PROPOSED REDESIGN AND RESTRUCTURING OF THE NATIONAL HEALTH INSURANCE SCHEME

Main Report

Submitted to the Hon. Minister of Health

By the Presidential NHIS Technical Review Committee

September 2016

Acknowledgements

The Review Committee would like to first thank the President of the Republic for the decision to set up this committee to review the NHIS as well as the Hon. Ministers of Health, Finance, and Gender and Social Protection for giving their full support and encouragement in many ways to this review process.

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List of Acronyms

CHAG	Christian Health Association of Ghana
CHN	Community Health Nurses
CHPS	Community-Based Health Planning and Services
CSOs	Civil Society Organizations
DHIMS 2	District Health Information Management System 2
DHS	Demographic and Health Survey
DPs	Development Partners
DRG	Diagnosis Related Group
eHealth	Electronic Health
EHIF	Estonian Health Insurance Fund
GDP	Gross Domestic Product
G-DRG	Ghana Diagnosis Related Group
GNAT	Ghana National Association of Teachers
GNI	Gross National Income
GOG	Government of Ghana
ID	Identity
IMR	Infant Mortality Rate
IT	Information Technology
LEAP	Livelihood Empowerment Against Poverty
LMIC	Low Middle Income Country
MCH	Maternal and Child Mortality
MDG	Millennium Development Goal
MOFEP	Ministry of Finance and Economic Planning
MOH	Ministry of Health
MPs	Members of Parliament
NCD	Non-Communicable Disease
NHA	National Health Accounts
NHIA	National Health Insurance Authority
NHIL	National Health Insurance Levy
NHIS	National Health Insurance Scheme
OOP	Out-of-Pocket
OPD	Out-Patient Department
PHC	Primary Health Care
SDG	Sustainable Development Goal
SSNIT	Social Security and National Insurance Trust
TOR	Terms of Reference
TUC	Trades Union Congress
UHC	Universal Health Coverage

U5M	Under-Five Mortality
VAT	Value Added Tax
WB	World Bank
WDI	World Development Indicators
WHO	World Health Organization

Executive Summary

O**verview**

1. The Ghana National Health Insurance Scheme (NHIS), set up by Acts 650 (2003) and 852 (2012), has made considerable strides in terms of offering affordable health care to millions of poor and vulnerable people in the country. It continues to be the most important social intervention in the health sector in the country's history.

2. The NHIS also has some great design features that are working well for its beneficiaries and the country and should be preserved:

- The most important by far is the reduced fragmentation within the insurance system signified by the single purchaser and single pool for the benefit package
- The reliance on a publicly financed social health insurance, not individual premiums, is in keeping with best practice in equitable health financing design
- The equitable benefit package for all members without distinction is a huge step forward that most African countries attempting to implement UHC schemes can only envy!

3. However, the scheme has come up against significant challenges to its sustainability and other performance criteria, which reflect some flaws in the design as well as operational inefficiencies that have also dogged it from the start. The most visible signs of these challenges are the delayed payments to providers that reached eight to nine months of arrears at the end of 2015 and the beginning of 2016; widespread unauthorised charges levied on insured patients who, under the law, should not have to pay for insured services at the facilities; long queues for, and numerous difficulties with, biometric registration of members; allegations of fraud and abuses by different parties of the NHIS; unfavourable media stories about the scheme; and rising public dissatisfaction with the NHIS.

4. The NHIS Technical Review Committee was set up by His Excellency the President in response to the above challenges, with a mandate to review the design and operations of the scheme and come up with findings and recommendations to improve upon its **sustainability, efficiency, equity and accountability as well as user satisfaction**. At end of its review work and deliberations, the committee made the following key findings:

On Sustainability

5. It is important to note upfront that in the design decisions around the NHIS in 2003 there is no evidence that the capacity of the country to pay for the benefit package was ever explicitly taken into account and explained to Ghanaians. In that connection, it is important to note also that when Ghana launched the NHIS in 2003, no other country at that level of income per capita (then well below $1000 per capita) or health spending per capita (even now still at about $60 per capita), had ever attempted such a sweeping and highly ambitious social health insurance reform with such a benefit package, acclaimed all over as very generous, without any cost controls of any kind to moderate the foreseeable expenditure growth.

6. **Though it was commendable and even innovative that specific sources of revenue were identified for the scheme, no answer was ever offered to the fundamental structural problem at the heart of the NHIS: what is the mechanism that will ensure that the revenues from the NHIL, which is the principal revenue source for the NHIS and whose growth has no demonstrable relationship to membership or expenditure growth, will balance the expected future expenditures of the scheme?** Even now, this conundrum remains one of the scheme's principal challenges that the Government will eventually have to face. A key part of this review has been to present specific proposals to Government (see later below) to address these challenges to the scheme.

7. The NHIS was set up in the context of the country's commitment and drive towards the MDGs, which set out health goals such as reduction of maternal and child mortality which the scheme tried to respond to, without reducing the generous benefits of the original design. More recently, the commitment to the SDGS and especially their UHC targets put further pressures on the scheme to respond accordingly, even as the country's graduation from low income to lower middle status is adding greater pressures on the public sector to fund an increasing amount of services and commodities such as vaccines and HIV drugs from domestic sources. Given limited resources all round, there is obviously a natural tendency on the part of the Government to try to put some of that burden on the resources of the NHIS.

Beyond the above factors, the sustainability of the NHIS has also been challenged by other features as well as developments since its inception.

8. It is clear from recent data that health sector funding is gradually shifting towards reliance on the NHIS, and less and less on the MOH budget, although the revenue bases of the NHIS have not expanded since inception. The ratio between MoH expenditure and NHIF expenditure decreased from 2.9 in 2012 to 1.7 in 2014. Not only that, but economic difficulties in recent years have constrained the fiscal space as a whole and growth in taxes such as VAT, the mainstay of NHIS revenue, in particular.

9. NHIS expenditures started to overtake income from 2009, although a real and growing deficit actually began to show in 2012 when the cushion provided by reserves was no longer available. Although about 75 percent of NHIS spending goes to health care costs, what actually constitutes those "costs" is disputable, due to widespread abuses and inefficiencies noted during the review. (See our comment below under Efficiency concerning this implied 75/25 medical loss ratio of the NHIS.)

10. Besides the dynamics of insurance such as adverse section and moral hazard which are present in the scheme, other drivers of future costs of the NHIS include: Ghana's graduation from low income to lower middle income status and consequent reduction of grants and impending withdrawal of GAVI and the Global Fund as key funding sources for crucial elements of the health sector; medical inflation which is usually higher than general inflation; and technological progress in medicine. All these will put pressure on the NHIS' expenditures.

11. This review proposes that, in the context of the country's current per capita income level and fiscal space, this balance be attained through (i) a rationalization of the benefit package, to ensure that it is more affordable and consistent with Ghana's priority health sector goals and (ii) integrating continuous actuarial modelling and projections into the scheme's financial analysis and reporting.

Solutions to the sustainability of the NHIS in the short to medium term must in particular address the immediate sources of inefficiencies discussed next.

On Efficiency

12. Although the NHIA has been undertaking a number of measures to enhance efficiency, including setting up four Claims Processing Centres, use of electronic claims, undertaking clinical audits, introducing unique provider IDs to facilitate better monitoring and claims analysis, initiating a digital claims entry strategy, and piloting and rolling out capitation in a number of regions, the scheme is still clearly beset with a considerable number of inefficiencies in its design and operations.

13. The biggest drivers of short term costs emanate from design and operational inefficiencies related to an almost complete lack of cost control mechanisms; reliance on mostly passive, instead of strategic, purchasing; adverse selection; widespread abuses; provider moral hazard; and a noticeable disconnect of members and even NHIA staff from the scheme and its management.

14. The lack of alignment of the benefit package to the country's health sector priorities is perhaps the most glaring inefficiency in the design of the scheme. Ghana is under-performing (compared to other countries in its income category) in key health indicators such as maternal and child mortality, while a rising burden of non-communicable diseases (NCDs) is exposing the weaknesses of investing heavily in curative care as the NHIS does at present., and neglecting key preventive services as well as primary health care (PHC) that could help check this rising threat to the nation's health.

15. The year-round design of open, voluntary enrolment favours adverse selection, despite the one month waiting period.

16. Operational inefficiencies arise from weak capacity of the purchasing agency in crucial dimensions and especially its inability to deploy its strategic purchasing potential, and hence making the scheme susceptible to fraud and abuses. Manual claims processing, emphasising vetting but not expenditure management, is one manifestation of this limited capacity.

17. Moreover, it should be stated that both Acts 650 and 852 were missed opportunities to define key efficiency targets for the NHIS. As a result, the NHIS has never operated according to any recognized legal norms regarding key efficiency indicators such as a medical loss ratio not to be exceeded or minimum reserve levels.

The 75/25 medical loss ratio cited in paragraph 5959 below is well below what the medical loss ratio should be for a social health insurance scheme, which normally should aim for a 95/5 ratio of health care spending to administrative costs, and at worst not below 90/10.[1]

Similarly, a social health insurance scheme is usually required by law to maintain a minimum level of reserves, with a recommended minimum amount equal to nine months of operational expenses.

18. The un-empowered membership is also a key source of inefficiency, since members are not incentivised to behave responsibly or see the NHIS as an ally or protector. The missed opportunities to engage actively with members, and to provide adequate information to them (using mobile technology for instance) about the consequences of certain behaviours including diet, life styles and choices, are reflections of such inefficiency.

On Equity

19. The good news is that equity in access has significantly improved in the NHIS in recent years. A World Bank study for the 2016 Public Expenditure Review (PER) shows unambiguously that access (or membership of the insurance scheme) is about equal between the lowest and highest wealth quintiles for both men and women, compared to earlier years of the NHIS when it was much criticized for being pro-rich.

[1] Compare best practice examples from Eastern Europe: The Estonian EHIF's operating expenses accounted for 0.98% of its total budget for 2014. In 2004 and 2005, operating expenses formed nearly 1.3% of the budget and decreased to 1.08% in 2006; since 2007, the EHIF's operating expenses have not exceeded 1% of its budget. This is similar to Hungary and Poland, but is much lower than Slovakia and the Czech Republic. Slovakian health insurance funds are legally restricted from spending more than 3.5% of their revenue on administration. The average among health insurance funds in the Czech Republic is 3.7%, with the larger funds having lower costs. Similarly, in South Korea available statistics suggest that only 4.4% of total expenditure was directed to administration as at 2013 (NHISK, 2014).

20. However, inequities continue to be manifested between insured and non-insured as well as in the availability and quality of the benefit package (which is not the same between rural and urban areas for instance) and a clear bias in the NHIS benefit package design against PHC and preventive services (which promote equity). There is also less (or more often no) choice of providers for rural dwellers, which tends to undermine some benefits of the capitation system being introduced.

On Accountability and user satisfaction

21. Taking user satisfaction first: recent focus group surveys carried out by consultants for this review found both positive and negative views about the scheme. Insured users for instance stated that the NHIS helped clients to get access to health care on timely basis and prevented unnecessary deaths in communities and also curbs patients waiting at home for long before reporting for treatment. They also described the NHIS Card as a "winning card" that enables the poor and vulnerable to access quality health care for free.

22. However, negative perceptions by the same groups were also pronounced: They described the NHIS services as of "low quality", with some of them describing the scheme as the "paracetamol scheme", because, they contended, that was most the frequent drug dispensed to them. The members also contended that they are made to wait for long hours before they are attended to at the health facilities because the providers tend to attend to those that are paying out of pocket first before them, with some even asserting that the NHIS is not working any more since many conditions and medications are not covered by the scheme.

23. The review also found that there was no regular mechanism for members to provide feedback of their experiences after service use, and for the NHIA to verify the actual receipt, quality and payment of services as claimed by providers, or any other issues encountered. The NHIA does not pay visits to random selections of patients to verify services received and obtain other feedback.

24. There is no mechanism in the NHIS to assist or defend patients with quality of care issues, including pro-actively working to reduce, or get redress for, medical errors. This is a crucial function in an insurance environment where the vast majority of beneficiaries are

vulnerable and powerless vis-à-vis both the providers and the purchasing agency. In such an environment, it is particularly important that the motives and actions of various actors can be challenged by the others for enhanced accountability.

25. We noted that this is the first comprehensive review of the NHIS after 12 years, which, though a positive sign, is not good enough. Going forward, periodic reviews every five years or so would be very useful, and should include, or rely on existing or planned, population level surveys of health outcomes, system responsiveness and degree of financial protection afforded.

26. The review noted that the NHIA's annual reports do not provide adequate performance metrics relevant to its operations and results for stakeholders, despite being voluminous documents. We propose that the outcomes-related performance criteria cited in paragraph 75 below be emphasized going forward, with less emphasis being placed on the uncritical use of utilization as a measure of NHIS success.

27. Transparency and accountability mean that people should have a good understanding of their entitlements and obligations and an understanding of efforts to improve quality and efficiency (for example, generic prescription), and that the government should periodically indicate the extent to which it is providing what it has promised. This behoves the NHIA to conduct periodic population satisfaction surveys containing questions regarding the population's awareness of their rights and obligations, and other aspects of performance, and to publish the results on its website as well as using them to plan more effective awareness campaigns.

28. Stakeholders also complained of lack of accountability by the NHIA, while the oversight mechanisms also appeared rather weak and/or ineffective. There appear to be no real incentives for strong oversight.

Proposed Redesign of the NHIS

1. Following from the above findings and additional analysis by the Committee, it is proposed that the NHIS be redesigned and reconfigured to improve upon its sustainability, efficiency, equity, accountability and responsiveness to users. The main features of the proposed redesign of the NHIS are as follows:

2. **Refocus the NHIS to provide primary health care (PHC) as well as maternal and child health care (MCH) for all the population on the basis of the public taxes that fund it. In other words, PHC and MCH should be guaranteed at public and CHAG/mission facilities at 100% with no user fees on such health services for all who need them (ie automatic coverage).** Private for-profit facilities including maternity homes, should be covered where they are situated within underserved areas of the country or where there is no realistic option within 5 km radius of the catchment population, but reasonable rates will be negotiated by the NHIA for such facilities.

3. No more fragmentation of the population based on insured/non-insured status for PHC /MCH services. The NHIS then becomes a strategic purchaser of these services on behalf of the Ghanaian public.

4. Since such care is guaranteed to everyone without distinction, the NHIS membership card will not be a condition of accessing primary health care. **However, a form of national or resident identification (including but not restricted to NHIA cards) should still be required, for anyone who is using these guaranteed services.** The providers have a duty to transmit all the relevant information on all persons seeking care to the NHIA as part of their contract agreement, whether that care is capitated or not. This would enable the NHIA to capture data that is essential for managing the scheme without the identification requirement becoming a bottleneck for accessing PHC.

5. A key challenge that must be addressed as part of these reforms to make the NHIS more equitable and responsive to poorer persons' needs, is how to make the NHIS also more attractive to better off sections of the population, who are needed not just for their financial contributions but also for their buy-in to the whole concept of publicly-financed health care for the whole population so as to sustain the system politically into the future. Some promising areas that may be explored include adding on high-value preventive

health care including dental and eye care services as part of an enhanced package, potentially for additional premiums that anyone can purchase.

6. The higher levels of care beyond PHC will be subject to stricter cost controls than in the past, including co-payments ('shared responsibility'), ceilings or caps in reimbursement and/or pre-authorization for very expensive care, retrospective reviews, intensive case management, database profiling, etc. Such cost controls will not however involve financial burden on maternal and child care at the higher levels.

The proposal is to guarantee **"coverage for all but not coverage for everything"**

7. The fundamental premise of this redesign is that the NHIL (or earmarked 2.5% VAT), which is the most important source of financing for the NHIS, is collected from all Ghanaians, and should be used to fund services that benefit the whole population and not just a minority pre-selected on inconsistent and not always justifiable criteria.

