



Health care financing and sustainability: A study of current conceptual dialectics in Ghana

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ABSTRACT

One major challenge in health policy and planning in third world countries is the sustainability of publicly funded health insurance schemes. Economic renegeance restricts the fiscal capacity of governments in Ghana to allocate limited public funds to financing a public sponsored health care insurance scheme. In the intervening time, the increasing demands within populations in the country for health care continue to escalate amidst political campaigns to increase access in health care and to motion towards universalism. General health care demands for the population grow as cost of treatment and enrolment increase resulting in sustainability issues; which are further perpetuated by institutional ineptitudes, limited public funds and managerial lapses. This study examines the current conceptual debates in Ghana on the funding and sustainability of the National Health Insurance Scheme (NHIS). Using data from public fora, interviews, conferences, newspapers, workshops, television and radio discussions and parliamentary Hansards and manuscripts, the study revealed that as part of the public policy making process the current debate is generally influenced by stakeholders' interest, power and solidarity even though there are attempts in some quarters to make political capital out of the debate. The complex relationship among the various stakeholders has stimulated an unabated discourse which has caused most of the stakeholders to adopt staunch positions in the debate.

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1. Introduction

Since independence, Ghana has implemented several health care funding mechanisms as part of a broader strategy to promote financial sustainability and to increase access in health care. In the 1990s, funding from health care was from user fees charged on clients at the point of service delivery. However, this invariably widened the disparities in access in health care within populations in high and low income groups' as the cost of health care was based on the ability to pay (Ataguba & McIntyre, 2012; Evans, Whitehead, Diderichsen, Bhuiya, & Wirth, 2001; Nyongator & Kutzin, 1999). Today, health care in Ghana is generally financed through the National Health Insurance Scheme (NHIS).

The NHIS was introduced in Ghana in 2003 by the government of Ghana through the National Health Insurance Act 2003, (Act 650) and the National Health Insurance Regulation 2004 (LI 1809). This was part of a political campaign by the largest opposition political party in the run-up to the 2000 general elections in

Ghana, and a general concern from civil society groups and the international community. To this extend, the consultative and policy building processes did not witness a lot of acrimony from public and private interest groups as has been the case in most public policies in Ghana (Abihiro, Mbera, & De Allegri, 2014; Pal, 1992).

The NHIS is expected to create a balance in equity, access and utilization of basic health care by all especially, for people living within the poorest bracket (NHIS Report, 2011; Jehu-Appiah, Aryeetey, & Spaan, 2011). Over a decade of implementation, the scheme appears to have considerably reduced financial barriers, risk and access in health care even though some equity issues still remain (Abbey, 2003; Owusu-Sekyere & Kanton, 2014; Schieber, Cashin, Saleh, & Lavado, 2012). The scheme covers about 95 percent of common disease burdens in Ghana and the cost of medicines for most essential diseases in the country (Agyepong & Adjei, 2008; Dalinjong & Laar, 2012; OXFARM, 2013). Current data on Ghana's Health Insurance Scheme reveal that the number of active members on the scheme has been phenomenal surpassing that of many other African countries that have been operating similar schemes. The scheme has an active membership of 10.9 million people representing about 40 percent of the population in Ghana (Peprah, 2015).

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Coverage levels (170 districts) in the country have been very momentous and responsible for accelerating access in health care (especially primary health care) and utilization levels. As a result, subscriber rates have been very encouraging. Data available indicates that the number of children who are under 18 years represent more than half of the active members of the scheme. Again, premium paying subscribers/clients, thus those in the informal sectors make up nearly 35.5 percent of the active subscribers/members on the scheme (Ataguba, Akazili, Mtei, Goudge, & Meheus, 2009; NHIS Report, 2012). Funds for running the scheme come from pooled public contributions of a Value Added Tax (VAT) of 2.5 percent, a 2.5 percent monthly salary deduction of formal sector workers, being pension contributions to the Social Security and National Insurance Trust (SSNIT), an health insurance levy of 2.5 percent, donor funding, contributions from informal sector members of the scheme, investment income or interest earned on investments (Abiuro & McIntyre, 2012; Owusu-Sekyere & Bagah, 2014; Abiuro & McIntyre, 2012). Nearly more than 70 percent of the scheme's expenditure comes from the 2.5 percent NHIL (Adonoo, 2016).

