Financial Protection and Improved Access to Health Care: Peer-to-Peer Learning Workshop
Finding Solutions to Common Challenges

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Accra
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Contents

- History of health coverage in Ghana
- Evolution of CBHI in Ghana
- Transition from CBHI to NHI
- NHI S Operational Performance
- Financial Sustainability
- Challenges/ Critical Considerations

NATIONAL HEALTH INSURANCE SCHEME
History of healthcare coverage in Ghana
Evolution of healthcare coverage in Post Independence Ghana

### 1957 - 1966
- Input shortages
- High Gov’t expenditure

### 1966 - 1969
- Continued high expenditure
- Input shortages
- Constriction of access

### 1969 - 1972
- Low fee recovery income
- Constriction of access

### 1972 - 1981
- Chronic shortages
- Deterioration in health status

#### Policies
- Expansion of infrastructure
- Removal of user fees/reimbursement of mission hospitals
- Cessation of private practice in public facilities
- Hospital Fee Act of 1971 passed to enable part cost recovery
- Attendance at rural facilities made free
- Continued investment in rural health infrastructure

#### Policies
- Re-introduction of user fees
- Suspension of user fees due to public dissatisfaction
- Reinstatement of user fees to take effect after government change
- Development of primary healthcare health for all policy
- Drastic reduction in funding for health due to poor economy

**NATIONAL HEALTH INSURANCE SCHEME**
Period before rapid evolution of community health insurance (1984 – 1999)

**Policy/Program**
- Surcharges on imported medicines and medical equipment
- User fees & full cost recovery for drugs (Hospital Fee Law, Legislative Instrument 1313)
- Bamako initiative (direct input supply to communities)
- Cash & Carry (payment for drugs by facilities at collection, Cost recovery for medicines & user fees for services)

**Effect**
- Shortage of medicines & poor state of equipment
- Improved drug availability
- Reduced demand for services
- Revenue loses due to ill-defined exemptions
- Illegal charges and fraud
- Full benefits not realized. Abandoned after 3 years
- Healthcare unaffordable to 69% of population
- Improved drug availability

*NATIONAL HEALTH INSURANCE SCHEME*
CBHI in Ghana

...Your access to healthcare
Lessons Learned from Community Health Insurance initiatives in Ghana (1)

• Best practices in scheme design are required for Community Health Insurance Schemes to be viable

• Small risk pools present challenges as few schemes had in excess of 10,000 members

• Inadequate quality of care, especially at public health facilities, is a key factor constraining growth of Community Health Insurance Schemes as poor quality is off-putting for potential members

• Strong provider contracting regimes are important for Community Health insurance Scheme survival

• Reimbursement of claims to members encourage fraud.

• Strong population willingness to participate in the NHIS due to previous exposure to risk pooling principles
Lessons Learned from Community Health Insurance initiatives in Ghana (2)

• Community Health Insurance Schemes helped decrease in OOP

• Community Health Insurance Schemes often use fee-for-service as they lack the capacity to develop more complex provider payment methods.

• Most Community based health insurance schemes lack suitable managerial and insurance-specific technical knowledge, community mobilization and participation, and monitoring and evaluation skills

• Enrolment of informal sector workers presents numerous problems

• A good regulatory regime is required to ensure sustainability of Community Health Insurance Schemes
Transition from CBHI to NHI
Transition from CBHI to NHI

- Lessons learned from CBHI shaped design of NHIS.
- NHIS was established by an Act of Parliament in 2003 (Act 650).
- Majority of 258 CHBIs in existence in 2003 were integrated into NHIS
- Initiative by Government to secure financial risk protection against the cost of healthcare services for all residents in Ghana.
- Act revised in 2012 – NHIS Act 852
Ghana’s NHIS has:

- Made significant progress in providing financial risk protection for residents in Ghana over the past decade.

- Improved health-seeking behaviour of a significant proportion of the population evidenced by substantial increase in membership and utilization of health care services.

- Been recognized as a globally as a promising model for social protection in health.
NHIL (2.5% VAT)
SSNIT Contributions (2.5% of payroll)
Interest on Fund (Investment Income)
Road Accident Fund
Workmen’s compensation
Premium & Registration Fees
Other Income

Ministry of Finance and Economic Planning
National Health Insurance Fund (NHIF)

1. Transfers for Claims Payment/Admin
2. Processing Fee Retention

Support to Partner Institutions (MOH) [Capped @ 10%]
Admin. & General Expenses of NHIA
Payment to Healthcare Providers

District Offices of NHIA
Mainly comprises a combination of the following three models:

- National Health Insurance levy (NHIL) – 2.5% VAT
- 2.5 percentage points of Social Security (SSNIT) contributions
- Graduated informal sector premium
Benefits Package

...Your access to healthcare
Benefits package

Outpatient Services
Inpatient Services
Emergencies

Exemptions
18 conditions are exempted from the package. These include cancers other that breast of cervical cancer.