8. Though this redesign will obviously involve additional costs for the PHC package of the NHIS, it is a working assumption of the review that the current key funding sources for the NHIS – the NHIL and social security contribution– should be sufficient to cover PHC services for the whole population plus referral care for MCH and a limited number of exemptions at higher levels of the health care system, if ring-fenced for this purpose. **For this redesign to be sustainable, it is important that this coverage is limited to the public and CHAG/mission facilities as recommended (with the exceptions for some private for-profit facilities as noted). This will also enable some of the other aims of the reform, such as adequate capitation funding for facilities involved, to be achieved.** Preliminary calculations show that this limitation will make the recommendation affordable within current NHIS income.

9. Due to justifiable concerns about sustainability of this proposal, it is important to explain further how this redesign is expected to work and to address the sustainability issue at the same time. The MOH will define the broad primary care package and the specific contents of what primary healthcare in Ghana will be. That is their mandate. The two NHIS sub-committees working on a benefit package for the scheme will then define the contents of a primary care package for the insurance scheme, drawn from the national

PHC package defined by the MOH. This is understandable because the MOH is concerned about what a full and ideal PHC package for Ghana should be, based on epidemiological and other factors, and without regard to financial constraints. This is also correct because the broad PHC so defined is to be funded from the multiple funding sources in the Ghanaian health system. The NHIS however, needs to define a more limited benefit package within its financial constraints (remembering that the NHIS is not the only funding source in Ghana's health sector, so cannot agree to fund everything defined by the MOH). The work currently ongoing is moving towards NHIS covering services at CHPS and health centre levels, as well as referrals to district hospital and basic preventive services, all within the guaranteed PHC package, at least initially.

10. The key to the new proposals is that what we propose to be the package has got to be affordable by definition - it will be constrained by our available annual budget for PHC and will also be constrained by the fact that we will be paying the package through a capitation mechanism for all the population, so the NHIA will always know the required budget each year in advance. This is not an open-ended commitment that could break the NHIS budget.

11. Note also that this budgetary constraint is meant to operationalise our country's aspirational goal of universal PHC within the present fiscal context, while allowing for this package to be expanded as the country's fiscal means improve, until we are able to provide the entire package defined by the MOH. Hence the importance of proper phasing-in that should be part of the mandate of an implementation working group that we also propose to be set up by the MOH.

12. Actuarial work is ongoing to test the above assumptions as well as how far it may be possible to cover additional services at higher levels, through costing and actuarial analysis. Depending on the results of the actuarial study, additional funding sources would need to be identified to pay for care at higher levels of the health system.

13. It is important to establish a principle that we missed the opportunity to do as a country in 2003, namely that for each group exempted or individuals eligible to join the NHIS, the precise funding source and arrangements for covering their care should be **clearly and explicitly** identified.

14. We propose the NHIS aims for a 90/10 medical loss ratio in the medium term, but working towards a 95/5 ratio in the longer term. Similarly we recommend minimum reserve requirements equal to nine months' operational expenses, to be constituted over a period of five years.

15. We propose better coordination of care, which has long been recognized as a key indicator of the quality of primary care, particularly in countries without a long history of gate-keeping, where continuity of care is limited. The need for such coordination also reflects the complexity of managing care for rising numbers of patients with chronic conditions. Coordinated care can prevent wasteful duplication (of diagnostic tests, for example), potentially harmful use of different drugs and confusion among patients.

Extending the gate-keeping requirement to all patients and strengthening and enforcing the policy (for example, requiring specialists to issue discharge notes to GPs to qualify them for payment) would have positive effects on care coordination and continuity, particularly for patients with chronic conditions, and would contribute to stronger primary care.

Institutional reforms recommended to address gaps identified during the review.

16. The **group practice or provider networks** under consideration could respond to the earlier observation regarding the wide variation in quality and capacity to deliver the benefit package across the country. We propose to push this idea further towards the Thai model of provider networks with **lead providers** taking on some greater responsibilities, in this case we propose responsibilities such as managing capitation payments to network members, ensuring quality care and compliance among network members, with appropriate performance incentives for these lead providers. NHIA district staff will then monitor performance and compliance at facilities lower than the lead provider while the staff at the national level will similarly hold the lead providers accountable for agreed performance targets.

17. Piloting different models, including one where the NHIA continues to pay directly to health facilities but lead providers handle the other functions above, can be tried and monitored before a final model is rolled out upon evaluation.

18. We propose a much needed institution, **a National Health Commission**, to be chaired by a very senior, respected and impartial, retired ex-public official and comprising all bodies to do with financing and service delivery in the sector, including reps from MOFEP, Ministries of Gender, Employment, etc, providers' bodies, development partners, regulatory bodies, as well as governance CSOs and beneficiary groups. Its roles should include:

- Serving as the locus of priority setting work to examine the justifications and affordability of new services and technologies for the NHIS to cover. This Review Committee received submissions from several groups who wanted to have their conditions covered by the NHIS. A priority setting lead body such as this Commission will coordinate and lead the processes for making decisions on new health services and technologies to be covered by the NHIS taking into account factors such as cost effectiveness evidence, affordability, equity, societal values, etc. A specialized technical sub-committee of the Commission could assemble the technical evidence before the whole Commission works with other stakeholders to make decisions taking the wider criteria into account.

- National health financing and regulatory policy coordination, including in particular coordinating and harmonizing the different sources of funding to health and ensuring that there are no gaps or that services do not fall through the cracks or get pushed onto one of the funding sources by default rather than by design with careful consideration of the available funding etc. it is important that NHIS funding for instance is coordinated with other sources of health funding so as to achieve the desired goals in an optimal manner. There exists a clear gap in this area.

- Harmonizing of rules and regulations in the health sector, or related to health, to avoid duplication and inconsistencies, or constraining the work of other agencies.

- Reviewing progress against performance metrics of relevant sector agencies as a necessary oversight function.

- Appointing ad hoc technical committees, such as an arbitration body or mechanism to mediate differences between parties to the NHIS **without however the power to over-rule the NHIA's legitimate purchasing roles and decisions**.

19. In order to more effectively address commonly encountered problems related to the high degree of lack of empowerment of users/scheme members, both with respect to the NHIA and to providers, the Committee recommends that a **Patient Protection Council** be set up as a consumer protection unit outside and independent of the NHIA to help foster safer, more respectful, transparent, and compassionate care and services.

The Council will have retired clinicians, governance CSOs, NGOS working with mothers and children, and others who know the system well and can be champions of safer care and more positive outcomes for patients and families in both the NHIA and clinical settings.

They will be able to receive and investigate complaints but their role is meant to be complementary to, not to compete with, existing regulatory ones such as the Medical and Dental Council. Thus this body will not normally rely on compulsion but the power of moral suasion and transparency. Another difference is that this Council will be more pro-active in leading initiatives to improve quality, safety and reduction of medical errors. They may also independently investigate medical errors on behalf of patients and aggrieved families and shine light on egregious cases that may not otherwise get the airing that they should have.

A possible model for this body is the former National Patient Safety Agency (NPSA) in the UK, which is now integrated into NHS England.

45. In countries where a large social health insurance scheme such as the NHIS is in place, it is usual to have the Ministry of Finance directly involved in negotiations and decisions that affect sustainability and efficiency, such as strategic purchasing decisions and negotiations with pharmaceutical companies, to strengthen the power of the agency in such areas. Such collaboration has been remarkably absent in our case, and we would urge the MoFEP, which has lots of expertise in areas crucial to NHIS sustainability and efficiency, to play a more pro-active role in such issues as the scheme's strategic purchasing deployment.

How our recommendations address the main review themes

The following are ways in which our recommendations address the main review themes:

20. **Sustainability**

a. The focus on cost-effective PHC means that the resources are being harnessed to pay for the least expensive care (especially CHPS and health centres), but which are also interventions that can eventually reduce or slow down the increasing expenditures on the more expensive care, including the rising tide of NCDs.
b. The further recommendation to define the primary care benefit package in accordance with what is affordable within the budget of the NHIS and not what is currently defined as PHC or primary care by the MOH, and to expand that package progressively and only in accordance with economic and revenue growth, will enhance sustainability.
c. The stricter cost controls on higher level care suggested will also help to reduce cost increases in future.
d. The capitated primary package for all eliminates adverse selection in PHC and promotes provider sustainability by extending the pool of enrollees to include the currently uninsured. This should help contain the currently strident agitation around the alleged inadequacy of the NHIS capitation rates.

e. The recommendations to have legal requirements for limits to the medical loss ratio and a minimum level of reserves will, if enacted and implemented, significantly strengthen NHIS sustainability.

21. **Efficiency**

a. Aligning the NHIS with the most pressing health priorities of Ghana would be the most important efficiency enhancing initiative since the inception of the NHIS.
b. Strategic purchasing measures including framework contracts for drugs and provider payment improvements (to include budget-neutral DRGs) would help to bring costs under control.
c. A closed enrolment period during the year will help address adverse selection in insurance for the higher levels of care.

22. **Equity**

a. The focus on PHC focus is an equity enhancing strategy, as many studies cited in the main report show.
b. Moving towards group practices or networks that can provide the entire package of guaranteed PHC services will help address the equity gap between urban areas and under-served rural areas by enabling the inhabitants of under-served areas to have access to a range of providers rather than a single one that may not provide all the services in the package.
c. Eliminating all fees for PHC services for all the population and exempting the poorest from fees at the higher levels will be equity-enhancing.

23. **Accountability and user satisfaction**

a. Eliminating user fees for PHC for all would likely increase user satisfaction.
b. Supporting care at CHPS and health centres would bring services closer to the community which can also increase user satisfaction.

c. Member empowerment measures including the proposed Patient Protection Council (PPC) would enhance both accountability and user satisfaction.
d. Proposals we have made for better reporting of NHIS results, to include patient outcomes and intermediate outcomes as well as responsiveness to users and degree of financial protection, would also help with accountability.
e. Other measures such as setting up a National Health Commission with the proposed mandate, including an arbitration mechanism for settling disputes between parties to the NHIS, would enhance accountability of the NHIS.

Introduction and context

Overview

29. The Ghana National Health Insurance Scheme (NHIS), set up by Acts 650 (2003) and 852 (2012), has made considerable strides in terms of offering affordable health care to millions of poor and vulnerable people in the country. It continues to be the most important social intervention in the health sector in the country's history.

30. The NHIS also has some great design features that are working well for its beneficiaries and the country and should be preserved:

- The most important by far is the reduced fragmentation within the insurance system signified by the single purchaser and single pool for the benefit package
- The reliance on a publicly financed social health insurance, not individual premiums, is in keeping with best practice in equitable health financing design
- The equitable benefit package for all members without distinction is a huge step forward, as further explained in paragraph 2828 below.

31. The National Health Insurance Scheme (NHIS) has also brought real benefits to poor and vulnerable people in the country, and is even now serving as a beacon to other countries of an effort to move towards UHC in a relatively resource-constrained environment.

27. The active membership base of the NHIS is estimated in 2016 at 11.2 million, or about 40% of the population. Since its inception in 2003, hospital attendance is reported to have quadrupled from 0.4 per capita to over 1. 6 per capita in some regions.[2] Facilities frequently report anecdotally that NHIS card bearers constitute over 90 % of their clients, which is plausible given that the data from the DHIMS 2 for OPD attendance between 2008 – 2015 shows 83% of patients were insured. This is further buttressed by the 2015 Annual Report issued by CHAG, which stated that 87% of their OPD clients in that year were insured.[3] These statistics attest to the wide popularity of the NHIS, at least for those who are using the health services.

[2] Dr E Appiah-Denkyira, D-G, Ghana Health Service, Written submission to NHIS Review Committee, 7 Dec 2015.

[3] Christian Health Association of Ghana (CHAG), "2015 Annual Report."

28. The design of the scheme is also unique in that it covers both the informal and formal sectors with the same benefit package entailing significant cross subsidization under a single national risk pool funded essentially by public taxes and statutory deductions (the VAT and SSNIT contributions).

29. The scheme covers care at both private and public sector health facilities and anecdotally also covers as high as 95 % of the country's disease burden. However, the NHIS' population coverage of around 40% contrasted with the overwhelming majority (over 80%) of patients being insured also suggests a very high adverse selection rate. This interpretation is not only borne out by intuition and abundant anecdotal evidence, but also by many published studies reviewed as part of this Review, ruling out alternative interpretations.[4]

30. Most of the membership of the scheme does not pay any premiums out of pocket when they join. These include SSNIT contributors and pensioners, persons under 18 years old, persons 70 years old and above, pregnant women, indigents (the core poor), categories of disabled persons designated by the Minister responsible for Social Welfare, as well as beneficiaries of the Livelihood Empowerment Against Poverty Programme (LEAP). These exempt categories account for about 69% of registered members of the scheme, and so only an estimated 31% of members pay premiums out of pocket on joining, although it is important to note that the 2.5% of SSNIT contributions going to the NHIS were also presented during the scheme design[5] as the premiums of the formal sector employees to the scheme.

31. These social achievements of the scheme (gains in national risk pooling, health coverage and utilization) do not however mean that the scheme's design and implementation can be described as optimal or the most effective in the circumstances. For instance, as pointed out in the TORs of the current NHIS Review exercise, "in a state driven social intervention program such as the NHIS, where the Scheme is funded mainly through tax revenues and statutory deductions, the country's health goals ought to guide

[4] NHIS Review Committee's review of published literature on the Ghana NHIS, 2016.
[5] Interview with Dr Sam Akor, coordinator of the NHIS technical design team and former CEO of the NHIA.

the design of the benefits package. Furthermore, the tax-paying population should be able to perceive the benefits package as valuable in order to sustain their support to the NHIS."[6]

32. However, the design of the NHIS originally was not preceded by an exercise to align with the sector's top priorities on which public resources should be focused, nor by an actuarial study of the feasibility of the selected benefit package. To address the top health priorities of the country, consistent with our income category, public resources should be focused on high impact, cost effective interventions to address the health conditions that are responsible for the country's underperformance in its key health indicators, such as unacceptably high maternal and child deaths, which resulted in Ghana missing out on the health-related MDG targets. In addition, preventive health and actions to slow or arrest the rising burden of NCDs need to be tackled as public health priorities.[7]

33. With an expansive and supposedly 'generous' benefit package that nevertheless did not clearly focus on the key health sector priorities of the vast majority of the population, it is hardly any wonder that many studies have demonstrated that the scheme is also inequitable.[8] Many studies worldwide also show that interventions that focus on primary health care and especially the community level are not only more cost effective, but also more equitable than those that focus on facility service delivery at higher levels of the health system (see the boxed text, Figure 1: " The Benefits of Focusing the Health System on PHC").

[6] MOH, Sept. 2015. "Terms of Reference for Defining Options for National Health Insurance Scheme Reforms "

[7] See President's State of the Nation Address, 2016.

[8] See SHIELD project studies; other references from review by Akuoku for the NHIS Review.

Figure 1: Evidence on the Benefits of Focusing the Health System on PHC

A review of international literature in 2004 found that the strength of a country's primary care system is associated with improved population health outcomes for all-cause mortality, all-cause premature mortality, and cause-specific premature mortality from major respiratory and cardiovascular diseases (Atun, 2004). This relationship is significant after controlling for determinants of population health at the macro and micro-levels.

Health systems in low income countries with a strong primary care orientation tend to be more pro-poor, equitable and accessible. At the operational level, the majority of studies comparing services that could be delivered as either primary health care or specialist services show that using primary care physicians reduces costs, and increases patient satisfaction with no adverse effects on quality of care or patient outcomes.

In low-income countries, evidence shows that expenditure on PHC is more pro-poor than aggregate expenditure that includes hospitals, and has a desirable distributive impact benefiting the poorer segment of the population proportionately more than the richer segment (Filmer D, et al. 1997). Greater investment in primary care increases access to care with associated lower mortality and morbidity (Starfield B. 1985). Conversely, a reduction in access to PHC results in a worsening health status.

