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GHANAS NATIONAL HEALTH INSURANCE SCHEME: RETROSPECTIVE CASE REVIEW

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Abstract:

Introduction: Several African countries have health insurance schemes or programs for their citizens and Ghana is one of such countries in Africa having taken bold steps to achieving such milestone. Programmes. These programmes seek to extend health insurance to the marginalised groups within the population and citizenry. The purpose of this article is to have retrospective review of the national health insurance scheme in Ghana, in relation to the restructured National Health Insurance Authority (NHIA) and their ability to serve all Ghanaians irrespective of one's financial capabilities.

Method: This study is a retrospective review using secondary data and records, reports as obtained from official manuals, from the former National Health Insurance Scheme (NHIS) of Ghana, published reports and data on their website as of 2018/19, world health organisation reports as of 2022 and manuals from the ministry of health Ghana and also reviews from works done by researchers of 2022 that used the National Health Insurance Scheme of Ghana as a case. This was done with search engines such as google scholar, world of science, academia.edu,

Results: The authors of this work found that health insurance been operated by the government of Ghana was the dominant model in Ghana but with open space that has accommodated many private funded health insurance companies to operate within laid done regulations although the private health insurance was still marginal as of 2022 with reference to the population of Ghana in 2022. The review also confirmed the limitations of contribution-based financing and the need to strengthen tax-based financing in a way that will not burden the ordinary Ghanaian.

Conclusion: The National Health Insurance Authority of Ghana is more likely to contribute to the achievement of universal health coverage (UHC) goals only if it ensures better management and enhance innovative way of adding resources on a larger scale while widening coverage on many diseases and treatment options with a unique feature of covering all primary health conditions and covering paediatric secondary conditions like some paediatric cancers and geriatric (old age) conditions with rolling out co - sharing premiums for diseases like renal failures or kidney diseases that warrant frequent dialysis for the working class.

Keywords: Health Insurance, Health care finance, Budget, Universal Health Coverage.

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Introduction

National Health Insurance Scheme (NHIS) of Ghana was made operational in 2003. Since then the Government of Ghana has made substantial progress toward its goal of universal health care. As of 2014, the NHIS covered 10.5 million people, or 40 percent of Ghana's population. The total number of inpatient and outpatient visits to health facilities rose from just under 0.5 per capita in 2005 to almost 3 per capita in 2014. The Ghana National Health Insurance Authority (NHIA) has strengthened its technical capacities over time, developing highly competent professional teams in the fields of actuarial sciences, financial management, insurance mechanisms, and health financing. Building robust actuarial analysis capacity is crucial to safeguarding the NHIA's financial sustainability. In addition, a clinical audit division was created in 2009 to review the authenticity of claims to reduce claims fraud. A revised NHIS medicine list was introduced to promote rational prescribing practices while authorities shifted provider payments for inpatient services from a fee-for-service model to Ghana Diagnosis-related-groups (GDRG).

The National Health Insurance Scheme operations as of 2012

Ghana's National Health Insurance Scheme (NHIS) was created by the National Health Insurance Act of August 2003, and is one of very few attempts by a sub-Saharan African country to implement a national-level, universal health insurance program. A newly-created National Health Insurance Authority (NHIA) was commissioned "to secure the implementation of a national health insurance policy that ensures access to basic healthcare services to all residents". The NHIA licenses and regulates district-level mutual health insurance schemes (DMHISs) as well as other schemes allowed under the Act, accredits providers, determines in consultation with DMHISs premium levels, and generally oversees and reports on NHIS operations. The NHIS is financed from four main sources: a value-added tax on goods and services, an earmarked portion of social security taxes from formal sector workers, individual premiums, and miscellaneous other funds from investment returns, Parliament, or donors.

The Law Governing Ghana's National Health Insurance Scheme as of 2012

Act 650 stipulates all Ghanaians to enrol in the NHIS or in another health insurance plan. Section 31 of Act 650 reads:

a. A person resident in Ghana other than a member of the Armed Forces of Ghana and the Police Service shall belong to a health insurance scheme licensed under this Act.
b. A person resident in a district, who is not a member of a private health insurance scheme or any other district scheme registered under this Act, shall apply to be enrolled as a member of the district mutual health insurance scheme in the relevant district." However, enrolment is de facto voluntary because there is no penalty for failing to enrol, and individuals or households are not automatically enrolled. Ghanaians generally must go in-person to a district management health information system (DMHIS) office, complete registration paperwork (often after waiting a substantial amount of time), and pay a small registration fee meant to cover the photo ID and administrative expenses of registration. In addition to SSNIT contributors, broad swaths of the population are exempt from paying premiums (but not registration fees), including:

1. People over age 70;
2. Children under 18 whose parents both enrol;

The "core poor," defined as being unemployed with no visible source of income, no fixed residence, and not living with someone employed and with a fixed residence16; and Since July 2008, all pregnant women. Official statistics on NHIS registration provided by the National Health Insurance Authority show the increase in enrolment since operations began in late 2005. A total number of active members reportedly increased from 2.4 million in 2006 to 11.1 million in 2009, suggesting that close to 50% of the population was covered by the insurance by 2009. More recently, however, the national health insurance authority (NHIA) changed its methodology for calculating active members and estimated in its 2010 annual report that about 34% of Ghanaians were active enrolees at the end of 2010.

Basic Features

a. Revenues and Expenditures

The National Health Insurance Scheme (NHIS) is financed primarily by tax revenue, and claims make up the bulk of its expenditures. The National Health Insurance (NHI) levy provides 74 percent of NHIS revenue, Social Security and National Insurance Trust (SSNIT) deductions comprise another 20 percent, and premium payments provide just 3 percent. Ghana is the only country in the world to finance its health insurance scheme primarily through value added tax (VAT) revenue. Using the VAT to finance health care also creates an implicit subsidy for basic care, and it provides a basis for pooling risks and costs at the national level, which prevents the scheme fragmentation experienced by many other countries. However, this mechanism has one major disadvantage, which is revenue does not increase as coverage expands.

b. Member Enrolment

All residents of Ghana, including non-citizens, are eligible for NHIS coverage, but not all enrolees are required to pay premiums. SSNIT contributors do not pay premiums, nor do enrolees under the age of 18 or over the age of 70. As of 2014, the NHIS covered about 40 percent of the population.

Benefits Package

NHIS covers 95 percent of diagnosed conditions, and it has no cost-sharing requirements. NHIS policy covers all outpatient, inpatient, and emergency care, and a list of excluded conditions is explicitly defined. NHIS members pay no out-of-pocket costs for services or pharmaceuticals based on policy.

Claims Management

Claims management is a vital component of NHIS operations. On average, National Health Insurance Authority (NHIA) processes 2.4 million claims each month. Most claims are submitted via paper forms; only 8 percent are submitted electronically. Once providers submit their claims, the NHIA subjects them to a 5 step process:

1. Fulfilment
2. Vetting
3. Data entry
4. Vetting-report generation
5. Payment request initiation.

A typical vetting report includes information on the total amount deducted for a given batch of claims from each facility. However, some providers have complained that these reports do not include specific information on individual claims.

Provider Payments

Under the NHIS, providers were initially paid only on a fee - for - service (FFS) basis, but over time the payment system evolved to encompass Ghana diagnosis-related-groups (GDRG) and capitation. As FFS payments can incentivize an oversupply of services, GDRG and capitation payments were introduced to contain costs. While capitation payments are used for outpatient primary care in some regions of Ghana, GDRG are used for all inpatient care, all outpatient care in non-capitation regions, and outpatient specialty care in capitation regions. Pharmaceutical costs are still reimbursed to providers on an FFS basis, which reflects predetermined tariffs and quantities of drugs submitted by provider. Private health care providers receive higher GDRG tariffs and capitation rates to compensate for their lack of public funding. Public providers (including Christian Health Association of Ghana CHAG facilities) receive funding from the ministry of health (MOH), whereas private providers do not receive it. Consequently, tariff rates differ significantly by facility type and ownership. For example, the reimbursable cost of a general consultation for an adult patient is 76 percent higher for a private primary hospital and 48 percent higher for a private clinic than it is for a public primary hospital.

Provider Accreditation

Health facilities require NHIA accreditation to provide services to NHIS members. Once an application is received, along with the required documentation and fees, the NHIA verifies that the submitted documents are complete and then sends an accreditation toolkit to the facility. The NHIA's quality-assurance department undertakes a detailed assessment of the facility and submits a report to NHIA management, which makes the final decision.

NHIS's Role in Health Care Financing

The National Health Insurance Fund is the second-largest component of public health spending. Value Added Tax (VAT) revenue and SSNIT deductions finance the fund.

In 2014, it provided about Ghanaian cedi (GH¢) 1.6 billion to the Ministry of Health (MOH), GH¢0.9 billion to the National Health Fund, GH¢3.3 million for capital investment, and GH¢ 0.5 billion for health-sector projects financed by external loans. Since 2012, the NHIS has played an increasing important role in public health financing. The National Health Fund has always represented about 3 percent of total public spending. However, the share of MoH expenditures rose to a peak of 8.5 percent of total public spending in 2012, then fell to 5 percent in 2014, the same share as in 2010. The NHIS is a major source of operational financing for health facilities. Funds allocated to the MoH cover more than 95 percent of personnel compensation but a negligible share of non-salary recurrent expenditures for frontline health care workers. Consequently, health facilities must rely on NHIS reimbursement to recover their operational expenses. Total public spending on goods and services for the MoH, Ghana Health Services and CHAG reached about GH¢140 million in 2014.

