The Role of Health Insurance in UHC: Learning from Ghana and Ethiopia
Experts

Presenters

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30+ years experience in public health
Former: British Columbia Min. of Health, New Zealand Min. of Health, World Bank

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Senior Associate/Health Economist, Abt Associates Inc.
25+ years experience in development and health
Former: Government of Ethiopia, several NGOs in Ethiopia including World Vision

Moderator

Jeanna Holtz, MBA
Principal Associate, Health Insurance Specialist, Abt Associates Inc.
25+ years experience in health insurance development and operations
Former: ILO (Microinsurance Innovation Facility), Allianz Group, Aetna
Sustainable Development Goals (SDGs) adopted by UN (Sept 2015):
“Ensure healthy lives and promote well-being for all, at all ages” & “end poverty in all its forms everywhere”

- Goal 3 is for health
- Includes target to: “achieve UHC, including financial risk protection, access to quality essential health care services and access to safe, effective quality and affordable essential medicines and vaccines for all.”
USAID’s Vision

“USAID’s own goals for international development, ending extreme poverty, and more specifically in global health to end preventable child and maternal deaths, achieve an AIDS free generation, and to protect communities from infectious diseases rely on the progressive realization of UHC”

UHC: Affordable, Equitable Access to Needed Care

The UHC Coverage Cube

Source: World Health Organization and Busse, Schreyogg, & Gericke
What About Equity? Quality? Sustainability?

Hypothetical view of UHC by income group

COSTS COVERED:
Covered by pooled resources

POPULATION:
Who is covered?

SERVICES:
Which are covered?

Source: Hsiao, Roberts and Reich
No single pathway
GHANA
National Health Insurance in Ghana:
Achievements, Challenges, and Opportunities

Chris Lovelace
March 2, 2016
Overview

- Introduction to Ghana and its National Health Insurance Scheme (NHIS)
- Achievements and Challenges
- Key Challenge of Financial Sustainability while Expanding Coverage
- Addressing the Challenge- Improved Expenditure Management
- National Technical Review of NHIS and the Way Forward
## Ghana Country Profile

<table>
<thead>
<tr>
<th>Economic Indicator</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population (2014)</td>
<td>26.7 million</td>
</tr>
<tr>
<td>Gross Domestic Product (2014)</td>
<td>$38.6 billion</td>
</tr>
<tr>
<td>GNI per capita, Atlas method (current US$ 2014)</td>
<td>$1590</td>
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<tr>
<td>Life Expectancy at Birth (M/F) (2013)</td>
<td>61.1</td>
</tr>
<tr>
<td>Under 5 Mortality Rate (per 1,000) (2015)</td>
<td>61.6</td>
</tr>
<tr>
<td>Population Under Age 15 (2013)</td>
<td>38%</td>
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<tr>
<td>Population Over Age 60 (2013)</td>
<td>5%</td>
</tr>
<tr>
<td>Population Living in Urban Areas (2013)</td>
<td>53%</td>
</tr>
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Source: World Bank Development Indicators, WHO GHO, CIA World Fact Book
Reforms in Ghana’s Health System

1957
Free health care policy implemented.

1970s
Ghana experienced economic shocks and began structural adjustment programs.
Nominal payments for health services introduced.

1985
User fees (cash & carry) was introduced. This policy excluded majority of people from access to healthcare
Community-based mutual health insurance schemes were introduced.

1990s
High out-of-pocket expenditure on health and very low utilization of health services.

2000

2003
National Health Insurance introduced.

Source: NHIS GHANA-Overview of Reforms and Achievements, Presented by CEO Sylvester A. Mensah, November 2013
Ghana’s National Health Insurance Scheme

- NHIS was established in 2003 to secure financial risk protection against the cost of healthcare services
- NHIS Model and Funding:
  
  Mainly comprises a combination of the following three models:

  - **Bervridgian**: National Health Insurance levy (NHIL) representing 2.5% VAT
  - **Bismarkian**: 2.5 percentage points of Social Security contributions
  - **MHO**: Graduated informal sector premium based on ability to pay

Source: NHIS GHANA-Overview of Reforms and Achievements, Presented by CEO Sylvester A. Mensah, November 2013
### Achievements: Membership, Utilization & Claims