Primary care physicians are more likely than specialists to provide continuity and comprehensive care resulting in improved health outcomes (Shear C L et al. 1983). Improved access to primary care physicians and their gate-keeping function have added benefits such as less hospitalization (*Moore S. 1979; Manning WG et.al. 1984; Alpert JJ et al 1976*), less utilization of specialist and emergency centres (*Martin D et.al. 1989; Hochheiser LI, 1971*), and less chance of being subjected to inappropriate health interventions (*Siu AL et al. 1988*). In contrast, when direct access to specialists is possible without a controlling mechanism by primary care physicians, the quality of care, as measured by appropriateness, worsens and health care costs increase (*Leape L et al. 1990*). Furthermore, evidence from a systematic review suggests that broadening access to primary care can reduce demand for expensive, specialist-led hospital care.

In low-income settings, the cost effectiveness of PHC compared to other health programmes is confirmed by a review (*Mills A, Drummond M. 1987*). This reinforces World Bank findings that selected primary care activities, such as infant and child health, nutrition programmes, immunization and oral hydration, appeared as "good buys" compared to hospital care (*Cochrane SH, Zachariah KC 1983*), and that interventions deliverable in primary care facilities could avert a large proportion of deaths (Jamison DT et al. eds. 1993).

The findings from these studies support policies that encourage a shift of services away from specialist care to PHC, as the substitution does not adversely affect quality but lowers cost.

The above boxed text is culled from: Atun R (2004). *What are the advantages and disadvantages of restructuring a health care system to be more focused on primary care services?* Copenhagen, WHO Regional Office for Europe (Health Evidence Network report).

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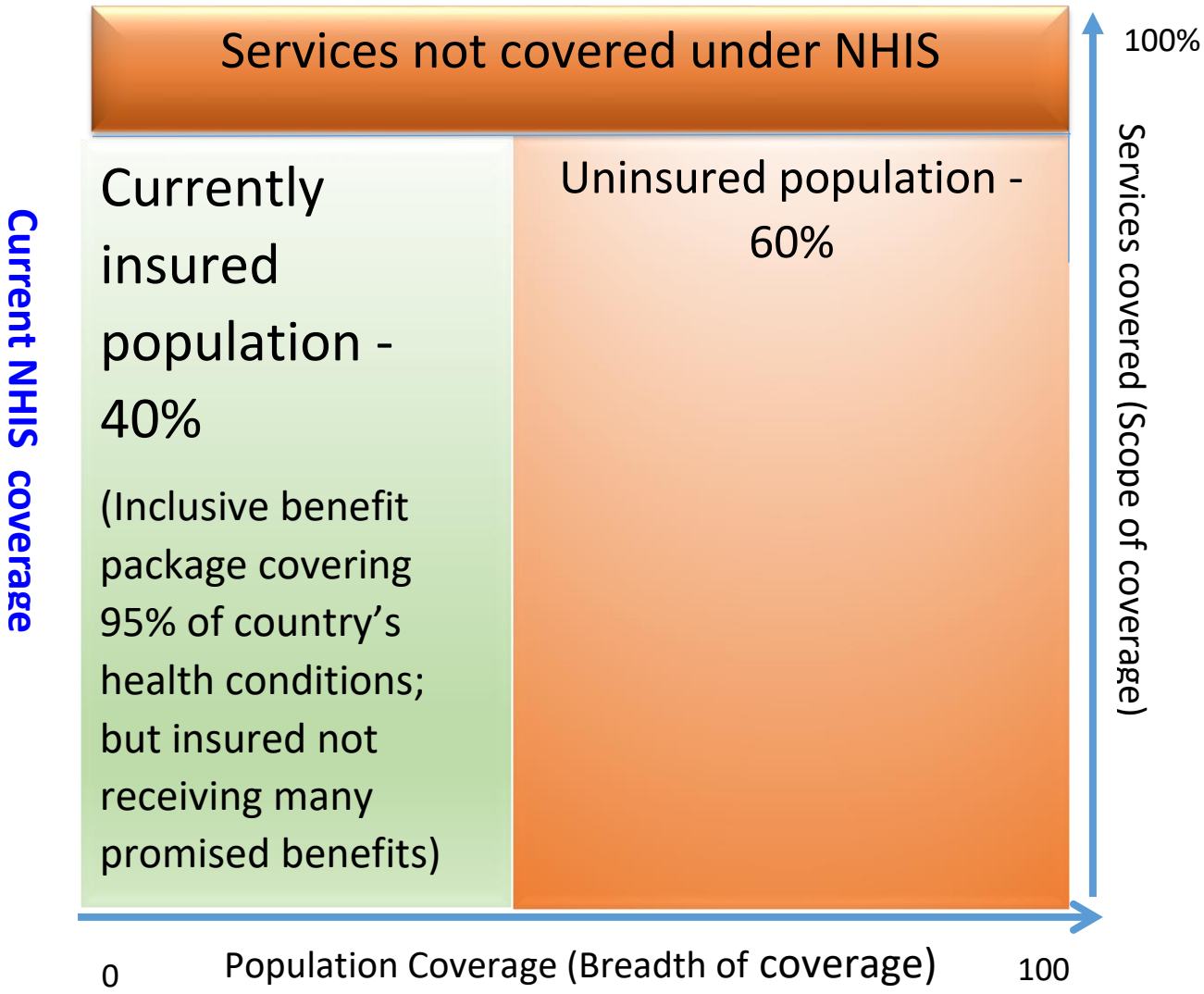
Boxed text #2: A systematic review of community health worker (CHW) programs in 2016 concluded that "CHW programmes were found to promote equity of access and utilisation for community health by reducing inequities relating to place of residence, gender, education and socio-economic position." Further, "CHWs can also contribute towards more equitable uptake of referrals at health facility level. Factors promoting greater equity of CHW services include recruitment of most poor community members as CHWs, close proximity of services to households, pre-existing social relationship with CHW, provision of home-based services, free service delivery, targeting of poor households, strengthened referral to facility, sensitisation and mobilisation of community." However, it also noted that "if CHW programmes are not well planned some of the barriers faced by clients at health facility level can replicate at community level."

McCollum, Rosalind, Woedem Gomez, Sally Theobald and Miriam Taegtmeyer. 2016. "How equitable are community health worker programmes and which programme features influence equity of community health worker services? A systematic review". *BMC Public Health (2016) 16:419; DOI 10.1186/s12889-016-3043-8.*

34. Moreover, after about 12 or more years since the original NHIS law was passed, as stated above, only around 40 percent of the Ghanaian population are effective beneficiaries of the scheme that is funded primarily by public taxes and statutory deductions. The majority of the tax-paying public is excluded from membership and so does not receive or perceive direct benefits from the scheme.

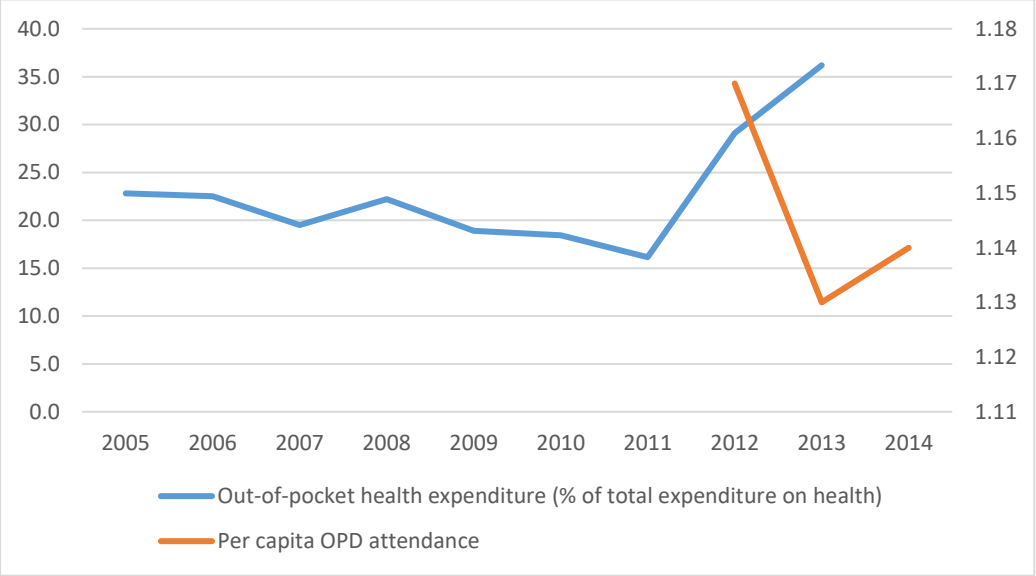
Figure 2: Heatmap of Current NHIS Coverage



35. Indeed, even for the beneficiaries of the scheme, there have been increasing challenges that undermine the promised benefits and the user experience over the years. Delays in reimbursing providers (up to eight months for much of the period of this review, though payments of the backlog have recently began to be picking up pace) have on several occasions led to the withdrawal of services to NHIS members by providers. It has also led to widespread unauthorized so-called co-payments and denial of service to NHIS members which have had the effect of eroding confidence in the scheme.

36. Figure 2 shows some possible effects of this declining health sector performance since 2011: it indicates that out-of-pocket (OOP) spending began to spike upwards quite sharply after 2011, coinciding with the increasing user charges or so-called co-payments that facilities started imposing on insured users. Similarly, OPD attendance declined sharply from 2012, with a slight recovery in 2013 but still well below the 2012 level.

Figure 3: Out of Pocket (OOP) health expenses and per capita OPD attendance



Source: OOP data from World Bank's WDI and OPD data from 2016 Holistic Assessment and Program of Work.

37. Since the NHIS has become the most important source of funding for the operational costs of most public and mission, as well as many other private, providers, delayed payments or reimbursements to providers have a serious impact on the financial sustainability of these facilities.[9] In the past, the NHIA has tended to blame the payment delays on high and increasing claims costs which ostensibly placed the scheme under severe financial pressure. But persistent allegations of widespread abuses and fraudulent claims by providers (allegedly in frequent collusion with scheme staff), many of which have been featured in the media over the years, as well as other inefficiencies often mentioned in stakeholder meetings (such as questionable allegedly NHIA expense patterns and sub-optimal deployment of strategic purchasing power), clearly must also be contributing to

[9] As the 2015 CHAG Annual Report notes: "Over 87% of OPD income and 85.9% of income from inpatient care were financed through the NHIS. Consequently, challenges with the NHIA have direct impact on the finances of the health institutions."

the financial pressures.[10] At any rate, those factors or perceptions tend to undermine both public and policy makers' sympathy for any arguments that the scheme needs further injection of public funds to resolve its current financial problems.

38. Besides delayed reimbursements, providers insist that NHIA payments for their services seriously undervalue those services, and since it appears that the NHIA sets tariffs based on market surveys that are usually at least a year out of date and in the absence of any objective understanding of what it costs the providers to offer the services, this leaves room for at least ambiguity and even dispute. This disagreement about what the correct or acceptable tariffs should be is also cited by providers as a further reason for their unauthorised charging of scheme members who use the health facilities.

39. But it should be noted that the question of what should be the correct tariffs for services is a complex one, in the absence of any objective costing evidence of what those tariffs should be. More importantly, in the absence of any such agreed evidence, providers have an incentive to continually demand higher tariffs irrespective of what their current levels are.[11] In particular, if the NHIA tariffs were set at the true economic cost of providing the services, they would be rewarding the most efficient providers who can produce at that economic cost, but in the same vein, they would penalise the inefficient providers whose costs exceed that level. The result would be that the provider agitation for higher tariffs would likely continue, as inefficiencies are clearly widespread in the current system.[12]

40. The NHIS as currently designed is heavily curative care-based, and is even somewhat biased against core PHC services such as preventive and basic health services since the NHIA does not pay tariffs or reimburse for outreach services, nor for task shifted activities such as midwives conducting deliveries at CHPS centres, leading to unnecessary referrals. As argued by the Director-General of the Ghana Health Service, these factors

[10] One of the questions that surveys commissioned by the Review seek to answer is to get an idea of the extent and forms in which such abuses and fraud take place.

[11] It has for instance been suggested that there is a tendency for suppliers to increase their prices whenever an NHIS price survey is anticipated, so the risks inherent in the current situation are not all on the provider side, as they repeatedly contend. This further suggests that the problem of considerably delayed payments may have so morally weakened the NHIA vis a vis the providers that the latter could be exploiting the situation to aggressively demand higher tariffs to make up at least for the time value of funds delayed, and potentially to capture ever higher earnings.

[12] Provider inefficiencies arise when delayed payments lead to their indebtedness to suppliers and cause the latter to build the costs of those delays into their future pricing, resulting in an inflationary spiral in medical goods and services. Similarly, the abuses and fraudulent claims referred to earlier also lead to higher costs; while inefficient provider prescription patterns as well as staffing patterns within the public sector all contribute to a distortion of true costs in the sector.

have contributed to our stagnant maternal mortality indicator especially at the two leading teaching hospitals, which contribute 40% of the total in Ghana.[13]

41. Another factor that impacts on access and that has come up repeatedly in the Review Committee's encounters with the public is an additional barrier to membership and hence access posed by the biometric registration exercise, which has created bottlenecks such as long waiting lines and queues for registration, sometimes lasting days. This also raises an important question about the capacity of the existing systems in the NHIS to respond to much greater numbers of the population wanting or needing to join the scheme, as is likely to happen under current proposals for reform of the NHIS coverage by this Review Committee.[14]

42. The upshot of all the above analysis is that, despite uncontested achievements and benefits, NHIS enrolees and especially non-enrolees continue to suffer too many obstacles to accessing basic primary health care services. This lack of universal access to good-quality PHC is arguably a significant contributor to some of Ghana's most pressing public health problems, including high infant and child mortality, high maternal mortality, high morbidity from preventable infectious disease such as malaria and recurring cholera attacks, and the rising burden of non-communicable diseases such as hypertension and diabetes.[15]

43. This is also the background against which the NHIS Review Committee was set up in September 2015 by His Excellency the President with the specific Terms of Reference that were announced, in order to come up with recommendations to build on the successes of the scheme and to try to redress the shortcomings noted.

Building consensus around the problems, priorities and objectives of reform

44. The context of the reforms to the NHIS include the fact that the country missed out on achieving its key health-related MDGs. Nevertheless, Ghana has recommitted to the new SDGs signed to by the President in New York in September 2015. The SDGs expand on the MDG goals and explicitly include targets, not only for MCH, but also

[13] Dr E Appiah-Denkyira, op. cit.
[14] Suggestions for how to facilitate access to the guaranteed package while increasing NHIS enrolments for higher levels of care are provided in our recommendations later in this document.
[15] In his 2016 State of the Nation Address, His Excellency the President called for action to address the twin disease burdens of communicable and non-communicable diseases facing Ghana. *Op.cit.*

universal health coverage. Ghana is a lower middle income country but its MCH indicators are above the average in its income group, as indicated in Table 1.

