PROPOSED REDESIGN AND RESTRUCTURING OF THE NATIONAL HEALTH INSURANCE SCHEME

Executive Summary

Final Draft

By
The Presidential NHIS Technical Review Committee
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Overview

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/responsiveness**. At the 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 sustainably pay for the benefit package for all the population was ever explicitly taken into account and explained to Ghanaians. In that connection, it is important to note also that when Ghana

[1] Much has been made of the actuarial study undertaken by the ILO in 2004, though nowhere in the design document of the NHIS was reference ever made to it. Even so, that study gave several scenarios based on coverage and otherassumptions.
One of those scenarios suggested scheme deficits as from 2009, but this was based on a coverage assumption of 60% of the population! So the fact that the scheme began to experience

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 large benefit package, acclaimed all over as very generous, without any cost controls of any kind to moderate the foreseeable expenditure growth.

6. **It was commendable and even innovative that specific sources of revenue, especially the additional VAT, were identified for the scheme. The VAT source (or the National Health Insurance Levy or NHIL as it is officially known) offered the advantage that the revenues of the scheme would grow broadly with economic growth. Despite this, however, 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 (which relate closely to membership growth)?** 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 had 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. The recent withdrawal of central budget support for utility bills of the public facilities are a clear indication of a Government response to these pressures.

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

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structural deficits from 2009 is not a vindication of the actuarial analysis as is often cited, but actually begs the larger question as to why expenses started exceeding revenues at coverage rates far below 60%!

The VAT may help to address longer term revenue issues but the scheme's expenditure rises due to membership ramping up pose a threat to sustainability in the near to medium term, and future economic growth projections would not solve those more immediate questions.

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 selection 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 one of the most glaring inefficiencies 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. Similarly, family enrolment is not enforced, neither are different forms of group enrolment, both of which factors also encourage adverse selection.

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 minimum reserve levels or a medical loss ratio not to be exceeded.

The 75/25 medical loss ratio cited in paragraph 9 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.

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. This reserve fund will usually be required to be set up over a period of years.

18. It should also be noted that one of the reasons that the NHIS is unable to benefit optimally from its strategic purchasing potential has to do with the fact that the vast majority of providers, namely the public and CHAG/mission facilities, do not generally have the flexibility to respond to signals transmitted by provider payment reforms such as capitation, compared to the private for profit sector. The individual managers of public and CHAG institutions do not often have the kind of control over their human resources,

[3]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).

and frequently some other areas of expenditure too, which would provide them with the levers for behaving more efficiently and improving quality of care, in response to reforms requiring them to do just that to survive and thrive.

19. 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

20. The good news is that equity in access within the scheme's membership 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.

21. 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 /responsiveness

22. Taking user satisfaction or responsiveness 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.

23. 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 mostly the frequent drug dispensed to them. (Indeed, one of the surveys carried out for this review found that paracetamol was the biggest drug prescribed by volume to NHIS members.) 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.

24. 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.

25. 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.

26. 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.

27. 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 26 above be emphasized going forward, with less emphasis being placed on the uncritical use of service utilization as a measure of NHIS success.

28. 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, and that the NHIS should periodically explain the extent to which it is providing what it has promised. This obliges 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.

29. 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.

Recommendations and way forward

(I) Proposed Redesign of the NHIS

25. 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:

26. **To align the NHIS with Ghana's priority health goals, we recommend refocusing the scheme to provide primary health care (PHC) as well as maternal, new born and child health (MNCH) care for all the population on the basis of the public taxes that fund it.** To translate this aspirational goal of universal access to PHC into operational objectives, however, we propose the definition of an NHIS primary care and MNCH benefit package that will be guaranteed at public and CHAG/mission facilities at 100% with no user fees on such health services for all who need them (i.e. automatic coverage), and, crucially, which is bounded by affordability and, specifically, the annual limits of the scheme's budget. Private for-profit facilities including maternity homes should be covered where they are situated within rural and 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. The guaranteed benefit package can be expanded with time as national income and NHIS revenues increase sustainably.

