poor for validation by the political District Assembly and/or the National Health Insurance Council. They will also supervise the stratification of residents into socio-economic groupings based on ability to pay and collection of contributions.

Towards Achieving Universal and Equitable Coverage

All residents of Ghana are required by law to belong to a health insurance scheme within a specified period of time. However, the way to encourage people to comply with the law will be predominantly in the form of incentives rather than by punitive measures. Operationally, as stated earlier all residents in Ghana are to join an insurance scheme of their choice within the next five years. There will be adequate time frame for public education to ensure that there is enough understanding and motivation for people to enroll into the health insurance schemes. The choice of scheme to enroll with, will however, be voluntary.

Membership shall be by contribution in the case of the social-type health insurance and premium payment in the case of the private commercial health insurance. Persons in the informal sector who wish to join the DMHIS shall pay direct contributions to the scheme. All workers in formal employment who contribute to the SSNIT pension fund whether in the public or private sector will have deductions made at source from their SSNIT contribution into a common fund.

Contributions from this fund shall be transferred to the DMHISs on behalf of subscribers . Workers will, thus, have automatic registration with DMHISs in districts or sub-metros that they reside.

Having a 'single payer' arrangement for all the formal sector as under this arrangement is more efficient, will better promote equity and is more readily coordinated than having multiple payers.

Government subsidy through the Health Fund will be provided to 'top up' the premium for the poor and vulnerable groups according to a defined criteria.

The council will calculate minimum community rated premium or contribution that it considers fair to assure access to the minimum package of mandated services as a guideline to the DMHISs. The District Health Insurance Assemblies (DHIAs) may modify the minimum contribution and benefit package to suit their local circumstances. Changes shall be done with they approval of the Councl. The calculations will be regularly updated.

The indigent and other categories of persons as defined by law and the health insurance regulations respectively will be exempted from paying contributions. Funds from the central source shall be allocated to make outright payment of contribution into DMHISs on behalf of such persons.

Minimum Contribution

Subject to ministerial approval, the current cost analysis indicates that the Minimum Benefit Package will be offered at a minimum of ¢6000 per adult person per month.

Children who are 17 years and below are exempted provided both parents and proven single parents have paid at least the minimum contribution. Also, pensioners who are formal sector contributors to Social Security and National Insurance Trust (SSNIT), the aged, 70 years plus in the informal sector and the indigent as defined by the Legislative Instrument shall be exempted from payment of any contributions.

Contributions in the informal sector will be categorized by ability to pay. Thus, the ¢6,000 per adult per month is the minimum that will be paid by those classified as the poor. These are categorized as follows in the table below;

Fig. 2 Informal Sector Categorization[4]

Social Group	Class	Definition
Core Poor	A	Adults who are unemployed and receive no identifiable income and therefore unable to support themselves financially
Very Poor	B	Adults who are unemployed but receive identifiable and consistent financial support from the source off low income
Poor	C	Adults who are employed but receive low returns for their efforts and are unable to meet basic needs
Middle Income	D	Adults who are employed and receive incomes which are just enough to meet their basic needs
Rich	E	Adults who are able to meet their basic needs and some of their wants
Very Rich	F	Adults who are able to meet their basic needs and most of their wants

These classification are not necessarily in water-tight compartments. Schemes may adopt different methods of classification depending on their local circumstances.

The Benefit Package

Council will define the minimum benefit package of services that must be provided by all health insurance schemes operating in Ghana in the rules and regulations from time to time. This is to allow for flexibility as that would not be possible if specified in the Law. Thus, the package will be a compromise between what people would want and what people need. A realistic package needs to be decided upon given the economic constraints and the limitation placed on what health services can be practically made universal.

The factors influencing defined package are;

- The health needs of the people as shown by existing morbidity patterns.
- Service availability at various levels of care
- Service affordability
- Existing infrastructure
- Quality of care
- Availability of financial resources
- Cost of healthcare services

[4] Organisation and Systems Ltd

In the case of the DMHISs, The minimum benefit package of insured services will be subsidized through earmarked tax revenue which shall be levied and collected into a National Health Insurance Fund and thus provide an advantage to those who take insurance cover. Families that can prove genuinely that, they are unable to pay even the minimum premium according to defined criteria will be eligible for subsidies from the Fund.

The objectives of the minimum healthcare benefits are;

- To ensure that every citizen of this country has access to a level of healthcare that provides adequate security against disease and injury, and promotes and maintains good health.
- To secure the financial sustainability of the schemes through protection from excess cost burden.