Table 1: Select Ghana socio-economic indicators[16]

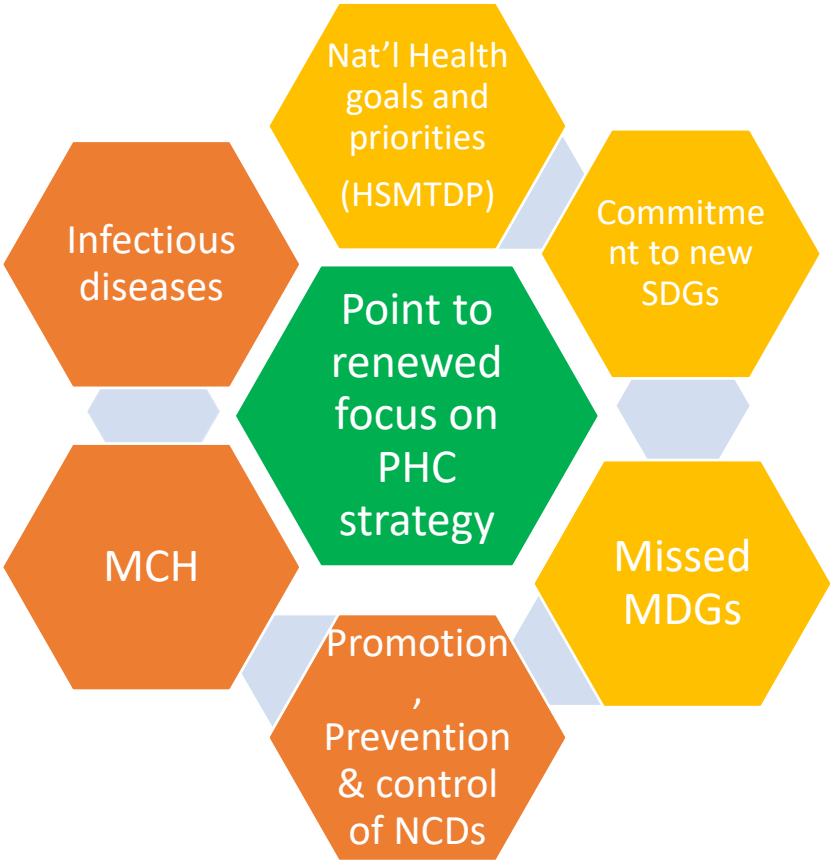
Sources: WB, WDI 2015; WHO, Country profile, Jan 2015

	Value (Ghana)	Value (LMIC)
Population (millions, 2014)	26.79	
GNI per capita ($Atlas method, 2014)	1,590	$1,026 - $4,035
Life expectancy at birth (years)	63	67
Maternal mortality , per 100,000 live births	320 - 380	253
Child (under 5) mortality, per 1000 live births	78	52.8
Skilled birth attendance (%, 2013)	67	
NCDs prevalence (% of total, 2013?)	48	
Total health expenditure per capita (US$, NHA 2010)	57.66	

[16] Note different DHS 2014 data where U5M was 60 per 1000 and IMR was 41 per 1000.

45. The epidemiological context includes the facts that Ghana continues to suffer from the burden of infectious diseases even while non-communicable diseases are rising rather fast. Such a context suggests that a focus on a primary health care strategy for the NHIS would offer the most gains for the investments and resources available. Building a consensus among stakeholders around these issues of priorities and objectives for the reform has therefore been a primary focus of the reform process.

Figure 4: Building consensus around problems and objectives



Reasons to invest in health: the health and economic returns of investing in health

46. The Lancet's Commission on Investing in Health (CIH), has calculated (Global Health 2035) that, to reach convergence[17], LICs and LMICs would need to enhance investments to scale-up coverage levels of currently available health tools and interventions to very high levels, 90% or higher, as well as to strengthen the health system to enable effective delivery of these interventions. The CIH modeling projects that Ghana would need to invest

[17] Convergence in the CIH parlance means that LICs/LMICs should be able to attain the health outcomes, such as maternal and child death ratios, that pertain in upper middle income and high income countries.

an additional about $US 11.3 billion over the coming 20 years to achieve convergence; roughly an additional $US 566 million annually on top of current spending levels (Table 2). They estimate that the largest expenditure – 68% – should be targeted towards health systems strengthening.[18]

Table 2. Estimated incremental costs to reach convergence

Category	**Average annual incremental cost ($)**
Estimated costs	
Family planning	5,309,000
Maternal and newborn	12,610,000
Childhood illness	16,405,000
Malaria	82,710,000
HIV	40,400,000
Health systems strengthening	466,000,000
Estimated savings	
Immunization	14,625,000
Tuberculosis	42,900,000
Total Incremental Expenditure	**565,882,000**

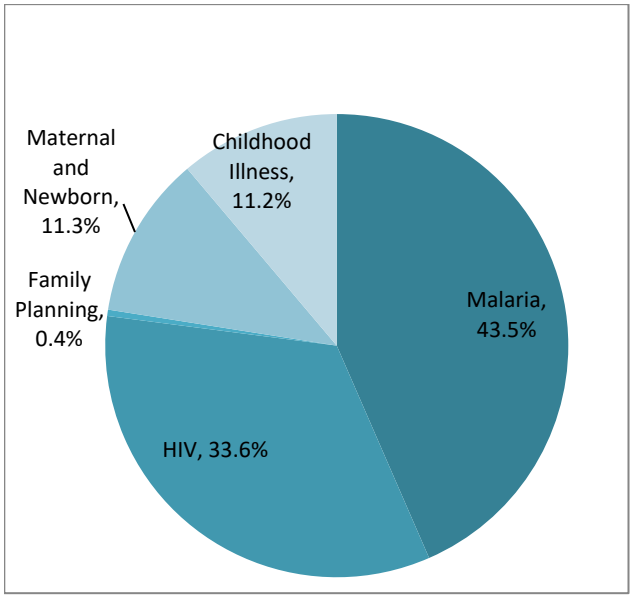


Figure 5: Estimated breakdown of programmatic costs, 2035
Source: School of Public Health (SPH), *op. cit.*

47. By making these strategic investments in the convergence agenda, Ghana could experience significant reductions in mortality due to infections and maternal and child health conditions (Table 3). For example, the number of maternal deaths could fall by almost half from 2015 to 2035, and the under-five child mortality rate could fall from 61 per 1,000 live births in 2015 to 36 per 1,000 in 2035, resulting in 65% fewer under-5 child deaths in 2035 (Figures 6).

[18] School of Public Health. April 2016. Fiscal implications for health financing in African countries recently graduating from low to lower-middle income status: the case of Ghana and Kenya. Report submitted to the African Health Economics and Policy Association.

Table 3. Estimated reductions in mortality by investing in convergence

Cause	2015 (# of deaths)	2035 (# of deaths)	% reduction
Maternal deaths	4,170	2,650	42%
Under-5 child deaths	71,900	25,250	65%
TB deaths	14,750	980	93%
HIV deaths	13,000	12,000	8%
Births	807,700	705,000	13%
Total fertility rate (births per woman)	4	2	50%
Under-5 mortality rate (per 1,000 births)	61	36	41%

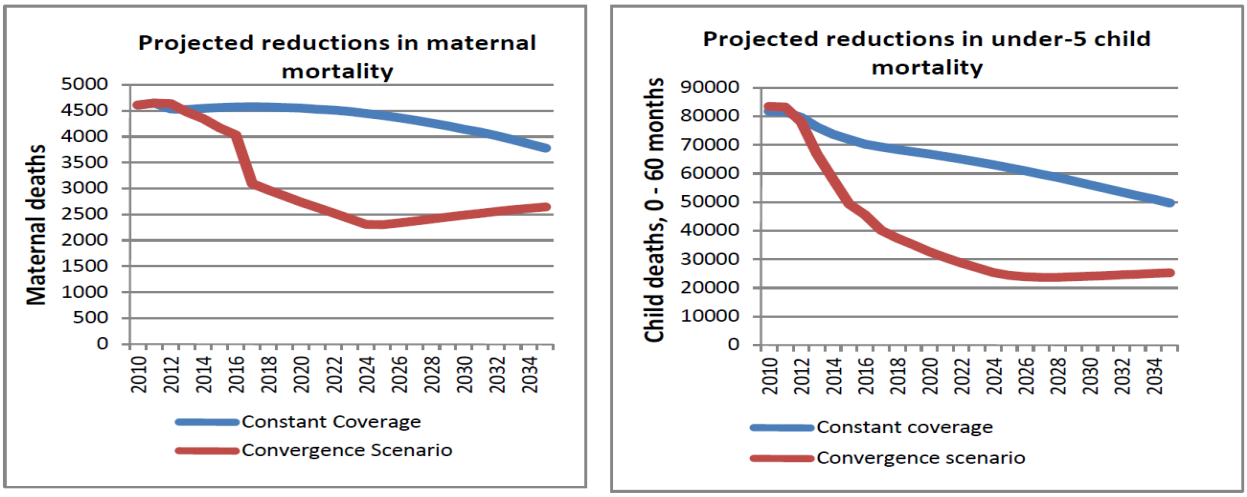


Figure 6: Projected reductions in maternal and under-five mortality. Source SPH, op.cit.

48. Using a full income approach, the CIH estimates that over the years 2016 – 2035, the country would experience a return of around $US 10 for each dollar invested in health to achieve convergence (Table 4). [19]

[19] Ibid. The report cites Bangladesh, where economic growth is explicitly stated in the constitution as an important health financing strategy.

Table 4. Costs, benefits, and benefit cost ratio

Population	25,900,000
Incremental expenditures (average annual)	565,882,000
Incremental expenditures per capita	22
Per capita income (2014)	1440
Deaths averted	
Stillbirths (weighted)	190
Deaths age 0 – 4 (weighted)	1,370
Maternal deaths	1,670
TB deaths	11,200
HIV/AIDS deaths (over 5)	9,500
Total	23,930
Cost per death averted	23,647
Benefit cost calculations	
Reduction in mortality (in SMU)	9.2
Per capita value of mortality reduction	238
Benefit: cost ratio	**10.91**

Source: Source: School of Public Health, *op. cit.*

54. The NHIS Technical Review Committee was set up by His Excellency the President in response to the above challenges, with a mandate to review the design and operations of the scheme and come up with findings and recommendations to improve upon its **sustainability, efficiency, equity and accountability as well as user satisfaction**. At end of its review work and deliberations, the committee made the following key findings:

On Sustainability

55. It is important to note upfront that in the design decisions around the NHIS in 2003 there is no evidence that the capacity of the country to pay for the benefit package was ever explicitly taken into account and explained to Ghanaians. In that connection, it is important to note also that when Ghana launched the NHIS in 2003, no other country at that level of income per capita (then well below $1000 per capita) or health spending per capita (even now still at about $60 per capita), had ever attempted such a sweeping and highly ambitious social health insurance reform with such a benefit package, acclaimed all over as very generous, without any cost controls of any kind to moderate the foreseeable expenditure growth.

56. **Though it was commendable and even innovative that specific sources of revenue were identified for the scheme, no answer was ever offered to the fundamental structural problem at the heart of the NHIS: what is the mechanism that will ensure that the revenues from the NHIL, which is the principal revenue source for the NHIS and whose growth has no demonstrable relationship to membership or expenditure growth, will balance the expected future expenditures of the scheme?** Even now, this conundrum remains one of the scheme's principal challenges that the Government will eventually have to face. A key part of this review has been to present specific proposals to Government (see later below) to address these challenges to the scheme.

57. The NHIS was set up in the context of the country's commitment and drive towards the MDGs, which set out health goals such as reduction of maternal and child mortality which the scheme tried to respond to, without reducing the generous benefits of the original design. More recently, the commitment to the SDGS and especially their UHC targets put further pressures on the scheme to respond accordingly, even as the country's graduation from low income to lower middle status is adding greater pressures on the public sector to fund an increasing amount of services and commodities such as vaccines and HIV drugs from domestic sources. Given limited resources all round, there is obviously a natural tendency on the part of the Government to try to put some of that burden on the resources of the NHIS.

Beyond the above factors, the sustainability of the NHIS has also been challenged by other features as well as developments since its inception.

58. It is clear from recent data that health sector funding is gradually shifting towards reliance on the NHIS, and less and less on the MOH budget, although the revenue bases of the NHIS have not expanded since inception. The ratio between MoH expenditure and NHIF expenditure decreased from 2.9 in 2012 to 1.7 in 2014. Not only that, but economic difficulties in recent years have constrained the fiscal space as a whole and growth in taxes such as VAT, the mainstay of NHIS revenue, in particular.

59. NHIS expenditures started to overtake income from 2009, although a real and growing deficit actually began to show in 2012 when the cushion provided by reserves was no longer available. Although about 75 percent of NHIS spending goes to health care costs, what actually constitutes those "costs" is disputable, due to widespread abuses and inefficiencies noted during the review. (See our comment below under Efficiency

concerning this implied 75/25 medical loss ratio of the NHIS.)

60. Besides the dynamics of insurance such as adverse section and moral hazard which are present in the scheme, other drivers of future costs of the NHIS include: Ghana's graduation from low income to lower middle income status and consequent reduction of grants and impending withdrawal of GAVI and the Global Fund as key funding sources for crucial elements of the health sector; medical inflation which is usually higher than general inflation; and technological progress in medicine. All these will put pressure on the NHIS' expenditures.

61. This review proposes that, in the context of the country's current per capita income level and fiscal space, this balance be attained through (i) a rationalization of the benefit package, to ensure that it is more affordable and consistent with Ghana's priority health sector goals and (ii) integrating continuous actuarial modelling and projections into the scheme's financial analysis and reporting.

Solutions to the sustainability of the NHIS in the short to medium term must in particular address the immediate sources of inefficiencies discussed next.

On Efficiency

62. Although the NHIA has been undertaking a number of measures to enhance efficiency, including setting up four Claims Processing Centres, use of electronic claims, undertaking clinical audits, introducing unique provider IDs to facilitate better monitoring and claims analysis, initiating a digital claims entry strategy, and piloting and rolling out capitation in a number of regions, the scheme is still clearly beset with a considerable number of inefficiencies in its design and operations.

63. The biggest drivers of short term costs emanate from design and operational inefficiencies related to an almost complete lack of cost control mechanisms; reliance on mostly passive, instead of strategic, purchasing; adverse selection; widespread abuses; provider moral hazard; and a noticeable disconnect of members and even NHIA staff from the scheme and its management.

64. The lack of alignment of the benefit package to the country's health sector priorities is perhaps the most glaring inefficiency in the design of the scheme. Ghana is under-performing (compared to other countries in its income category) in key health indicators such as maternal and child mortality, while a rising burden of non-communicable diseases

(NCDs) is exposing the weaknesses of investing heavily in curative care as the NHIS does at present., and neglecting key preventive services as well as primary health care (PHC) that could help check this rising threat to the nation's health.

65. The year-round design of open, voluntary enrolment favours adverse selection, despite the one month waiting period.

66. Operational inefficiencies arise from weak capacity of the purchasing agency in crucial dimensions and especially its inability to deploy its strategic purchasing potential, and hence making the scheme susceptible to fraud and abuses. Manual claims processing, emphasising vetting but not expenditure management, is one manifestation of this limited capacity.

67. Moreover, it should be stated that both Acts 650 and 852 were missed opportunities to define key efficiency targets for the NHIS. As a result, the NHIS has never operated according to any recognized legal norms regarding key efficiency indicators such as a medical loss ratio not to be exceeded or minimum reserve levels.

The 75/25 medical loss ratio cited in paragraph 5959 above is well below what the medical loss ratio should be for a social health insurance scheme, which normally should aim for a 95/5 ratio of health care spending to administrative costs, and at worst not below 90/10.[20]

Similarly, a social health insurance scheme is usually required by law to maintain a minimum level of reserves, with a recommended minimum amount equal to nine months of operational expenses.

68. The un-empowered membership is also a key source of inefficiency, since members are not incentivised to behave responsibly or see the NHIS as an ally or protector. The missed opportunities to engage actively with members, and to provide adequate information to them (using mobile technology for instance) about the consequences of certain behaviours including diet, life styles and choices, are reflections of such inefficiency.

[20] Compare best practice examples from Eastern Europe: The Estonian EHIF's operating expenses accounted for 0.98% of its total budget for 2014. In 2004 and 2005, operating expenses formed nearly 1.3% of the budget and decreased to 1.08% in 2006; since 2007, the EHIF's operating expenses have not exceeded 1% of its budget. This is similar to Hungary and Poland, but is much lower than Slovakia and the Czech Republic. Slovakian health insurance funds are legally restricted from spending more than 3.5% of their revenue on administration. The average among health insurance funds in the Czech Republic is 3.7%, with the larger funds having lower costs. Similarly, , in South Korea available statistics suggest that only 4.4% of total expenditure was directed to administration as at 2013 (NHISK, 2014).