<table>
<thead>
<tr>
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<th>2005</th>
<th>2014</th>
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<tbody>
<tr>
<td><strong>Active Membership</strong></td>
<td>1.3 million</td>
<td>10.2 million</td>
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<tr>
<td>(38%)</td>
<td></td>
<td></td>
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<tr>
<td><strong>Outpatient Utilization (visits)</strong></td>
<td>597 thousand</td>
<td>29.6 million</td>
</tr>
<tr>
<td><strong>Inpatient Utilization (visits)</strong></td>
<td>29 thousand</td>
<td>1.6 million</td>
</tr>
<tr>
<td>(2013)</td>
<td></td>
<td></td>
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<tr>
<td><strong>Claims Payment (Amount GH¢)</strong></td>
<td>7.6 million</td>
<td>968.4 million</td>
</tr>
</tbody>
</table>

**Source:** Ghana NHIA Annual Reports
Ghana NHIS: Achievements and Challenges

- Clear improvements in health-seeking behavior: membership and utilization
- Positive results on financial risk protection
- Challenges: financial sustainability, lack of cost containment, slow growth, equity in membership coverage, quality of care
- Lessons to be learned and shared
Key Challenge of Financial Sustainability

Spending has exceeded revenues since 2009 and claims liabilities continue to increase.

Trend of NHIS Income & Expenditure (GH₵ Million)

Source: Presentation by Caroline Jehu-Appiah, Experiences of Ghana’s National Health Insurance Scheme, African Development Bank, June 11, 2015
Addressing NHIS Financial Sustainability

Turning NHIS from a passive bill-payer to an evidence-based strategic purchaser

- Improve expenditure management and contain costs
- Strategic health purchaser
- Enhanced ability to generate and use evidence for decision-making
- NHIS Technical Review
- Financial sustainability and expanded coverage
Improving Strategic Health Purchasing

- Capitation Scale-Up Implementation
- G-DRG Refinement
- Claims Management and Costing
- Policy Dialogue and Collaborations

Strategic Health Purchasing

“Closing the Hole” (Efficiency Gains)

- Sustainability of NHIS
- Improved Service Delivery
- Better Financial Protection
Improving the Use of Evidence in Decision-Making

**Goal:** Strengthened generation and use of evidence in NHIS operations

- **Objective #1:** New tools developed for data visualization and interpretation
- **Objective #2:** Advanced knowledge & skills among NHIA staff in using data for management decisions
- **Objective #3:** Improved strategies for generation, management, and sharing of data

- **Activity #1:** Dashboard Development and Use
- **Activity #2:** Operations Research
- **Activity #3:** M&E Policy
- **Activity #4:** Learning and Knowledge Exchange
National technical review of NHIS underway to determine viable reform options

- Technical Committee- will prepare draft report
- Advisory Committee- will make recommendations based on draft report
- Final report expected completion in mid-2016
ETHIOPIA
Community Based Health Insurance as a Pathway to Universal Health Coverage: Lessons from Ethiopia

Hailu Zelelew

March 2, 2016
Outline

- Background (Country profile, health system in 1990s, and health finance)
- Health sector initiatives and synergy with financing reforms
- Health outcome trends
- Rationale for CBHI in Ethiopia
- Piloting: Scope, policy and technical processes
- CBHI pilot evaluation findings
  - Funding and management
  - Achievements
  - Challenges
- Current developments
- Lessons from Ethiopia
Ethiopia Country Profile

- Population: 96.96 million (2014)
- 43% under age 15
- Life expectancy (63 in 2013)
- 29.6% in poverty (2011)
- GNI per capita: $550 (2014)
- Over 85% of the population in the informal sector


Source: https://jelford.files.wordpress.com/2013/05/where-is-ethiopia.jpg
Limited physical and financial access to health care
Shortage of operational budget in health facilities
Shortage of essential drugs
Misallocation of funds (higher spending on tertiary care, mismatch of resources → inefficiency)
Centralization of decisions
Sustainability - prospects low
Inequity in health → No systematic protection mechanisms for the poor

Late 1990s and early 2000, Ethiopia introduced a wide range of reforms.
Background: Health Financing

Per capita spending trend

Sources of health finance

Government 15.6%
Households 33.7%
Rest of the world 49.9%
Others 0.8%
Health Finance Synergy with Other Initiatives