The package may cover in-patient care, emergency and transfer services and out-patient care at primary and secondary levels. This focus is to ensure that at least the top 10 diseases, which constitute 80% of all diseases that afflict all people living in Ghana are covered. See details in Appendix I. It must be noted that depending on the capacity of Districts to absorb additional cost, districts can up-grade the minimum healthcare benefit package. This means the minimum healthcare benefit package can be adjusted upwards to meet special needs of districts provided it is viable financially and approved by Council.

Facilities Providing Healthcare Services under the NHIS

Under the National Health Insurance Scheme healthcare services covered under the minimum benefit package will be delivered by service providers that will be accredited by the scheme.

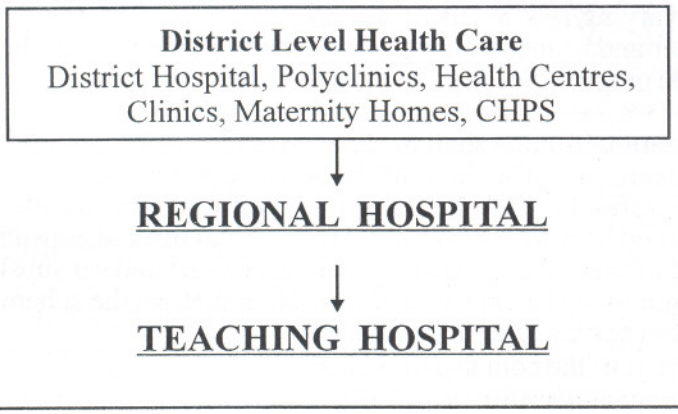
Categories of Healthcare Service Providers that may be accredited under the NHIS are;

- Teaching Hospitals
- Regional Hospitals
- District Hospitals
- Health Centers
- Maternity Homes
- Private Hospitals and Clinics
- Quasi-Government Hospitals and Clinics
- Mission Hospitals
- Pharmacy Shops and Drug Stores

Accessing Services Under the NHIS

- A gatekeeper system will be put in place involving all the different categories of service providers.
- The system will function in such a way that the first point of call for all outpatient services will be the primary healthcare facilities.

Fig. 3 The Gatekeeper System



Accreditation and Quality of Care

All providers and institutions must meet a minimum set of accreditation requirements before they can be contracted to provide services to members of registered DMHISs.

Types of purchaser arrangement, identification system, tariffs, national health insurance drug list (a subset of the national Essential Drug List) and use of standard treatment protocol shall be developed.

Funding the District Mutual Health Schemes

Health Insurance as a financing mechanism will replace out of pocket payments at point of service use. General tax revenue will continue to be used for funding of health services as in the past. However, people will pay contributions regularly to a scheme of their choice to obtain cover under the minimum healthcare benefit package of insured services with a defined group of accredited providers depending on the scheme they belong to.

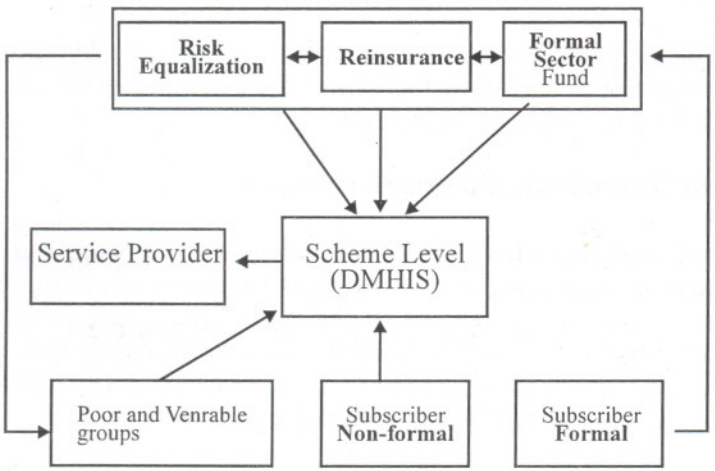
Workers contributions to the DMHIS shall be made through their SSNIT Contribution. 2.5% out of the 17.5% SSNIT contribution will be deducted and transferred into a central fund. Thus contributors to the SSNIT fund shall not pay further contributions to the DMHIS. They will be automatic members of the DMHIS. Non-SSNIT contributors will pay direct contributions to the schemes in the district where they reside.