1.1. The need for the financial sustainability debate

In most third world countries like Ghana, public funded health care schemes such as the NHIS are a major pecuniary challenge to governments. Moreover, population growth and structural adjustments will strongly affect Ghana's ability to meet its future health care financing needs. The country's population is expected to double in the coming years and the burden of diseases will keep on shifting from communicable to non-communicable diseases and injuries (Schieber et al., 2012). In the interim, the country will have to grumble with a dual disease burden, and this will considerably impose severe cost on the country's health care system. Considering the hazards in revenue mobilisation in Ghana and the fact that about 80 percent of the labour force in the country is in the informal sector alone will pose a major challenge to revenue generation and enrolment (Blanchet, Fink, & Osei-Akoto, 2012; Schieber et al., 2012). At the moment the, "National Health Insurance Scheme is seriously challenged as far as finances are concerned. There is a huge funding gap that the National Health Insurance Scheme faces as we speak... Mr. Speaker, it is no wonder that the National Health Insurance Authority is unable to pay the claims of most health providers as we speak" (Dr. Kwabena Twum-Nuamah – NPP MP for Berekum East. Debates of 26 March 2015).

In 2005, the active subscriber base of the scheme was 1.3 million, and the corresponding expenditure on claims was GHC 597,859 (\$153,336 US Dollar). In 2014, the subscriber base stood at 10.2 million, with an associated expenditure on claims being in excess of GHC 960 million (\$ 244,663,282 US Dollar), and an outpatient utilization of 29 million. A comparative analysis of these two cases (2005 and 2014) visibly illustrates the financial trajectory of the scheme today. Additionally, in 2014, the scheme recorded a funding gap of close to GHc300 million (\$76,457,276 US Dollar), and in 2015, the figure increased to a little more than GHc800 million (\$ 203,886,068 US Dollar) (Dr. Kwabena Twum-Nuamah, 2015 – NPP for Berekum East. Debates of 26 March 2015).

The NHIS funding gap is having restrictive implications for people accessing health care under the NHIS. Even though the government since 2004 has been able to sustain the NHIS in the midst of a huge funding gap, and public outcry and complaints of poor service delivery; what is certain is that the coming years will be even more taxing. According to Mathew Opoku Prempeh, an opposition member of parliament (New Patriotic Party MP – 6th Parliament) in Ghana's parliament, "if 100 per cent of NHIS money is even given upfront like we started in 2014 or 2015, by the time we finish 2016, there would be a claim arrears of more than half

a million Ghanaian cedis. That is the issue we have to confront". (Dr. Matthew O. Prempeh, NPP MP for Manhyia South. Debates of 26 March 2015). To this extent, there have been a lot of concerns from key interest groups. For instance, "the GMA is gravely concerned with the gradual re-introduction of cash and carry at the various health care facilities across the country. It is a fact that, the facilities are restoring to cash and carry because of prolonged indebtedness of the NHIS to them. Indeed, some facilities have not been paid their claims in the last quarter of 2015" (Awuni, 2016).

The problem with the NHIS fund gap is largely attributed to the increasing numbers of active members on the scheme even though administrative and managerial hazards cannot be ruled out. Recent happenings show that the survival and sustainability of the scheme is under serious threat if new financing or policy options beyond the traditional ones are not sought. Incessant withdrawal of services by health providers and delays in claim payments substantiate the financial challenges confronting the scheme. At the moment, there are many health providers mostly private that have entirely withdrawn their services from the scheme, and even for public facilities, patients have been forced to make OOP payments for health care services already covered under the scheme due to non-payment of claims submitted to the scheme. Several patients have also been turned away from accredited health facilities. Considering the rising numbers in new subscribers, treatment cost and cost of drugs both consumables and non-consumables, it is clear, that the cost of claim payments to health care providers will continue to heave amid an increasing demand within vulnerable population groups in seeking health care.

Even though there have been attempts by other studies to discuss NHIS funding and sustainability in Ghana, this present study discusses the various arguments in the NHIS funding and sustainability debate, the interest groups and the factors influencing the debate. In doing this, the study has been sub divided into three sections. The first section contains the introduction of the study. This deals with general discussions about health care financing. The second section contains the methodology of the study. In this section – methodology, the authors discussed how they collected data. In the final section of this study, the results and discussions of the study are presented.

2. Methodology

2.1. Data collection

In this study, the researchers collected data from community public fora, district/municipal and metropolitan public fora, regional public fora and national public fora. In-depth interviews with health directors, health professionals, technocrats, directors and staff of the NHIS, members of parliament, past ministers of health, service providers, clients and academicians were conducted as part of a broader and nationwide stakeholder consultation on how to finance the NHIS. The authors also collected data from stakeholder workshops, conferences and student symposiums (see Fig. 1 for break down). Apart from the primary data sources, other secondary sources of data such as books, journals, media briefings and bulletins, radio and television discussions, newspapers, reports, parliamentary Hansards and manuscripts and online resources were utilised.

Thirty-two (32) different public and private television and radio stations were monitored across the country through the air waves and online websites. These televisions and radio stations were selected based on their popularity (most listened to) and wide media space. Panel discussions and news bulletins on NHIS funding were the main items monitored. Six (6) national daily newspapers

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