On Equity

69. The good news is that equity in access has significantly improved in the NHIS in recent years. A World Bank study for the 2016 Public Expenditure Review (PER) shows unambiguously that access (or membership of the insurance scheme) is about equal between the lowest and highest wealth quintiles for both men and women, compared to earlier years of the NHIS when it was much criticized for being pro-rich.

70. However, inequities continue to be manifested between insured and non-insured as well as in the availability and quality of the benefit package (which is not the same between rural and urban areas for instance) and a clear bias in the NHIS benefit package design against PHC and preventive services (which promote equity). There is also less (or more often no) choice of providers for rural dwellers, which tends to undermine some benefits of the capitation system being introduced.

On Accountability and user satisfaction

71. Taking user satisfaction first: recent focus group surveys carried out by consultants for this review found both positive and negative views about the scheme. Insured users for instance stated that the NHIS helped clients to get access to health care on timely basis and prevented unnecessary deaths in communities and also curbs patients waiting at home for long before reporting for treatment. They also described the NHIS Card as a "winning card" that enables the poor and vulnerable to access quality health care for free.

72. However, negative perceptions by the same groups were also pronounced: They described the NHIS services as of "low quality", with some of them describing the scheme as the "paracetamol scheme", because, they contended, that was most the frequent drug dispensed to them. The members also contended that they are made to wait for long hours before they are attended to at the health facilities because the providers tend to attend to those that are paying out of pocket first before them, with some even asserting that the NHIS is not working any more since many conditions and medications are not covered by the scheme.

73. The review also found that there was no regular mechanism for members to provide feedback of their experiences after service use, and for the NHIA to verify the actual receipt, quality and payment of services as claimed by providers, or any other issues encountered. The NHIA does not pay visits to random selections of patients to verify services received

and obtain other feedback.

74. There is no mechanism in the NHIS to assist or defend patients with quality of care issues, including pro-actively working to reduce, or get redress for, medical errors. This is a crucial function in an insurance environment where the vast majority of beneficiaries are vulnerable and powerless vis-à-vis both the providers and the purchasing agency. In such an environment, it is particularly important that the motives and actions of various actors can be challenged by the others for enhanced accountability.

75. We noted that this is the first comprehensive review of the NHIS after 12 years, which, though a positive sign, is not good enough. Going forward, periodic reviews every five years or so would be very useful, and should include, or rely on existing or planned, population level surveys of health outcomes, system responsiveness and degree of financial protection afforded.

76. The review noted that the NHIA's annual reports do not provide adequate performance metrics relevant to its operations and results for stakeholders, despite being voluminous documents. We propose that the outcomes-related performance criteria cited in paragraph 75 above be emphasized going forward, with less emphasis being placed on the uncritical use of utilization as a measure of NHIS success.

77. Transparency and accountability mean that people should have a good understanding of their entitlements and obligations and an understanding of efforts to improve quality and efficiency (for example, generic prescription), and that the government should periodically indicate the extent to which it is providing what it has promised. This behoves the NHIA to conduct periodic population satisfaction surveys containing questions regarding the population's awareness of their rights and obligations, and other aspects of performance, and to publish the results on its website as well as using them to plan more effective awareness campaigns.

Stakeholders also complained of lack of accountability by the NHIA, while the oversight mechanisms also appeared rather weak and/or ineffective. There appear to be no real incentives for strong oversight.

Principles of NHIS re-design

The key principles underlying the NHIS reforms proposed by the Technical Review Committee in the following pages are the following:

49. The NHIS benefits policy should be better aligned with Ghana's most pressing public health problems and available resources. It should be re-prioritized toward universal access to primary health care in the medium term, and progressive realization of universal access to higher levels of care in the long term.

50. A core PHC benefit package should be guaranteed for all residents. In other words, User charges and insured status should not constitute barriers to **entry** into the health system. This package should be paid for from the NHIL and SSNIT contributions.

51. In addition, the poorest in our society as well as certain vulnerable groups must be protected from the financial burden of user charges even above the PHC level – indigents or core poor, children under 12 years old, pregnant women, pensioners and the aged, and people with disabilities.

52. Beyond this guaranteed core package, it may be worth asking that those who are in a position to do so should contribute a little bit more towards the cost of their health care ('shared responsibility' as it has been termed during the course of this review), ie for the cost of their health care at the higher levels of the health system.

53. User charges may be applied to referrals and prescriptions at higher levels of the health care system. Such charges may be used to steer patients towards more cost-effective care and drugs.

54. Cost control measures above PHC level should include pre-authorization for expensive care, and where feasible too, pre-admission tests, intensive case management, database profiling etc. For this to work, NHIA needs to beef up on data management and clinical staff (also needed for claims vetting etc.). Currently the NHIS lacks sufficient expertise for these vital functions which are central to any cost containment strategy in health insurance.

55. Since experience shows that people value choice, wherever possible, people should be given choices together with sufficient information about the costs and other implications of the different choices to enable them make informed decisions.[21, 22]

56. Changes to the benefits policy should benefit from more deliberate, participatory, transparent, and evidence-based priority-setting processes than has occurred in the past. The current Review will propose a priority-setting process for periodically examining the NHIS benefit package, evaluating new technologies and currently excluded services for possible inclusion and payment under the NHIS, taking into account cost-effectiveness, potential budget impact and affordability, changing societal values and equity factors.

57. Reforms to NHIS benefits should take greater account of variation in capacity of health providers and facilities across the country—aiming to minimize differences between benefits on paper and benefits actually available on the ground.

58. The NHIA must complete the transition it has begun from passive bill-payer to strategic purchaser of health services, including the move away from simple (and inflationary) fee-for service and toward capitation payment for PHC and budget-neutral bundled payments (refined DRGs) for secondary and tertiary care. As a "single payer" for its benefit package[23], the NHIA's purchasing power should be used more effectively, especially in relation to drug prices.

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[21] For example, while the generic drugs policy of the NHIA is technically correct and indeed scientifically sound, it fails the test of acceptability because it assumes that a population in which non-scientific beliefs of all kinds are still widely prevalent will be convinced merely by the scientific evidence that these are equivalent to the branded drugs. That scientifically-based assertion not only bucks the generally sound experience of people that price differences tend to denote quality differences as well, but also the fact that many doctors, for pecuniary or other reasons, have been telling their patients that the generics are inferior to the branded ones. Indeed not only their doctors, but multinational pharmaceutical companies have invested lots of money to buy brand loyalty by recruiting clinical staff to promote their brands and indoctrinating the public on the supposed superior quality or efficaciousness of their branded drugs. In this situation therefore, instead of a blunderbuss approach of refusing to pay anything for branded drugs, the NHIA might be wiser to simply insist on paying only the price of the generic drug, but leaving the choice to the patient to take the branded one and pay the difference out of pocket. This of course involves accepting a little inefficiency for a bigger purpose, which is user satisfaction and avoidance of further damaging the already fragile reputation of the NHIS in the eyes of the public.

[22] This could even be part of a transitional policy towards a future where the power of the NHIA as a purchaser is so much greater that they can effectively drive out all but the generics where those alternatives are available; in other words, when the generics are the vastly predominant ones available at pharmacies and in facilities, the current distinctions with brands will likely vanish for lack of comparators.

[23] It is worth recalling that the NHIS is not the only or even largest source of funding for the health sector (the 2016 Public Expenditure Review by the World Bank estimates the NHIS share of public health spending at 23% while public spending constitutes around 57% of total health spending). Other funders include: GoG (for salaries and some goods and services in the public sector including CHAG facilities though allocations for goods and services have declined sharply in recent years; donors and DPs; companies; communities; and individuals.

59. Our proposals or options have the overall objective of preserving the parts of the NHIS that are working well and considered to be international good practices for equity-enhancing coverage expansion, while ensuring fiscal sustainability and making further progress toward universal coverage across all 3 dimensions (expanding population coverage, deepening financial protection, increasing access to high-quality services).

60. The parts of the NHIS that should be preserved because they enhance equity, access to services, and financial protection are: (i) progressive funding (because it relies mainly on public taxation; (ii) equitable benefits; and (iii) a single pool and single purchaser for the NHIS benefit package, which allows cross-subsidization (equity-enhancing) and strategic purchasing (as yet under-utilized efficiency gains).

61. The current benefit package however was not designed with a focus on addressing the priority health sector goals of the country (primary health care and maternal and child health), given limited resources. This is an area that the current proposals seek to improve upon.

62. **The redesign will seize the opportunity offered by the Government's ongoing focus on CHPS zone expansion and reinforcement to redirect public resources and efforts principally towards primary health care and maternal and child health with the limited public resources.** Other health goals will be addressed with any additional resources including any that could be further raised.

Basic features of the proposed redesign

The following are the main features of the proposed redesign of the NHIS:

63. **PHC at public and CHAG facilities will be guaranteed at 100% with no user fees on health services for all the population (ie automatic coverage).** Private facilities including maternity homes, should be covered where they are situated within underserved areas of the country or where there is no realistic option within 5 km radius of the catchment population, but reasonable rates will be negotiated by the NHIA for such facilities.

Issues /options/questions for further discussion: *Should coverage at all other private*

facilities be capped at NHIA rates for CHAG or public facilities? This may not be an efficient option as there can be no control over the proliferation of such facilities which will reduce the numbers of enrolled persons for the public and CHAG facilities, defeating a key plank of the reform.

64. No more fragmentation of the population based on insured/non-insured status for PHC /MCH services. The NHIS then becomes a strategic purchaser of these services on behalf of the Ghanaian public.

65. Thus NHIS goes from 41% coverage as at present to 100% coverage for a **guaranteed** core benefit package.

66. **Since such care is guaranteed to everyone without distinction, NHIS membership card will not be a condition of accessing primary health care. A form of biometric identification (not restricted to NHIA cards) should still be required, especially for anyone who is using these guaranteed services.** The providers have a duty to transmit all the relevant information on all persons seeking care to the NHIA as part of their contract agreement. This would enable **the** NHIA to capture data that is essential for managing the scheme without this requirement becoming a bottleneck for accessing PHC.

67. *TBD: Ways of managing this new system while collecting adequate data could include a transition period during which first time users will be treated and registered at the same time.*

68. A key challenge that must be addressed as part of these reforms to make the NHIS more equitable and responsive to poorer persons' needs, is how to make the NHIS also more attractive to better off sections of the population, who are needed not just for their financial contributions but also for their buy-in to the whole concept of publicly-financed health care for the whole population so as to sustain the system politically into the future. A survey is being carried out to help determine what specific measures might be put in place to attract better off persons to join the NHIS willingly where they currently have a choice to do so but not taking it up. But some promising areas that may be explored include whether preventive health care including additional high-value dental and eye care services as part of an enhanced package for additional premiums could be a feasible way forward.

69. While the key proposal here to provide guaranteed PHC to everyone is already being referred to in the media and in public parlance as "free PHC", which is understandable, it is important to stress the ways in which this proposal will differ from the phenomenon of "free health care" that used to be prevalent in our country and others in Africa, and was often justifiably frowned upon as cheap, low quality and therefore not of much value.

- PHC access for all is not going to be a political declaration of free services without indication of how it will be funded (the biggest flaw of previous and even existing such schemes in Africa); instead this policy will be funded directly based on the NHIL and SSNIT contributions paid by the public.
- The proposal is to guarantee **"coverage for all but not coverage for everything"**
- The guaranteed PHC coverage will be managed not by the providers or MOH as in the past but by an autonomous strategic purchasing agency, the NHIA, which will thus act as an agent and the purchaser of these services on behalf of the Ghanaian public.

70. In addition to the above, we propose that the notion of 'actively informed membership' be instituted for this benefit package, with the following features:

- Actively informed membership means that beneficiaries will receive information by various means spelling out that in return for the guaranteed package paid by public funds, they accept part of the responsibility for their own health, that part that is related to lifestyles and personal choices (eg drinking and smoking, careless driving etc). The NHIA should explore ways in which people (excluding children and those incapable of making such decisions themselves) are informed regularly of the potential impacts that individuals' life style choice could impose on all society and the viability of the NHIS, including on taxation rates and other financial burdens.[24]
- **It also means that all patients must be issued with a statement of the costs or bill for their consultation /treatment after attending a health facility.** Wherever possible, these should be e-statements sent by mobile phone or other electronic communication according to the individual's preference. The same communication should then invite the individual to send feedback on their experience by mobile phone or other

[24] No sanctions however should ever be imposed or contemplated except for moral or peer sanctions that the explicit health messages might entail.

appropriate means, including directions as to how they could lodge a complaint if not satisfied (not through a call centre).

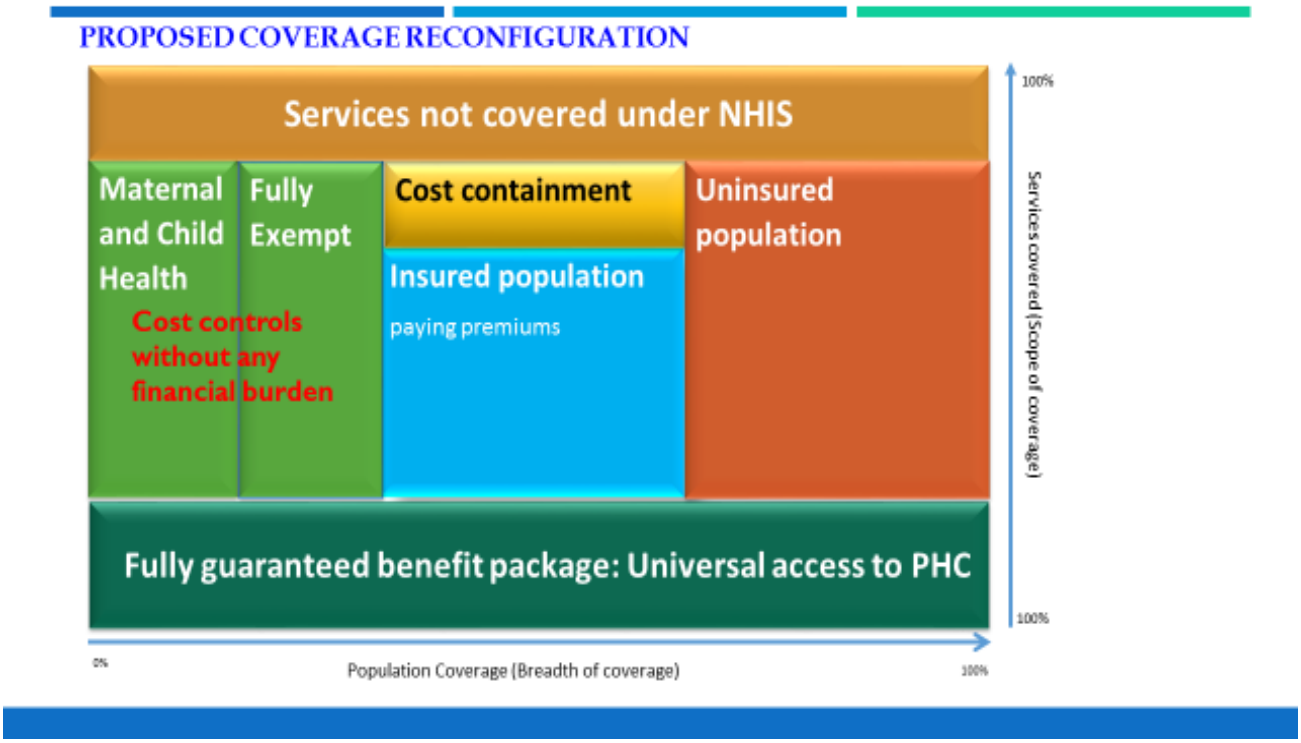

Figure 5: Schematic of proposed redesigned NHIS benefit package

Funding and Benefit Package

71. The fundamental premise of this redesign is that the NHIL (or earmarked 2.5% VAT), which is the most important source of financing for the NHIS, is collected from all Ghanaians, and should be used to fund services that benefit the whole population and not just a minority pre-selected on inconsistent and not wholly justifiable criteria, as explained next.