Apart from the payment, a national health insurance fund shall be created at the central level to play a reinsurance role especially for catastrophic events, equalize the varying risk levels of disease that exist from one geographical area to another and to make outright contribution on behalf of the core poor and vulnerable groups. (See Fig. 3)

A risk-equalization formula shall be developed to allocate central funds to the scheme in order to subsidise the contribution levels of the poor and vulnerable groups. The formula will be based on information on the expected contributions and health expenditures of individual insured consumers over a fixed interval of time (e.g., a month, quarter, or year) and set subsidies to the DMHIS to improve efficiency and equity. Nonetheless, the schemes shall be required to meet certain criteria including:

- Coverage of the poor and vulnerable
- Public accountability to their members
- Transparency in all financial dealings
- Regular annual external audits of all their financial transactions to verify that standard financial management procedures are being followed.

Fig. 4 FUND FLOW
National Health Insurance Fund



Work needs to be done on what kind of payment mechanisms will apply for services provided by public sector providers versus services provided by private sector providers. This is because the government subsidy provided in the public sector is not available to the private sector.

Figure 4 above shows the likely fundflow diagram for the proposed health insurance program. Health Insurance as a financing mechanism will replace out of pocket payments at point of service use. General tax revenue will continue to be used for funding of health services as in the past. However, people will pay premiums regularly directly to a scheme of their choice to obtain cover under the minimum basic package of insured services with a defined group of accredited providers depending on the scheme they belong to.

Regulating the Schemes

A National Health Insurance Council will oversee and guide the establishment of Health Insurance Schemes on a national scale. It will be a regulatory body, and also have monitoring and evaluation functions. The council will be an autonomous body established by an act of parliament. The Council will be responsible for the creation and monitoring of an enabling environment for the development and operation of health insurance in Ghana.

The council will have an executive secretary that will have the direct day-to-day responsibility of ensuring that the policy decisions taken by the council are effectively implemented. The Council will report to the President of the Republic of Ghana through the Minister for Health. As part of the process of reporting to stakeholders, the council will ensure the preparation of an annual report describing the state of the National Health Insurance Scheme. To assist it to effectively execute its functions, the council will have four units namely:

- Policy, Planning, Monitoring and Evaluation unit
- Licencing and Accreditation unit
- Administration, Management Support and Training unit
- Fund Management and Investment unit
- Other units that the Council will consider appropriate

Policy, Planning, Monitoring and Evaluation Unit

The functions of this unit will include:

1. Review and analysis of policy options and advice to the council on the formulation of policies related to the National Health Insurance Scheme
2. Development of schemes and budget for the execution of the Councils decisions
3. Setting of tariffs for payment to accredited providers
4. Financial analysis on the state of the scheme
5. Compilation, analysis and evaluation of data
6. Carrying out and commissioning of research as indicated

Under this Unit will be a research and data management section. It will be responsible for receiving, compiling and analysing data on an agreed set of variables from all health insurance schemes operating in the country as part of the process of monitoring, coordination and evaluation of their performance. The Data center will also be responsible for the compilation of national annual reports.

Licencing and Accreditation Unit

Working through this unit, the Council will exercise the authority to licence and regulate all health insurance schemes in the country. It will also have the authority to revoke the license of insurance schemes that fail to conform to the law.

Additionally, the unit will be responsible for the accreditation of health care providers by setting quality of care standards that need to be met by providers in order to be eligible for entering into contracts with health schemes. This unit will also be responsible for leading the process of negotiation between providers, professional bodies and the council on a regular basis to agree on standard rates to be applied to medical and surgical procedures across the country.

Council will annually publish a list of providers who have met the accreditation requirements. These lists will be made available to health insurance schemes so that they can contract out services to their clientele to the appropriate providers and reimburse them. It will also be responsible for monitoring on a regular basis the minimum licencing requirements of the schemes.

Administration, Management Support and Training Unit

The council will monitor and evaluate the operation of all health insurance schemes in the country and ensure that their efforts are properly coordinated to bring about the ultimate realization of the policy goals of government.

Where monitoring and evaluation points to a need, it will arrange and ensure that the needed technical support and training is made available to the Mutual Health Organizations and other health insurance schemes operating in the country to assist them meet the set standards of operation and management required for legal operation.

Fund Management and Investment Unit

The National Health Insurance Fund will be a fund that will provide support to District Mutual health Insurance to cover poor and vulnerable groups. It will also play equity and a re-distribution role to ensure that equal provision is made for equal need and unequal provision for unequal need regardless of socio-economic or socio-cultural status. Furthermore, it will play a re-insurance role for schemes that meet certain criteria. The use of the health insurance fund is reserved solely for the not-for-profit schemes.
A percentage of the Health Insurance Fund will be used as administrative overhead to finance the work of the council in consultation with and subject to the approval of Parliament.