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

28. **To avoid abuses and to ensure collection of data vital for NHIS management, a form of national or resident identification (including but not restricted to NHIA cards) should be required for anyone who is using these guaranteed services.** Since such care is guaranteed to everyone without distinction, however, the NHIS membership card will not be a condition of accessing primary health care. 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.

29. 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.

[4]Wherever such essential data is already being captured through the routine health management information system of providers, this data should be shared with NHIA and providers will not be given the additional burden of separate NHIS reporting forms. Where data is not already being captured, data capture forms should align with already existing routine systems to reduce the burden.

Some promising areas that may be explored include adding on high-value (and even non-essential) health care services as part of an enhanced benefit package, potentially for additional premiums that anyone can purchase.

30. The proposal is to guarantee **"coverage for all but not coverage for everything".** The higher levels of care beyond the basic PHC level 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 must **not** however involve any financial burden on maternal and child care at the higher levels.

31. 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.

32. 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 MNCH 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, however, 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 and increased choice for underserved populations, to be achieved.** Preliminary calculations show that this limitation will make the recommendation affordable within current NHIS income.

33. 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 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

'Shared responsibility' refers not only to the patients, but providers as well must be prepared to accept some limits on their pricing to ensure the sustainability of the scheme.

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.

34. 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.

35. 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 Government.

36. 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.

37. 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.

38. We propose the NHIS aims for a 90/10 medical loss ratio in the medium term, but work 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.

39. We propose better coordination of care, long been recognized as a key indicator of the quality of primary care, particularly in contexts like ours without a long history of gate-keeping, with limited continuity of care. The complexity of managing care for rising numbers of patients with chronic conditions is another reason for such coordination. 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 the referring providers 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.

(l) Institutional reforms recommended to address gaps identified during the review

40. 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.

41. 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.

41. 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 representatives from MOFEP, Ministries of Gender, Employment, etc, the TUC, Employers' Association, 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**.

43. 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 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, reduction of medical errors, 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. The MoFEP should also generally play a more active role in assisting the NHIA in the management of its resources to attain financial sustainability.

(l) Other Key Recommendations

46. It was noted earlier that the vast majority of providers, namely the public and CHAG/mission facilities, do not generally have the flexibility to respond to signals transmitted by provider payment reforms such as capitation. In that connection, reports that the Government has plans to move towards granting greater autonomy to facilities in a further decentralization effort may offer the opportunities needed to allow those facilities to respond appropriately to strategic purchasing reforms requiring them to do just that to survive and thrive.

47. To improve accountability to stakeholders, it is not sufficient to take steps at the national level and account through national institutions, but more importantly, the NHIS should account to users, beneficiaries and stakeholders at the operational level, in this case at district level. Periodic district level review meetings convened and chaired by the district authorities should be held at which issues of concern to such stakeholders and users can be aired and possible solutions agreed.

48. In view of the numerous observations and representations we received from various stakeholders and the public about the current over-centralisation of the NHIS, it may be wise to evaluate the impacts of the policy to see if improvements may be warranted. In our view, what should guide decisions about which function should be performed at what level (central, regional or district) should be this: at what level is this function more effectively and efficiently performed? It is for instance not at all clear to us why dealing with complaints should be handled through an impersonal centralized call center in Accra. The close and personal touch that can be afforded by being able to talk to a human being in the district office would offer many obvious advantages. The NHIS may also benefit more from training staff in the district offices to be in a position to help monitor provider compliance and be responsive to user feedback and interests.

49. In view of the backlog of debts owed by the NHIS to providers and the information we gleaned that even if the MoFEP released all funds owed to the scheme to the NHIA, there would still be a financing gap of several months, we propose the Government considers a one off grant to the NHIA to enable them to defray the past debts and start afresh, in return for firmly agreed and clear steps to avoid a repeat of the deficits and for the scheme to keep within its income in future.

How our recommendations address the main review themes

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

50. 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 promise the best returns and can help the country achieve its priority health goals, especially reduced maternal, newborn and child mortality, and 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 or contain cost increases in future.
d. The capitated primary package for all eliminates adverse selection in PHC/MNCH 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.

51. 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, as well as insisting that if anyone enrolls then their whole family should also do so, will help address adverse selection in insurance for the higher levels of care.

52. 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.

53. Accountability and user satisfaction/responsiveness

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.