Public health Programmes
• 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
# NHIS accredited facilities by type 2014

<table>
<thead>
<tr>
<th>Type</th>
<th>Number Of Facilities</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemical Shops</td>
<td>197</td>
<td>4.92</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>317</td>
<td>7.92</td>
</tr>
<tr>
<td>CHPS</td>
<td>1399</td>
<td>34.94</td>
</tr>
<tr>
<td>Clinics</td>
<td>302</td>
<td>7.54</td>
</tr>
<tr>
<td>Dental Clinic</td>
<td>9</td>
<td>0.22</td>
</tr>
<tr>
<td>Diagnostic Centres</td>
<td>61</td>
<td>1.52</td>
</tr>
<tr>
<td>Eye Clinic</td>
<td>13</td>
<td>0.32</td>
</tr>
<tr>
<td>ENT</td>
<td>1</td>
<td>0.02</td>
</tr>
<tr>
<td>Health Centres</td>
<td>939</td>
<td>23.45</td>
</tr>
<tr>
<td>Laboratories</td>
<td>111</td>
<td>2.77</td>
</tr>
<tr>
<td>Maternity Homes</td>
<td>214</td>
<td>5.34</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>1</td>
<td>0.02</td>
</tr>
<tr>
<td>Polyclinics</td>
<td>26</td>
<td>0.65</td>
</tr>
<tr>
<td>Primary Hospitals</td>
<td>330</td>
<td>8.24</td>
</tr>
<tr>
<td>Secondary Hospital</td>
<td>8</td>
<td>0.2</td>
</tr>
<tr>
<td>Tertiary Hospital</td>
<td>2</td>
<td>0.02</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>75</td>
<td>1.87</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>4004</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
IV. Challenges & Way Forward

Active membership trend

ACTIVE MEMBERSHIP TREND (2005-2015)

- 2005: 1,348,160
- 2006: 8,163,714
- 2007: 11,158,420

Nov.

- 2014: 11,158,420
- 2015: 40.2%

NATIONAL HEALTH INSURANCE SCHEME
Is the Exemption Regime sustainable under the current benefit package?

<table>
<thead>
<tr>
<th>Category</th>
<th>Premium</th>
<th>Processing Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informal sector</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Under 18 years ?</td>
<td>No</td>
<td>✓</td>
</tr>
<tr>
<td>70 years and above ?</td>
<td>No</td>
<td>✓</td>
</tr>
<tr>
<td>SSNIT contributors ?</td>
<td>No</td>
<td>✓</td>
</tr>
<tr>
<td>SSNIT pensioners</td>
<td>No</td>
<td>✓</td>
</tr>
<tr>
<td>Indigents/LEAP beneficiaries</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Pregnant Women ?</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Persons with mental disorder</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
Outpatient Utilization Trend

<table>
<thead>
<tr>
<th>Year</th>
<th>Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>597,859</td>
</tr>
<tr>
<td>2006</td>
<td>2,434,008</td>
</tr>
<tr>
<td>2007</td>
<td>4,648,119</td>
</tr>
<tr>
<td>2008</td>
<td>9,339,296</td>
</tr>
<tr>
<td>2009</td>
<td>16,629,692</td>
</tr>
<tr>
<td>2010</td>
<td>16,931,263</td>
</tr>
<tr>
<td>2011</td>
<td>25,486,081</td>
</tr>
<tr>
<td>2012</td>
<td>23,875,182</td>
</tr>
<tr>
<td>2013</td>
<td>27,350,847</td>
</tr>
<tr>
<td>2014</td>
<td>29,637,189</td>
</tr>
</tbody>
</table>
IV. Challenges & Way Forward

Claims Payment Trend (GH¢ Million)