Factors Affecting Level and Efficiency of Claims Expenditures

Three factors determine the size and efficiency of claims expenditures in Ghana: coverage expansion, behaviours of service providers and National Health Insurance Scheme (NHIS) members, and the internal management of the National Health Insurance Authority (NHIA). Insurance intends to remove financial barrier for accessing care by expanding coverage. Policymakers' ability to influence this dimension is inherently limited. However, the authorities can affect the behaviour of service providers and patients through measures to address adverse selection during enrolment, the suboptimal composition of the benefits package, low levels of cost-consciousness, and weak performance incentives. The NHIA can also enhance its own internal efficiency by reforming its systems for claims processing, provider oversight, and member engagement.

Adverse selection is a major problem in insurance markets.

High-risk individuals tend to have greater demand for insurance than low-risk individuals. Left unchecked, the tendency can threaten the stability of a national insurance program. An analysis of NHIS membership data reveals that adverse selection is increasing the cost of insurance. NHIS members are more likely to be in high-risk age groups. Compared to national census data, the NHIS membership has a greater concentration of children under the age of five and individuals over the age of 55. These groups have significantly higher per-member health costs than those in the middle of the age range. There is a great deal of turnover among NHIS members. Out of all active members in January 2014, only 42 percent remained in the scheme in January 2015. This suggests that members may enroll during periods when they anticipate.

Designing Policies for Efficient Spending

This page provides recommendations to address the two major groups of factors affecting expenditure level and efficiency; behaviours of service providers and National Health Insurance Authority (NHIA) internal management. Behaviours of service providers are largely affected by designs and implementation of National Health Insurance Scheme (NHIS) policies such as enrolment benefit package, provider payment mechanism and cost-sharing. By reforming these policies, perverse incentives for service providers and NHIS members can improve efficiency of NHIS. More importantly, the implementation of these policy changes need to be supplemented with improvement in NHIA's capacity in managing expenditures so that behaviours of service providers and members can be monitored and affected.

Areas for Further Analytical Work

The NHIA should collect more comprehensive information on interactions between patients and health care providers. Beyond the basic information needed to process claims, the NHIA should record patients' health status, any tests undertaken, any procedures

performed, the results of laboratory work, any medicines prescribed, and any out-of-pocket costs incurred. This information will enable the NHIA to more effectively judge the appropriateness of diagnoses, claims coding, and treatment plans. This will also help the NHIA adjust the case mix while paying providers. Further analysis will be necessary for NHIS to spend more efficiently. Monitoring the effects both intended and unintended of cost-containment policies will be essential to their successful implementation. In addition, policymakers require more detailed information on out-of-pocket spending in the health care sector, particularly by NHIS members. A thorough assessment of existing systems for measuring and assuring service quality in health sector would help identify priority areas for intervention, particularly in primary care.

NHIA Accreditation Criteria

A facility that wishes to apply for NHIA accreditation must:

• Have already received accreditation from a national regulatory body: Ghana Health Services, the Health Professional Regulatory Authority, or the Pharmacy Council.

• Have been in operation for at least six months prior to the application.

• Be in good standing for service provision.

• Provide information on staff levels, physical infrastructure, and services provided.

• Accept the NHIA's quality-assurance standards and payment mechanisms.

• Agree to allow on-site inspections by the NHIA or its authorized representatives and Implement corrective measures as necessary.

Conclusion and Recommendation

In a country like Ghana with a deficit for formal sector operations and a substantial number of people with low contributory capacity needs an efficient but payment flexible health insurance schemes. The review also confirmed the limitations of contribution-based financing and the need to strengthen tax-based financing and this affirms the work done by (Ly, Bassoum and Faye 2021). If the health insurance model of Ghana adapts major accountability, probity and standardized auditing and financial management principles that enhance better management, there will be many avenues created for the pooling of resources on a larger scale. With this achieved, the NHIA should gradually widen coverage, premiums on many diseases and treatment options with a unique feature of covering all primary health disease conditions and covering paediatric secondary conditions like some paediatric cancers and geriatric (old age) conditions with rolling out co - sharing premiums for diseases like renal failures or kidney diseases that warrant frequent dialysis for the working class.

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