72. For these purposes, NHIS beneficiaries may be categorised into two broad groups: those who are exempted under the broad exemptions policy (the exempt categories), and those pay an additional premium to benefit (currently essentially informal sector adults). In the case of that section of the exempted categories who fall into the poor and vulnerable population groups, it is clearly a justifiable use of public funds to ensure, on the one hand, that the poorest in society have access to the care they need, and on the other, that there

are no financial barriers to accessing priority health interventions, especially maternal and child care, whose uptake is socially beneficial but which without this coverage would otherwise be less than optimally utilised.

73. In the case of the second category of current beneficiaries of the NHIS, those paying an additional small premium per year, as well as those exempted but not falling into either the poor or vulnerable groups, this is less justifiable on equity grounds:[25] for one thing, those premiums are not actuarially-calculated or nowhere close to being enough to pay for the NHIS services they use, so that in effect, public funds are used to substantially subsidize care for a minority pre-selected on the basis that they were willing and had the means to pay a very small premium for this privilege,[26] or were otherwise exempted on political or other such grounds.

74. Exempt categories under the reform would be: beneficiaries of maternal and child health services (**where child shall be from age 0 to 12**, ie up to primary school level); indigents, aged, and other vulnerable groups defined in the NHIS Law. This however does not mean that children 12 to 18 years old should be left without coverage. Under our proposals, a different and additional source of funding must be identified to cover all of them. One option is to add the premium to school fees, or have this paid by another statutory source. To enforce this, as provided under the NHIS law, it should be made obligatory to register school children above 12 years through a specific mechanism.

75. Though this redesign will obviously involve additional costs for the PHC package of the NHIS, it is a working assumption of the review that the current key funding sources for the NHIS – the NHIL and social security contribution– should be sufficient to cover PHC services for the whole population plus referral care for MCH and a limited number of exemptions at higher levels of the health care system[27], if ring-fenced for this purpose. Actuarial work is ongoing to test this assumption as well as how far it may be possible to

[25] Or those with health conditions that make them predisposed to need to use health services more intensively.

[26] Note that to the extent to which public taxes continue to be used to subsidize care at the higher levels of the health system, the redesigned package will not eliminate this source of inequity at the higher levels of the health system. The chief justification for the redesign is that all the population – and all tax payers – get to benefit from the country's priority health services, now expanded to include other primary care services in the NHIS benefit package, and not only those beneficiaries currently pre-selected as described. This is socially desirable and will enable Ghana to achieve its priority health goals more efficiently and sooner, and will also promote greater equity than the present system.

[27] Adolescent health, see Lancet April 30, 2016, vol 387.

cover additional services at higher levels, through costing and actuarial analysis. An additional assumption is that additional funding sources would need to be identified to pay for care at higher levels.[28]

76. It is important to establish a principle that we missed the opportunity to do as a country in 2003, namely that for each group exempted or individuals eligible to join the NHIS, the precise funding source and arrangements for covering their care should be **clearly and explicitly** identified.[29] Thus we are now proposing, as a first translation of this principle, that the NHIL and SSNIT contributions be devoted to covering the primary care package plus exemptions for MCH and the care of indigents, aged and children up to 12 years old. The coverage of other groups, including the subsidies that are required to enable those informal sector persons paying the small premiums for the benefits, should be clearly identified as well. We have suggested elsewhere that the care of formal sector employees for higher levels should be contingent on additional premium payment in the form an employer contribution (private sector employers for now) of not less than 2.5% of employee's salary. Similarly for children aged 12 to 18 years, another revenue source as argued above should be urgently identified.

77. The following suggestions may be pursued for encouraging people to pay **realistic** premiums[30] for higher levels of care through the NHIS:

- A greater onus is put on the providers and the NHIA to pay closer attention to quality of care and of services needed
- Providers should be sensitised that these reforms require a sea change in attitudes and understanding of how to operate sustainably in the new environment

[28] It is important to establish, as noted above, just how far additional health service areas might be supported beyond the core package of PHC/MCH. There have recently been suggestions, including from the Ministry of Finance, that the NHIA funding deficits may not be due mainly or entirely to structural underfunding of the benefit package, ie that the revenues are not sufficient to cover the cost of the benefit package.

[29] The NHIS designers claim to have had some sources of funding identified for different exempted groups; however, even best, these appear to have been unreliable back of envelope calculations that were neither subjected to actuarial tests nor shared with the public at large.

[30] By realistic premium, we do not imply premiums should cover the cost of the services as we have sometimes heard during public meetings. However, the actuarial study must determine how far all the various revenue sources are enough to cover the estimated costs of the benefit package, so that the residual, which is to be paid by premiums, can be used to calculate the premiums required if the scheme is to be financially sustainable, or else specific additional revenue sources must be identified to subsidise the premiums.

- Seek group registrations (eg market women, GNAT, professional and other associations, etc),
- The SSNIT contributors should continue to be automatically included with payment of an additional premium by the private sector employers (see further below on this)
- As previously argued, make it obligatory to register school children above 12 years through school fees or other mechanism.
- Institute a set enrolment period for NHIS each year, say for three months at the beginning of the scheme year, to avoid adverse selection but also to be able to do massive campaigns to raise awareness and maximise enrolments (but infrastructure for registration?). A side benefit will be that no waiting period after registration will be needed any longer as adverse selection will be minimised.
- If possible, devise targeted mechanisms for specific segments of the population to ease their paths to enrolment.

78. Predictability and timeliness of NHIS funding are very important to help address the inefficiencies identified earlier and allow the NHIA to plan appropriately. A dashboard of indicators of NHIS overall performance, which we advocate, should include the percentage of NHIL and SSNIT contributions owed to the NHIS that were transferred on time. These indicators are to be reported on annually to the Ghanaian public, not simply to a meeting of select stakeholders (see Figure 6 for an example of the kind of dashboard that we recommend; obviously this would be adapted to the Ghanaian NHIS.)

79. Increasing premiums to beef up NHIS income has been recommended to the Review Committee endlessly and from many sources. Indeed, given that the focus is going to be on PHC for all, the question of what funding is going to be available for higher level care is likely to arise. A quick calculation of what capitation rate might be required to cover the primary package indicates that the amount of NHIS income left over would not cover a substantial package at the higher level. Therefore, the NHIA may choose to raise premiums for accessing higher level care to help raise the revenues required to pay for that care. But it is important to note that informal sector premiums will not make a huge difference to the NHIS' bottom line in the immediate future. If they are increased by a lot, the NHIA could get even less money as many people currently paying no longer choose to renew their membership.

80. On the other hand, if premiums are properly understood as inclusive of the formal sector contribution, which was the way the designers of the NHIS intended the 2.5% SSNIT contribution to be seen, then yes, increasing that portion of the premium could make a big difference. And let us remember, the contribution by formal sector workers is well below what workers in most countries with social health insurance pay into the scheme, typically 5% is the lower end, and 7% and over is quite common.[31] That form of contribution is also more sustainable, more equitable and more efficient (addressing three of the Review's thematic areas at once).

81. A grand bargain with the TUC and employers would be required to obtain agreement on some revised premium arrangements: for instance, we have proposed that the SSNIT contribution goes to the pot for guaranteeing universal and quality PHC; that requires additional premiums from workers' employers for care above PHC levels, which would cover the worker's spouse as well.

82. We propose private sector employers contribute an additional percentage, not less than 2.5% of each employee's salary, into the scheme.[32] The Government as employer is not included in this proposal to start with, due to the significant investments that Government still makes to the health sector through public and mission health sector salary transfers and infrastructural payments. Private sector employers, on the other hand, can now have their workers enrolled onto the NHIS and no longer have to pay any medical bills. It is true that not all employers so far have taken this path, though some have indeed done so, and are therefore making savings and enjoying other benefits of the NHIS.

83. To encourage workers and employers to join the NHIS where they still have separate schemes, the NHIA should commit to better quality that should be monitored with worker participation (eg through higher capitation rates to providers but with some of the revenue ring-fenced by providers for specific quality improvement areas), and reduced friction for workers registering or seeking care. The spouse of the worker should also be covered under the new arrangements proposed here.

[31] Here are a few country examples: Ethiopia 7% split between employer and employee; Tanzania, 6% of gross salary split between employer and employee; Tunisia - Contributions at 1st October 2010 were 6.75% shared between the employee and employer. 2.75% is paid by the employee directly from their salary and 4% by the employer; Senegal – ranges between 4% and 15% by work place split between employer and employee.

[32] The exact percentage required will be recommended as a result of the actuarial study that the Committee has commissioned.

84. As many stakeholders have also argued forcefully during the committee's public and stakeholder consultations, it is important to look too at the overall pattern of expenditures as well as the lack of cost containment measures in the NHIS as originally designed. Some strong cost containment measures for care at the higher levels of the system (including co-payments, reimbursement ceilings or pre-authorization on expensive technologies etc.) coupled with more efficiency gains from deploying more of the NHIA's strategic purchasing potential (eg on drug purchasing), will be needed to bring the overall costs down.

85. To promote greater equity and to encourage staff serving in rural and remote facilities by giving them more means to obtain simple necessities for their facilities, the capitation rate should be adjusted to pay higher rates, at least 25% and increasing over time (it is twice the rate in some other countries), for such generally disadvantaged facilities and areas.

86. The PHC strategy would also not work if key elements of the strategy such as CHPS zones are not adequately provided for. For example, the capitation rate must take into account outreach and community services which are the most equitable of all and are core to the mission of the CHPS zones. Additionally, a protocol must be established to permit the NHIA to either pay for task-shifted midwifery and CHN services at CHPS levels or for emergency referral services to facilities for deliveries.[33]

87. Over and over again throughout the review process, we encountered suggestions that the current NHIS benefit package and exemptions were both too broad, and needed to be trimmed or slashed, in the interests of sustainability. The Committee noted the positive and laudable intentions behind these observations and arguments. However, it should also be pointed out that:

- It is not easy to take away benefits from people who have been granted these by the national laws, although the funding arrangements for different groups can be reviewed and may be a more feasible approach to ensure sustainability, which is the real concern of those who criticise the package and exemptions.

[33] See: Aradeon, Susan B and Henry V Doctor. 2016. Reducing rural maternal mortality and the equity gap in northern Nigeria: the public health evidence for the Community Communication Emergency Referral strategy. International Journal of Women's Health, 2016:8 77–92.

- Our proposals require the exemptions for indigents, pregnant women, children under 12 years, and aged to be catered for by NHIL and other statutory deductions.

- Children over 12 should be covered using other funding mechanisms eg additional tax source or school fees plus a variation to account for equity (see more on solution for school kids, under footnote 27 above).

- The overall thrust of our proposals is that while sustainability should always be uppermost in re-evaluating the benefit package, the country's declared commitment to UHC eventually also means that every effort should be made to ensure that a viable and sustainable path exists for everyone's eventual entry into NHIS system above PHC level so that no one is left behind.

- It is also arguable that the real problem with the benefit package is not that it is too broad, but that it lacks cost control measures and is not aligned with national health priorities in order to guide how scarce resources should be invested to maximise health gains.

- The classic way to resolve the conflict between unbounded population and individual health needs versus limited resources for attaining them is, as we propose in this report, to set up a priority setting agency (or at least institutionally recognise such a function) for defining and leading the processes for deciding on which services and new technologies, etc should be covered by the NHIS benefit package, and to guide payment decisions for such services and new technologies.

88. We also encountered a surprising number of concerns about the cost of maternal benefits in the NHIS benefit package, but these concerns seem to the Committee to be either misplaced or based on misunderstandings, especially given the country's underperformance in maternal mortality compared to our LMIC peers. To be fair, though, this also reflects a wider societal issue of people and even authorities frequently divorcing costs or so-called 'efficiency' concerns from any associated benefits.

89. The result is that budget impact often becomes the sole criterion for decision making, leading sometimes to bad decisions. It should be noted that just because something is cheap or cheaper does not mean it is worth doing or is preferable to alternatives which are also within the budget constraint but are not necessarily the cheapest option. A case in point is new medical technologies, which are nearly always far more expensive than what they replace, but are worth investing in because they increase

productivity, improve quality, provide greater accuracy or offer other substantial benefits over the existing or old technologies. Similarly, the gains from providing unimpeded maternal care benefits to all mothers who need them irrespective of their status far outweigh the costs.[34]

90. The Committee also encountered considerable disquiet from stakeholders about the NHIA funds being allocated for MPs' health projects, allegedly with little to no accountability. Many objected to the very idea itself as an unnecessary expense on the insurance while the NHIA is unable to pay its bills. While the total sums involved are not huge, it is suggested that, for better transparency as well as accountability, and to allay the concerns, the funds currently going to MPs' projects should be used or tied to supporting the country's priority CHPS policy, and not left to discretion of MPs and district assemblies.

Relevant operational questions regarding registration, capitation and other issues

91. It was clear to us during the review that the NHIA's infrastructure was inadequate to register even the 40% of the population currently in the scheme and needing to renew their cards during the peak renewal times of 2015-16.[35] And yet, there are more than a half dozen agencies all undertaking biometric registration and collecting basically the same types of information from the public, mostly urban dwellers and better off people. The Committee believes that better coordination and synergies between them would avoid too many overlaps and enable their resources to be shared or pooled more optimally to cover the entire population while collecting all the data that they all need.

[34] Nevertheless, given the frequency of complaints about offering 'free' maternal care to wealthy people, the NHIA could address this in a wider sense by setting up a separate account (which should be managed transparently with periodic reports to the public) for donations into which those who feel that they should pay for the care they have received can pay into. This would be facilitated by our other recommendation for the NHIA to provide the cost of health care accessed by everyone after every encounter.

[35] The situation eased considerably at many offices after the peak renewal times; however, facilities for waiting members of the public, eg sanitation and drinking water, as well as crowd management, remain concerns that need to be better managed in future.

92. To that end, we have encouraged the IT/eHealth sub-committee of the Review to examine, in collaboration with the other agencies, the feasibility of such coordination and synergies.

93. It is also proposed that some impartial arbitration mechanism should be set up to enable parties to the NHIS to appeal to if they are dissatisfied with a decision or action of one of the parties. To avoid setting up a new expensive bureaucracy, however, this function could be lodged in an existing public body that has the requisite skills and similar mandate. We recommend that this function be lodged in the proposed National Health Board or Commission which should set up ad hoc technical committees to handle specialised areas like these. CSOs and beneficiary groups should also be included in any such mechanism so that the concerns and perspectives of the public and especially beneficiaries are not forgotten.

94. **This mechanism must however not be allowed to limit or constrain the NHIA in any way in carrying out its legitimate purchaser functions e.g. it cannot be allowed to set or revise the NHIA tariffs.**

95. What constitutes PHC needs to be clearly defined. For these purposes, the following clarifications regarding the thinking behind the Review Committee's recommendations should be noted:

- Universal PHC is an *aspirational* goal, but the *operational* guaranteed benefit package in the near term will be the NHIS capitated primary care package as currently being defined, plus district referral level services.
- Core services at CHPS (including outreach and task-shifted services), and health centres will be included in the capitated package.
- Some clinical services at district (hospital or other first referral) facility level will also be included, for referral services only, and paid under a different (G-DRG) arrangement, depending on the actuarial study that has been commissioned by the Review Committee to look at the redesigned package of this review.
- **To avoid confusion in the minds of the public and also to limit the anecdotally widely observed phenomenon of 'internal referrals' at higher levels of the health**

system tending to undermine the cost control function of capitation pilots and thus driving up costs, it is proposed that the guaranteed PHC package should be limited to those services dispensed at district hospital level (for referral care only) and levels below that (health centres and CHPS zones). PHC offered at secondary and tertiary levels will therefore not be reimbursed by the NHIA, though individuals are free to use such services at their own costs.