Conclusion

The framework for health insurance in Ghana i.e the administrative and fund flow model are summarized in figures 1 and 2. It is based on the existence of multiple health insurance schemes.

These schemes will be facilitated, coordinated and regulated by an independent National Health Insurance Council to ensure that the policy goal of government in instituting a national health insurance program is attained. The Figure 5 below summarises the framework of the National Health Insurance Scheme which shows the roles and relationships between the Subscribers/Clients, the Health Insurance Schemes, the Health Care Facilities and the National Health Insurance Council.

APPENDIX I

MINMUM HEALTHCARE BENEFIT

Out-patient Services
Consultations including reviews: These include both general and specialist consultations.
Requested Investigations (including laboratory investigations, x-rays, ultrasound scanning etc) for general and specialist out-patient services.
Medication (prescription drugs on National Health Insurance Scheme Drugs List, traditional medicines approved by Food and Drugs Board and prescribed by accredited practitioners).
Out-patient/ Day Surgical Operations.
(e.g. hernia repair, incision and drainage etc).
Out-patient Physiotherapy.

In Patient Services
General and Specialist In-patient care
Requested investigations (including laboratory investigations, x-rays, ultrasound scanning etc) for in-patient care
Medication (Prescription drugs on National health Insurance Scheme Drug List, blood and blood products)
Cervical and Breast Cancer treatment

Surgical Operations.
In-Patient Physiotherapy.
Accommodation (General Ward).
Feeding (where available).

Other Specific Services

A. Oral Health Services

- ❑ Pain Relief (e.g. incision and drainage, tooth extraction, temporary relief)
- ❑ Dental Restoration (Simple Amalgam Fillings, Temporary Dressing)

B. Eye Care Services

- ❑ Refraction
- ❑ Visual Fields
- ❑ A - Scan
- ❑ Keratometry
- ❑ Cataract Removal
- ❑ Eye Lid Surgery

C. Maternity Care

- ❑ Antenatal Care
- ❑ Deliveries (normal and assisted)
- ❑ Caesarian Section
- ❑ Postnatal care

Emergencies

All emergencies shall be covered. These refer to crisis health situations that demand urgent intervention. They shall include:

- ❑ Medical emergencies
- ❑ Surgical emergencies (including brain surgery due to accidents)
- ❑ Paediatric emergencies
- ❑ Obstetric and Gynaecological emergencies (including Caesarian Section)
- ❑ Road Traffic Accidents
- ❑ Dialysis for acute renal failure

Public Health Services funded under special programme

Some services are already being provided free of charge by Government through its public health programs.

Under the National Health Insurance Scheme government will continue to provide these services free of charge. These are;

- ❑ Immunization
- ❑ Family planning
- ❑ In-patient and Out-patient treatment of mental Illnesses
- ❑ Treatment of Tuberculosis, Onchocerciasis, Buruli Ulcer, Trachoma)
- ❑ Confirmatory HIV test on AIDS Patients

Exclusions List

- ❑ These are services that will not be covered under the National Health Insurance Scheme
- ❑ This means health insurance schemes have the freedom to decide whether or not they will offer them as additional benefits to their members

The following healthcare services fall under this group:

- ❑ Rehabilitation other than physiotherapy.
- ❑ Appliances and prostheses (optical aids, hearing aids, orthopaedic aids, dentures etc).
- ❑ Cosmetic surgeries and aesthetic treatments.
- ❑ HIV retroviral drugs (symptomatic treatment of opportunistic infections and other AIDS related diseases will be covered).
- ❑ Assisted Reproduction (e.g. Artificial insemination) and gynaecological hormone replacement therapy.
- ❑ Echocardiography.
- ❑ Photography.
- ❑ Angiography.
- ❑ Orthoptics.
- ❑ Dialysis for chronic renal failure.
- ❑ Organ transplantation.
- ❑ All drugs that are not listed on the NHIS drug list,
- ❑ Heart and Brain Surgery (other than those resulting from accidents) and Cancer treatment (other than breast and cervical)
- ❑ Mortuary Services
- ❑ Diagnosis and treatment abroad
- ❑ Medical examinations for purposes other than treatment in accredited health facilities (e.g. visa applications, educational, institutional, driving licence etc)
- ❑ VIP ward (Accommodation)

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