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount (GH¢ Million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>7.60</td>
</tr>
<tr>
<td>2006</td>
<td>35.48</td>
</tr>
<tr>
<td>2007</td>
<td>79.26</td>
</tr>
<tr>
<td>2008</td>
<td>183.01</td>
</tr>
<tr>
<td>2009</td>
<td>362.64</td>
</tr>
<tr>
<td>2010</td>
<td>395.06</td>
</tr>
<tr>
<td>2011</td>
<td>548.71</td>
</tr>
<tr>
<td>2012</td>
<td>616.21</td>
</tr>
<tr>
<td>2013</td>
<td>787.24</td>
</tr>
<tr>
<td>2014</td>
<td>1,077.00 (Prov.)</td>
</tr>
</tbody>
</table>

Data Source: Unaudited Financial Statement
Financial sustainability

Trend of NHIS Income & Expenditure (GH₵ Million)

INC > EXP

INC < EXP

<table>
<thead>
<tr>
<th>YEAR</th>
<th>Income (GH₵ Million)</th>
<th>Expenditure (GH₵ Million)</th>
<th>Surplus/Deficit (GH₵ Million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>200</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>2006</td>
<td>300</td>
<td>200</td>
<td>100</td>
</tr>
<tr>
<td>2007</td>
<td>400</td>
<td>300</td>
<td>100</td>
</tr>
<tr>
<td>2008</td>
<td>500</td>
<td>400</td>
<td>100</td>
</tr>
<tr>
<td>2009</td>
<td>600</td>
<td>500</td>
<td>100</td>
</tr>
<tr>
<td>2010</td>
<td>700</td>
<td>600</td>
<td>100</td>
</tr>
<tr>
<td>2011</td>
<td>800</td>
<td>700</td>
<td>100</td>
</tr>
<tr>
<td>2012</td>
<td>900</td>
<td>800</td>
<td>100</td>
</tr>
<tr>
<td>2013</td>
<td>1000</td>
<td>900</td>
<td>100</td>
</tr>
</tbody>
</table>
IV. Challenges & Way Forward

Efficiency measures

1) Institution of Clinical Audits
2) Establishment of Claims Processing Centers
3) Implementation of MOH uniform prescription form
4) Introduction of electronic claims
5) Linkage of Diagnoses to treatments to achieve the Phased implementation of Capitation
6) Enforcement of prescribing levels
Effect of efficiency measures

### AVERAGE OUTPATIENT CLAIMS

Average outpatient claims paid **increased** by 88% from **GHC 8.95** in 2005 to **GHC 16.84** in 2009 and **increased** by 5% to **GHC 17.66** in 2013.

However, if the amounts are adjusted by inflation, based on 2005 constant prices, the average outpatient claims paid **increased** by 9% from **GHC 8.95** in 2005 to **GHC 9.80** in 2009 and **decreased** by 28% to **GHC 7.03** in 2013.
Sustainability levers

### Key Income side factors

<table>
<thead>
<tr>
<th>Key Income side factors</th>
<th>Level of Control</th>
<th>Impact Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>• NHIL</td>
<td>Limited</td>
<td>Very High</td>
</tr>
<tr>
<td>• SSNIT Contributions</td>
<td>Limited</td>
<td>High</td>
</tr>
<tr>
<td>• Premium</td>
<td>Little Control</td>
<td>Low</td>
</tr>
<tr>
<td>• Efficiency gains</td>
<td>Full Control</td>
<td>Medium</td>
</tr>
</tbody>
</table>

### Key Expenditure side factors

- Benefit Package (Cost of services and medicines)
- Membership coverage
- Utilization of health care services
Challenges

...Your access to healthcare
Challenges

- Sustaining pro-poor focus
- Financial sustainability
- Fraud and abuse
- Providers agitating for higher tariffs and prompt payment of claims
- Increasing enrolment under the current financial constraints
- Agitation to expand benefits package
- Quality of services
- Governance & stakeholder engagement challenges
Purpose of NHIS reforms instituted by HE the President in September 2015

• To establish a sustainable, pro-poor and a more efficient NHIS, by redesigning, reorganizing and reengineering the scheme;

• To create a solid ground for improved service delivery across the scheme, in order to facilitate better provision of services to residents; and

• To create a smart scheme based on knowledge and evidence.
Objectives of NHIS reforms

- financial sustainability of the scheme;
- an increase public confidence of the scheme;
- an increase coverage of poor and vulnerable groups in the scheme;
- efficiency in health service purchasing;
- improvement in knowledge and information systems for decision making;
- accountability and efficiency in the operations of the scheme;
- provision of a framework for periodic review of the scheme; and
- alignment of the scheme to broad health sector goals.
Thank You