- Work is ongoing involving the MOH, the NHIA's capitation committee, and the Epidemiology and Benefit package sub-committee of the NHIS Review to harmonise different exercises to define the primary care package for both the health system as a whole and for the NHIS.
  Issue for discussion/resolution: What preparatory work is required for implementation in cases where districts that have no appropriate referral facility, in order for them to be ready for this restructured NHIS?

96. Pharmaceutical costs emerged during the review as a key cost driver in the NHIS for which adequate solutions must be found. Our pharmaceutical sub-committee made the following recommendations, among others, for tackling the issue:

- Establishing an e-health platform - participation in this system should become part of the credentialing requirements
- Delisting - Review and modify the reimbursement list to prioritize life-saving medicines
- Copayment at higher levels - improve tools for managing use of expensive medicines, consider tiered co-payment or prescription fee for higher levels of care but avoid creating access barriers for the poor
- Address payment delays, ring-fence money for reimbursement of medicines through virtual accounts
- Separate prescribing and dispensing
- Review the NHIS reimbursement and price setting methodology
- Include medicine expenses into capitation
- Introduce cap on medicines in facilities' IGF
- Use 'strategic' purchasing for medicines, negotiating framework contracts

97. Also, there is a need to clarify how to handle emergencies and referrals /gatekeeping enforcement. These can be the subject of more detailed discussions and planning but it is important to recognise the potential challenges these could pose for the proposed new system.

98. In a transitional period, the coverage for above PHC-level services might continue to be provided based on the current system of rationing care. The redesigned system should also be phased in; with the distinct phases and their sequencing to be defined in further work.

Additional recommendations for reform

New institutions recommended to address gaps identified during the review.

99. The **group practice or provider networks** under consideration could respond to the earlier observation regarding the wide variation in quality and capacity to deliver the benefit package across the country. We propose to push this idea further towards the Thai model of provider networks with **lead providers** taking on some greater responsibilities, in this case we propose responsibilities such as managing capitation payments to network members, ensuring quality care and compliance among network members, with appropriate performance incentives for these lead providers. NHIA district staff will then monitor performance and compliance at facilities lower than the lead provider while the staff at the national level will do similarly for the lead providers.

100. Piloting different models, including one where the NHIA continues to pay directly to health facilities but lead providers handle the other functions above, can be tried and monitored before a final model is rolled out upon evaluation.

101. A new and much needed institution, **a National Health Board or Commission**, to be chaired by a very senior, respected and impartial, retired ex-public official and comprising all bodies to do with financing and service delivery in the sector, including reps from MOFEP, Ministries of Gender, Employment, etc., providers' bodies, development partners, regulatory bodies, as well as governance CSOs and beneficiary groups. Its roles should include:

- National health financing and regulatory policy design and coordination, including in particular coordinating and harmonizing the different sources of funding to health and ensuring that there are no gaps or services do not fall through the cracks or get pushed onto one of the funding sources by default rather than by design with careful

consideration of the available funding etc. it is important that NHIS funding for instance is coordinated with other sources of health funding so as to achieve the desired goals in an optimal manner. There exists a clear gap in this area.

- Harmonizing of rules and regulations in the health sector (and beyond) to avoid duplication and inconsistencies

- Monitoring and evaluating the progress against performance metrics including reviewing the annual reports of relevant sector agencies as a necessary oversight function, etc.

- Appointing ad hoc technical committees, such as an arbitration body or mechanism to mediate differences between parties to the NHIS without however the power to over-rule the NHIA's legitimate purchasing roles and decisions.

- Serving as the locus of priority setting exercises to examine the justifications and affordability of new services and technologies for the NHIS to cover. This area too could be assigned to a specialized technical sub-committee of the Board/Commission.

As noted, the Board/Commission could carry out its work with the aid of a number of technical sub-committees.

102. In order to more effectively address commonly encountered problems of a high degree of lack of empowerment of users/scheme members, both with respect to the NHIA and to providers, the Committee recommends that a **Patient Protection Council** be set up as a consumer protection unit outside and independent of the NHIA to foster safer, more respectful, transparent, and compassionate care and services. The Council will have retired clinicians and others who know the system well and can be champions of safer care and more positive outcomes for patients and families in both the NHIA and clinical settings. They will be able to receive and investigate complaints and to compel any NHIS party to redress complaints found to be justified, and they may independently investigate medical errors and similarly compel redress for wronged patients and families.

Scheme members/users (NOT subscribers)

This subsection discusses findings and recommendations related to scheme members and service users.

103. There is a dearth of patient and community voice in how the NHIS is run. Despite occasional user satisfaction surveys, there is no systematic or organic means for allowing the beneficiaries to participate in how the NHIS is run; neither are there sufficient feedback mechanisms to integrate user views into the plans and activities of the NHIA. Some suggestions received during the review for improvements in this area, in addition to others made elsewhere in this report, include:

- Devise means to integrate community monitoring of NHIS services into the operations of the NHIS
- Record and make available to communities data on drugs or funds received by facilities
- Integrate visits to randomly selected patients to monitor/verify receipt of services and drugs prescribed /dispensed
- Integrate beneficiary group and CSO participation into NHIA activities and oversight work.

104. It is arguable that the need for annual registration and renewals of membership constitute a considerable burden on members and it is not clear why this is always necessary: While periodic verification of exempt status and continuing eligibility is obviously necessary, it is not so obvious why that should be annual for children under 5, indigents and the aged? Apart from relieving the burden on individuals, less frequent renewals consistent with the situation of the person (eg a one year old need not renew for the next four years), would also save the scheme precious money.[36]

105. We learnt that there is a widespread perception that insured patients receive worse quality of care than non-insured. This perception is not always unfounded. For example, insured persons nearly always experience more friction in receiving attention at the facilities because of the verification requirements involved; and the perception that generic drugs are inferior to branded ones, while incorrect, has some plausibly strong foundations.

106. It is therefore important to point out that this kind of problem is not restricted to Ghana but is common in nearly all mixed financing models where a substantial non-insured population exists side by side with the insured. And so long as this distinction between insured and non-insured exists, such, scientifically invalid, comparisons will tend to persist. Thus, generic drugs etc will tend to be viewed as inferior until nearly everyone is receiving

[36] Note also that the strategic recommendation to guarantee PHC for everyone is a partial answer to this problem, since no renewals are needed for the PHC package so long as a person's ID is valid.

the same drugs due to preponderance of the insurance agency as the main purchaser and ultimate source of drugs in the system. That is, universal or near universal coverage is the ultimate antidote here.

Providers /Service Delivery

This sub-section presents recommendations relevant for providers and service delivery aspects of the NHIS.

107. Where that is not the case, CHPS zones need to have clear referral pathways and be linked to emergency referral services as many of new patients coming to them will have cases beyond the capacity of that level.

108. The issue of health professionals practicing in the public and private sectors and the conflict of interests involved was raised in our meetings. The following points were raised:

- How far is this practice consistent with the employment contracts of those professionals involved?
- NHIA should support the approach of the Pharmacy Council whose rule is apparently to deny the use of licenses from one agency to practice elsewhere
- NHIA should dis-credential facilities where the key operational staff are public health professionals, irrespective of the name on registration certificate.

109. Separating prescribing from dispensing: we recognize that this suggestion is controversial, not least because facilities like to dispense drugs as an additional income generation activity. However, we find merit in the suggestion to separate dispensing from prescribing to mitigate the perverse incentives for polypharmacy inherent in prescribing and dispensing in the same facility. At the same time, it must also be acknowledged that the separation cannot happen overnight nor everywhere, given the concentration of private pharmacies in urban areas.[37] Our recommendation is to pilot this separation in some urban areas as a start, and then progressively roll this out as the infrastructure and alternative revenue sources for facilities losing their income from drugs can be found. This

[37] It has also been argued that if this separation policy were instituted, that would be sufficient incentive for private or community pharmacies to open up outside their urban enclaves to serve the new demand in other parts of the country.

would facilities collapsing as anecdotal evidence points to some facilities depending on drugs for over 50 percent of their income.

110. Put drugs into capitation and let patients asked to buy drugs from outside facility to get reimbursed from NHIA and latter takes cost from the capitation payment of provider.

111. E-vouchers can be issued or triggered by the provider each time a patient has not received the drug which is captured immediately by NHIA for reimbursement and charging the facility – these can be used to cross check with the receipt from the patient.

112. Disagreement about tariffs will persist for long, since the providers do not know their real costs and have grown used to operating at rates of inefficiency encouraged by current NHIA inability to deploy strategic purchasing to an appreciable extent.

Purchaser - National Health Insurance Authority (NHIA)

113. The NHIA's management should formally remind their staff that the practice of referring to scheme members as subscribers is wrong and contrary to NHIS Acts 650 and 852. Scheme members are not subscribers, which tends to disempower the members rather than empowering them.

114. The committee encountered a widespread and persistent concern, not least from most staff of the NHIA itself encountered, about over-centralisation of the NHIS and especially of the NHIA. It appears that the 2012 law that introduced this level of centralisation did not take account of the history of highly centralised state institutions in our country, nor did it distinguish between functions that should be centralised for greater efficiency (eg claims administration), and those that ought to be tackled closer to the operational level for maximum efficiency as well (eg complaints). The result is a top-heavy institution that is seen as detached from the public, dictatorial by reflex, very opaque, and insensitive to other parties in the NHIS such as the providers, the public and even its own staff in the field.

115. The Governance sub-committee's report provides options for easing over centralization, among other recommendations for reform. The Committee is also producing a separate report for the NHIA's own management and staff.

116. The NHIS in our view, needs a data revolution, with a focus on what is required to run NHIS efficiently and report to the stakeholders. For example, it is clear that digitising the claims data is a top priority. Also inter-operability of the IT platforms and data systems with other partners such as providers' and other biometric data systems in the country should be prioritised.

117. NHIS performance metrics should go well beyond what are currently reported. Monthly, quarterly and annual performance metrics for NHIA need to be tracked and monitored with independent beneficiary group participation; as well as health outcome surveys periodically (in collaboration with the Ghana Statistical Service).As an illustration, one may compare the paucity of information that can be gleaned from the current NHIA annual reports (which in recent years provide even less information to the public than when the NHIS was founded), and what can be gleaned from the following table of headings from one 'best practice' example in this field, namely, the 2014 Annual Report of the Estonian Health Insurance Fund (EHIF):

Figure 6: EHIF Key indicators 2010–2014

	2010	2011	2012	2013	2014	Change compared to 2013
Number of insured persons at year end						
Revenue (thousand euros)						
Health insurance expenditure (thousand euros)						
Operating expenses of EHIF (thousand euros)						
Health insurance expenditure as percentage of GDP (%)*						
Total healthcare expenditure as percentage of GDP (%) **						
Number of insured persons who used specialised medical care						
Average length of stay (days) in inpatient care						
Emergency care as a percentage of expenses of specialised medical care (%)						
outpatient care						
day care						
inpatient care						
Average cost per case in specialised medical care (euros)						
outpatient care						
day care						
inpatient care						
Volume inflation of specialised medical care (%)						
Number of reimbursed prescriptions						
Number of insured persons who used						

reimbursed pharmaceuticals	
Average cost of reimbursed prescription for EHIF (euros)	
Average cost of reimbursed prescription for patient (euros)	
Days paid for by the EHIF	
Cost of benefit per day	

118. It would appear that the NHIA has not always given consideration to the most important factors that ought to guide the buying and installation of new technologies such as a national call centre and online-based biometric registration system. In particular, there is little evidence of how the cultural and social dynamics of Ghanaian society as well as the available technical infrastructure such as reliable electricity and internet connectivity were taken into account in the decisions to buy and install such technologies.

119. We recommend that before any new technology is purchased, either the supplier of the technology should be required to provide independent evidence of user impact assessments in Ghana, taking account of different kinds of use cases and target groups, or alternatively, where that is not feasible or none of the suppliers have such evidence, the NHIA itself should undertake such user impact assessments of all new technologies meant for the public before roll out. The results of such independent assessments should be shared with the proposed National Health Board/Commission.

120. In a similar vein, in order to re-establish the reputation the of the NHIA before the Ghanaian public and the stakeholders, it is important for the Authority to take greater pains consider the potential public perceptions when they make investment decisions and undertake other expenditures that can affect how it is viewed. For example, even when the economic case for building new offices is sound, it still matters that the NHIA appears to prioritise such expenditures at a time that they are unable to pay the providers on time. However unfair or even inaccurate that may be, that sort of activity sends a clear and loud public signal that the NHIA places their own comfort and convenience above their supposedly primary purpose of existing, which is to pay for the health care of their members.

Specific near-term recommendations for the Government (H.E. the President and Ministers of Finance and Health)

121. We recommend that the Government urgently advances funds to liquidate the outstanding debts of the NHIA to enable the Authority to pay providers for all their outstanding debts and start afresh, in return for specific, verifiable changes in financial management and accountability that the Government, the proposed National Health Board and the public at large can hold the Authority to in order to avoid a recurrence of the chronic deficit situation.

We make this recommendation because it has become clear that the deficits of the NHIA, and delayed payments to the providers, will remain chronic even if the Ministry of Finance and SNIT begin regularly transferring the NHIL and social security contributions to the Authority on time. We learnt during the review that the Government itself has recognized that even if all the outstanding transfers were paid to the NHIA, there would still be a three month gap in payments, in addition to the statutory three month allowed payment gap.

122. While some have contended that the NHIS' revenues are structurally lower than the expenses, that view remains unproven. Whereas even a cursory examination of expenses in the NHIS as a whole (the claims and other expense categories) leads us to the conclusion that these deficits are much more likely the accumulated outcome of all the inefficiencies in the operations of the NHIS (described in this report) since it was set up.[38] That is why it is necessary not only to liquidate the debt (also noting that all the oversight bodies failed to prevent those deficits from occurring and recurring), but also to insist on specific measures to avoid the recurrence and to protect the taxpayers' interests.

123. We also urge the Government to take steps to immediately set up the various institutions recommended in this report (particularly the National Health Board including its arbitration function, and the Patient Protection Council) in order to improve the functioning of the NHIS as a whole.

[38] The NHIA started to have delays in paying the providers as far back as 2007, as reported in the media at the time. Ref?

124. The Government should enter into negotiations with the trades unions and employers to reach a grand bargain on future contributions into the NHIS as suggested earlier in this report, beginning with an employer contribution of not less than 2.5% of workers' salaries.

125. A worrying and pressing concern that requires Government's attention is whether the providers, having gotten the upper hand against the NHIA due to the latter's morally weakened position in not being able to hold up its side of the bargain to pay providers promptly, and having gotten used to charging insured patients indiscriminately for services that ought to be free, will return to compliance even after the NHIA has been able to clear its backlog of debts.

We have already noted that the providers include perceived low tariffs as an additional reason for these unauthorised charges. While clearing up the past debts can be empirically established to have happened or not, it is not so clear what tariffs would satisfy the providers since even they do not know what are the true costs of their services, with widespread inefficiencies contributing to clouding the picture.

In this situation, upon the completion of the actuarial analysis that our committee has commissioned, Government needs to convene meetings between the providers and NHIA to agree the appropriate tariffs for services under the NHIS, after which a directive can go out banning any further unauthorised charges. Enforcement of the directive with sanctions for providers who flout the directive will be needed to give it teeth.