Service coverage interventions

- Accelerated training of HWs
  - Health Extension Program: 2 HEWs per kebele (42,336 HEWs, 2014/15)
  - Training of mid-level HWs, and more recently physicians
- Accelerated construction of health facilities:
  - Over 15,000 health posts
  - 300 health centers (1990s) to 3,586 (2015)
- HSDPs (4 b/n 1997-2015)
  - Prioritization of health services
  - Preventive and promotive care-focused

Health financing interventions

- Increased donor funding ➔ Harmonization and alignment (including MDG pooled fund)
- Fee waivers (to protect the poor) and exemptions (for provision of priority services)
- Decentralized planning and budgeting (prevention focused district level planning and budgeting)
- Facilities retain and use revenues
- More recently HI introduced
Selected Health Outcome Trends

Under 5 Mortality Rate - Trend

- Ethiopia achieved MDG – 4 in 2012
- Encouraging progresses recorded in other health related MDGs
- Overall health outcome has improved

Sources:  
* UN Inter-Agency Group for Child Mortality Estimation: 2013  
**Ethiopia DHS (2000, 2005 and 2011 Reports)
CBHI: Rationale for Ethiopia

- > 85% of Ethiopians dependent on the informal sector
- Household OOP spending accounts 34% of THE
- Very low health service utilization (0.3 per capita visit)
- Build on existing community solidarity systems
Lessons from other countries (literature reviews and visits)

- Ghana, Rwanda, Senegal, Mexico, Thailand and China

Technical documents and policy recommendations presented to government

- Health insurance strategy developed and endorsed in 2008
  - SHI for the formal sector
  - CBHI for informal sector (over 85% of population)

CBHI Piloting

- Pilot design: Membership, benefit packages, member contribution, subsidies, risk management, organizational arrangement, etc.
- Piloting launched in January 2011: 13 districts in largest 4 regions
2014 CBHI EVALUATION: FINDINGS, ACHIEVEMENTS, AND CHALLENGES
Piloting: Funding and Management

- 13 districts, with an average population about 140,000 each
- 300,799 eligible households (1.8 million population)
- Contributions from paying members (amounts determined by individual schemes) ➔ 52% of total fund
- Government subsidy (two types) ➔ 48% of total fund
  - Targeted (for the poor)
  - General (for everybody)
- In addition, local governments hired 3 staff per scheme and cover scheme’s operational costs
- Each scheme linked to local government structure
CBHI Achievements

- Enrollment: **52%** (157,553 households/over 700,000 beneficiaries)
  - Voluntary at household level
  - Enrollment variable by district (25-100% penetration)
  - Indigents average 15% of all members (variation across districts)

- Increase in health service utilization (0.7 visit per capita for insured vs 0.3 for national average)
  - Effect on health-seeking and treatment-giving behavior

- Poverty reduction effect:
  - 7% for insured vs 19% for non-insured (out of pocket expenditure >15% non-food expenditure)
Major Challenges

- Low membership renewal and new enrollment
- Financial difficulty among some schemes
- Variation in commitment of local officials
- Facilities differ in their readiness to deliver quality care (staffing, medicines, laboratory facilities, reception, outpatient services, etc.)
- Inadequate mechanisms to address complaints
Current Developments

- Government satisfied by pilot results and decided to scale up
- CBHI is being expanded to 185 districts in the four regions + over 131 in process
  - About 1.6 million HHs (over 22% poor HHs) joined CBHI schemes, and over 7.3 million people are covered (Dec. 2015)
- Piloting in urban settings and pastoral areas about to start
- Government is aware of the resource implication of scale up
- National CBHI scale-up strategy and directive developed
- Government plan to cover 80% of the districts and 80% of the population by 2020
Lessons from Ethiopia

CBHI is promising pathway to UHC

- High coverage rate ➔ 52%
- Provides financial risk protection including the poor
- Enhances health service utilization
- Creates pressure on providers for quality care
- Requires strong government commitment
  - Organizational, staffing, and budgetary implications
- Partners’ support is critical
Q&A

Chris Lovelace  Hailu Zelelew  Jeanna Holtz
Ghana

- Video: Tackling the Challenge of Financial Sustainability: Ghana’s National Health Insurance Authority
- Brief: Building on Community-based Health Insurance to Expand National Coverage: The Case of Ghana

Ethiopia

- Brief: Ethiopia’s Community-based Health Insurance: A Step on the Road to Universal Health Coverage
- Report: Universal Health Care in a Low-Income Context: An Ethiopian Case Study

Questions? Email us at: hfgproject@abtassoc.com.
Thank You!

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