Summary and Conclusions

OR HOW THE RECOMMENDATIONS ADDRESS THE MAIN REVIEW THEMES OF SUSTAINABILITY, EFFICIENCY, EQUITY AND ACCOUNTABILITY AND USER SATISFACTION.

Sustainability

126. Prioritising PCH with the NHIL and SSNIT funds before the higher levels of care will be a more sustainable use of the country's limited resources:

- Primary care is less expensive than higher levels of care
- The capitated package means that the total cost can be known in advance each year
- The further recommendation to define the primary care benefit package in accordance with what is affordable within the budget of the NHIS and not what is currently defined as PHC or primary care by the MOH, and to expand that package progressively and only in accordance with economic and revenue growth, will enhance sustainability.
- The PHC focus will enable prevention to be more central to NHIS investments, away from focusing more heavily on curative-based system as at present
- Limiting the PHC package to lower level facilities plus covering only referrals from those levels will help with the well-known problem of "internal referrals" and other practices by higher level facilities which take the capitation funds and find additional ways to get the NHIA to pay for the same services through referring the patients to their non-primary care departments.
- The stricter cost controls on higher level care suggested will also help to reduce cost increases in future.

127. Moreover, this time round, the Review insists on an actuarial study of the cost implications of our recommendations as a key tool for refining these recommendations and planning the needed sustainability revenue and expenditure profiles of the NHIS into the future.

128. The total population coverage solves the current problem of adverse selection as far as the basic PHC package of services are concerned, since there is decision to join or not to join, there are no barriers to access, and the new capitation regime covers all the population (see further below).

129. We have noted the agitation among nearly all providers concerning the perceived low tariffs in general, and capitation rates in particular (in Ashanti). As far as the latter issue is concerned, the problem we observed, however, is not necessarily with the capitation rate as such but with the total mass of funds available to each facility, as we discovered when we toured facilities in the Ashanti Region as part of this review. Health centres visited

for instance were receiving very small sums of money reflective of the small numbers of insured persons enrolled with them.[39]

130. But capitation income is dictated by **the rate** as well as **the numbers enrolled** with the facility, especially the latter. However, as the NHIS only has 40% of the population (and an even smaller percentage, at 36%, in Ashanti Region), and those are mostly high users (due to adverse selection), the capitation in those circumstances is not a very attractive or even viable proposition for some of the providers. Our NHIS Review recommendation to capitate the whole population will help to address this issue:

- It brings a far bigger population to the mix, without increasing the total number of facilities if this is restricted essentially to public and CHAG facilities
- Moreover, the additional population will be much healthier (and probably also financially better off) than the currently capitated population
- This recommendation also begins to tackle additional issues such as differential perceived quality and the widespread unpopularity of generic drugs, as we will explain further below.[40]

131. The recommendations to have legal requirements for limits to the medical loss ratio and a minimum level of reserves will, if enacted and implemented, significantly strengthen NHIS sustainability.

Efficiency

132. As the boxed text of Figure 1 showed, when properly implemented, a focus on PHC is more cost-effective, costing less than delivering the same care at higher levels of the health system without sacrificing quality. It is therefore a more efficient approach than the NHIS' currently unfocused and highly curative-care biased design.

[39] A further issue is the almost complete lack of awareness among public providers of what capitation actually means, and what it requires in terms of changes in business attitudes, skills and practices. The fact that such public providers have assured salaries disconnected from their actual performance only buttresses this situation as there are no strong incentives to innovate to attract operational funds.

[40] Universal coverage, although it is for a limited package in this case, initially at least, could be the answer to many problems attendant to the health insurance system, as we explain under the subsection on Governance, accountability and user satisfaction.

133. Our recommendations will improve upon most or all of the inefficiencies identified earliet in this report, by:

- Aligning the NHIS benefit package with the most pressing health priorities of the country
- Starting to reverse adverse selection in the primary care package by making it available to all without exception
- Pushing back against provider moral hazard through cost containment measures for higher levels of care and strategic purchasing recommendations that will seek to arrest fraud, abuses and cost escalation
- Strategic purchasing measures including framework contracts for drugs and provider payment improvements (to include budget-neutral DRGs) would help to bring costs under control.
- A closed enrolment period during the year will help address adverse selection in insurance for the higher levels of care.
- Commissioning an actuarial analysis of the cost implications of our recommendations and matching them against revenue projections to facilitate planning and additional revenue mobilisation if required.

Equity

134. The evidence presented in Figure 1 including the more recent systematic review by McCollum *et al* all support a focus on PHC and community health as a means of strengthening equity in the health system. Strengthening CHPS compounds and health centres, as our recommendations suggest, will improve equity by brining much needed services closer to the population and making them available to all persons irrespective of their ability to pay. Additionally, our recommendations call for continuing to exempt specific poor and vulnerable groups from payment of any fees at the higher levels of the health system.

135. Moving towards group practices or networks that can provide the entire package of guaranteed PHC services will help address the equity gap between urban areas and under-served rural areas by enabling the inhabitants of under-served areas to have access to a range of providers rather than a single one that may not provide all the services in the package.

136. Eliminating all fees for PHC services for all the population and exempting the poorest from fees at the higher levels will be equity-enhancing

Governance, Accountability and user satisfaction

137. We make specific proposals to improve governance and accountability in the NHIS, such as the National Health Board, the Patient Protection Council, the reporting requirements and format for the NHIA, suggestions to improve patient voice in the NHIS, and less centralisation of certain NHIA functions that will be contained in a separate report to the NHIA board. Improving patient voice as we suggest and setting up a Patient Protection Council will also help with user satisfaction.

User satisfaction is addressed also by the elimination of user fees for all the population for accessing PHC services, as well as the PHC focus recommended, as services are brought closer to communities and those who were excluded from such care can now benefit without anxieties about payment etc.

138. There are other potential advantages of moving towards universal coverage and not a discriminatory system that leaves out most of the population: The persistent complaint that non-insured persons get better quality of care than the insured only exists because of the fragmentation of the population between insured and non-insured. As we move to abolish that fragmentation, the country is also abolishing the distinctions that give rise to this kind of complaint. When all or nearly all the population has the same experience of health care, it would make no sense to compare one's experience against that of a non-existent or infinitesimal group. This argument applies similarly to the issue of generic drugs being considered inferior. So long as the branded drugs are also widely available in the facilities and pharmacies, those impressions will likely persist. But if the NHIS becomes the major force in the medicines market to the extent that everyone or nearly everyone receives only the generics where those exist, we should expect the complaints to die down, much as they have in countries where UHC is the norm of the health system. . Universal coverage for all would appear to be a solution to other inefficiencies in the health system as well.

139. Other measures such as setting up a National Health Commission with the proposed mandate, including an arbitration mechanism for settling disputes between parties to the NHIS, would enhance accountability of the NHIS.

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Terms of Reference for Defining Options for National Health Insurance Scheme Reforms

1. Background

Ghana has been undergoing transformational changes in its healthcare financing over the past decades. Among other developments, the National Health insurance Scheme established by National Health Insurance Act 2003 (Act 650) replaced the "Cash and Carry" system during this period. The primary objective of the scheme is to ensure financial access to basic health care services for residents without having to pay out-of-pocket at the point of health care service delivery. The National Health Insurance Scheme has become an integral part of Ghana's strategy to move towards universal health coverage.

The active subscriber base of the NHIS as at December 2014 was 10.5 million. Over 29 million attendances at healthcare facilities were made on account of the NHIS in 2014. Currently, 69% of NHIS registered subscribers are exempted from paying premiums. These include SSNIT contributors and pensioners, persons under 18 years old, persons 70 years old and above, pregnant women, indigents (the core poor), persons with mental health conditions, categories of disabled persons designated by the Minister responsible for Social Welfare, as well as beneficiaries of the Livelihood Empowerment Against Poverty Programme (LEAP). These exempt categories count for close to 69% of registered members of the scheme, and as a consequence only an estimated 31% of members pay contributions, which contributions are also not at fixed actuarially determined rates.

Revenues emanating from contributions collection over the years form a relatively small proportion of NHIS inflows, accounting for 3.4% of total revenue in 2014. The NHIL contributed 73.8% of total revenue while SSNIT contributions accounted for 20.4%.

From fragmented pools of funding prior to 2012, the scheme now operates a single pool of funds from which services are procured from providers and administrative and operational expenses covered.

The NHIS benefits package is anecdotally estimated to cover 95% of disease conditions reported in Ghana, with services ranging from primary curative care to care at tertiary facilities for all enrolled persons without co-payments or usage limits of any kind. In a state driven social intervention program such as the NHIS, where the Scheme is funded mainly through tax revenues and statutory deductions, the country's health goals ought to guide the design of the benefits package. Furthermore, the tax-paying population should be able to perceive the benefits package as valuable in order to sustain their support to the NHIS.

In a well-designed public health insurance scheme such as the NHIS is, the criteria for choosing essential health interventions to be covered should include the following:

- Ability to technically deliver the desired results and the capability to deliver services successfully;
- The targeted diseases constituting heavy burden on society, taking into account individual illness as well as social spillovers;
- Social benefits exceeding costs of the interventions;
- The needs of the poor being stressed.

A scanning of the literate leading to the establishment of the NHIS however does not show any significant evidence that such rigour was taken into account.

Purchasing of health services within the NHIS is mainly through fee-for-service and diagnosis related groupings, with capitation being piloted in the last couple of years in the Ashanti Region, and currently being scaled up in three additional regions from July 2, 2015. Methods of paying providers have had an effect on provider behavior within the NHIS. Accordingly, payment methods have to be carefully selected and implemented in a way that incentivizes providers to exhibit appropriate behaviours and reduce the risk of perverse incentives.

Moral hazards facing the scheme in the form of fraud and abuse have been estimated to be losing the scheme anything ranging from between 5 and 10% of claims costs. Initiatives by the NHIA such as centralized claims processing, clinical audits and linking of diagnoses to treatment, to mention a few, have had an effect of reducing the prevalence of fraud and abuse, but more needs to be done.

In recent times, high and increasing claims costs have placed the scheme under severe financial pressure. This has contributed to the scheme's inability to pay claims in time to healthcare providers for services rendered to NHIS subscribers. This is in part due to an increase in the active membership of the scheme, as well as an escalation in medical costs, especially the cost of medicines.

Indeed since 2005, the cost of providing health care to NHIS subscribers has increased much faster than the financial resources allocated to the scheme. The NHIS has therefore experienced persistent and increasing annual deficits since 2009.

Delays in reimbursing providers have on several occasions led to the withdrawal of services to NHIS subscribers by providers. It has also led to unauthorized copayments and denial

of service to NHIS subscribers which has had the effect of lowering confidence in the scheme.

On the side of the costs of operating the scheme, concerns have also been raised by some. In some quarters, it is felt that the scheme should have a lean and efficient operational structure. In other quarters, it is felt that the legacy of the heavy administrative and operational structure bequeathed by the previous structure had yet to be fully rationalized. The foregoing and several other factors have led to calls from stakeholders for the scheme to be reformed.

Indeed, with the strong commitment shown by Government to a robust NHIS and Universal Health Coverage, the time is opportune for such a reform to be undertaken.

2. Objectives

The main objectives of the NHIS reforms proposed to be carried out are to ensure:

- 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.

3. Purpose

The purpose of the reform proposed to be carried out is as follows:

- Establishing a sustainable, pro-poor and a more efficient NHIS, by redesigning, reorganizing and reengineering the scheme;
- Creating a solid ground for improved service delivery across the scheme, in order to facilitate better provision of services to residents; and
- Creating a smart scheme based on knowledge and information.

4. Outputs

- **As-is analysis:** In cooperation with all relevant practitioners, document current NHIS design, identify shortcomings, constraints to operational efficiency and bottlenecks;

- **To-be analysis:** Provide recommendations on options for NHIS reforms, taking into account the long term sustainability of the scheme in the areas of financing and benefits package design, coverage of poor and vulnerable groups, equity, accountability mechanisms and operational efficiency;
- **Action plan draft:** Based on all of the previous analyses, an action plan should be prepared, containing steps and processes for implementing the proposed recommendations including stakeholders to be consulted and strategies for mitigating risks of implementing the proposed recommendations; and
- **Change Management and Communication Strategies**; Develop change management and communication strategies to support implementation of the proposed recommendations.

5. Key Questions to be answered

The key reform questions to be asked include the following:

- **What is happening**
  - What are the gaps in the existing system;
  - Are there any issues of concern;
  - What is being done to address the gaps and concerns and are they working.
- **What are the reasons for what is happening**
  - What are the issues and why are they occurring;
  - Do we know their root causes;
  - Do we need to do further diagnostics to identify the root causes.
- **What needs to be done**
  - What actions should be taken to bring a permanent resolution to issues identified;
  - Should these actions be undertaken in clearly defined phases
- **Apportionment of responsibility**
  - Identify persons and institutions that should take actions;
  - What support do they need to be successful
- **Definition of timelines**
  - Prioritize actions;
  - Set deadlines for their completion.
- **Measurement of success**
  - Determine key indicators for success;
  - Set up systems for measuring success;
  - Determine reporting structures.

6. Deliverables

- **Inception Report**, which shall consist of the work plan to carry out the assignment detailed note on the proposed approach and methodology as well as an identified list of key stakeholders. The terms of reference may be improved and refined for better achieving the outcomes, through mutual discussions at the inception report stage;
- **Draft report,** to be submitted to Advisory Committee for comments;
- **Advisory Committee Report,** to be taken into consideration in producing the Final Report;
- **Final Report**, and
- **Power Point Presentation,** Presentation to His Excellency the President, Minister for Health and other selected persons on the Final Report.

7. Expected Duration of the Assignment

It is expected that the assignment will require a total of 4 months with the following schedule:

- Inception Report: within 2 weeks of inauguration of the Committee
- Draft Report: Within 2 months after acceptance of Inception Report
- Advisory Committee Report: Within 14 days of Advisory Committee Meeting
- Final Report: Within 30 days after completion of Advisory Committee Report

8. Structure for Work Delivery

- **Technical Committee**

  The Technical Committee will be responsible for securing relevant information for producing the various reports listed above. It will also be responsible for producing and coordinating stakeholders and organizing an Advisory Group workshop to consider the Draft Report.

  The Technical Committee will be made of the Following

Mr. Chris Atim	-	African Health Economics and Policy Association
Hon. Dr. Victor Bampoe	-	Deputy Minister for Health
Dr. Obeng Apori	-	CEO Ridge Hospital
Mr. Peter Yeboah	-	Executive Director, CHAG
Prof. Irene Agyepong	-	School of Public Health, University of Ghana
Dr. Huihui Wang		Senior Economist, World Bank
Mr. Nathaniel Otoo	-	Acting Chief Executive, NHIA

- **Advisory Committee**

  The Advisory Committee will consider and make recommendations on the draft report submitted by the Technical Committee. The report will be considered at a two day workshop with the option of members sending in written comments if they are unavailable.

  The Advisory Committee will include any of the following:

  International Experts

  Mr. Ricardo Bitran - Bitran & Associates, Chile
  Prof. Winnie Yip - Oxford University

  Local Experts

  Prof. Badu Akosah - Former Director General GHS
  Mr. Nuamah Donkor - Former Minister of Health
  Prof. Frimpong Boateng - Former CEO Korle-Bu
  Mr. Charles Abugri - SADA
  Dr. Eli Atipui - Registrar, Medical & Dental Council
  Representative of Ministry of Finance
  Representative of Ministry of Gender, Children & Social Protection

  Legislators

  Hon. Richard Anane
  Hon. Yileh Chireh
  Hon. Mohammed Muntaka
  Hon. Matthew Poku Prempeh

  Academia

  Prof. Adonoo - School of Public Health, University of Ghana

  Civil Society

  Dr. Steve Manteaw - ISODEC
  Mr. Kofi Asamoah - TUC
  Rep. Coalition of NGOs in Health