

Review of the Ghanaian NHIS: What Lessons Have We Learned?

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4th Conference of the African Health Economics and Policy Association (AfHEA)
Sofitel Rabat Jardin des Roses – Morocco, 26th 29th September 2016

Outline

- ▶ Intro and Architecture of the Ghana NHIS
- ▶ Promise, achievements
- ▶ NHIS Review – why, objectives, methods
- ▶ Findings
- ▶ Recommendations
- ▶ What next?



Intro and Architecture



Legislative framework

- ▶ The Ghanaian National Health Insurance Scheme (NHIS) was introduced in 2003 by Act 650 of Parliament
- ▶ Purpose: to protect Ghanaian residents from financial risks in healthcare
- ▶ The Act was revised in 2012: Act 852



Benefit package

- ▶ 95 percent of health conditions affecting the population
 - Outpatient services
 - Inpatient services
 - Oral health
 - Eye care
 - Maternity
 - Emergencies
- ▶ “Generous”?



Exclusions

- ▶ Cosmetic surgery and aesthetic care
- ▶ HIV retroviral drugs
- ▶ Assisted Reproduction e.g. Artificial insemination and gynecological hormone replacement therapy
- ▶ Echocardiography
- ▶ Angiography
- ▶ Dialysis for chronic renal failure
- ▶ Heart and Brain surgery other than those resulting from accidents.
- ▶ Cancer treatment other than cervical and breast cancer
- ▶ Organ transplanting
- ▶ Diagnosis and treatment abroad



Sources of funds and enrolment

- ▶ The NHIS levy: 2.5% of VAT => 70% of revenue
- ▶ SSNIT contribution: 2.5% of SSNIT Contribution
- ▶ Premiums from informal sector
- ▶ Investment income



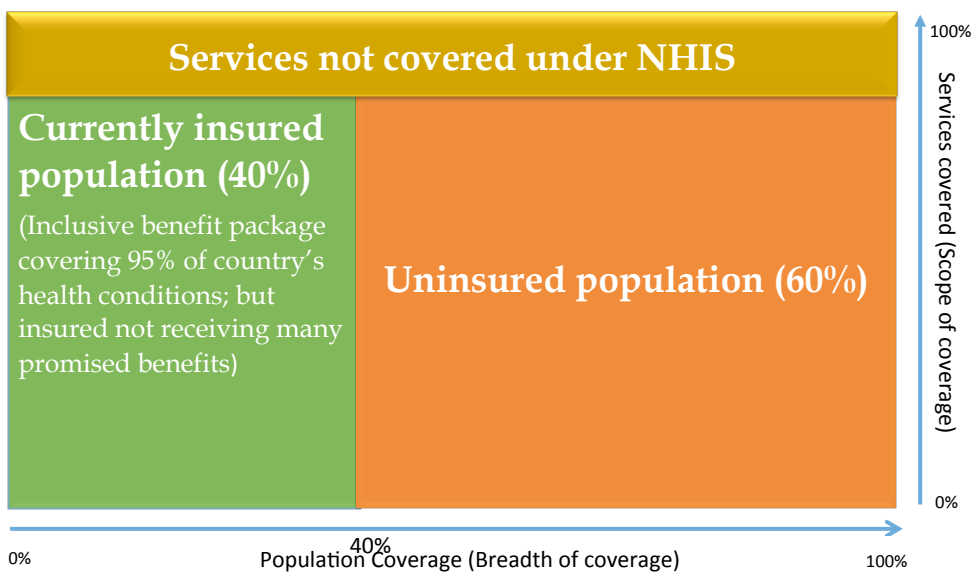
Exemptions

- ▶ SSNIT contributors do not pay at point of joining
 - But contribute via 2.5% SSNIT off-take
- ▶ Children up to 18 years old
- ▶ Aged, above 70 years old
- ▶ Indigents
- ▶ Pregnant women



Promise and achievements

CURRENT NHIS COVERAGE



NHIS has some great design features and advantages

- ▶ An important one is reduced fragmentation within the insurance system
 - Publicly financed social health insurance, not individual premiums
 - Equitable benefit package for all members
- ▶ Single pool and purchaser for the insurance benefit package
 - Strategic purchasing potential currently under-utilized
- ▶ But 'single purchaser' undermined by fragmentation of wider health system financing
 - GoG financing is through 4 channels (Salaries, NHIF, goods and services, credits)
 - OOPs, donors, companies and communities are other financing sources



Ghana's NHIS' tangible population gains

- ▶ **Health coverage:**
 - About 40% of population enrolled in 2016
- ▶ **Utilization:**
 - Utilization, according to GHS, quadrupled from 0.4 per capita to 1.6 per cap since 2003 in most regions
- ▶ **Financial protection:**
 - Early study found OOPs reduced by 50% for curative care and 44% for deliveries
 - DHIMS2 data for 2008 – 2015 show 83% of OPD attendees insured



Source: NHIS Review Main Report, 2016

NHIS Review – why, objectives, methods



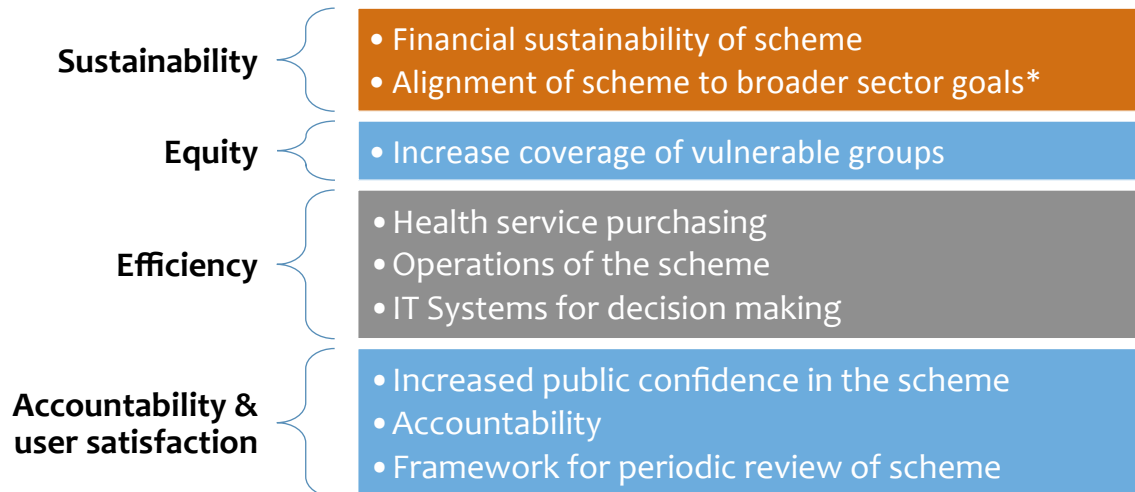
Why the Review? Key near term issues causing widespread concern with political implications

1. Unauthorised charges or so-called ‘co-payments’
2. Long waiting lines and queues for registration
3. Delayed payments to providers
 - 8 – 10 months delays at start of review
4. Provider dissatisfaction with NHIS tariff levels
5. Fraud and abuse in claims system and other areas



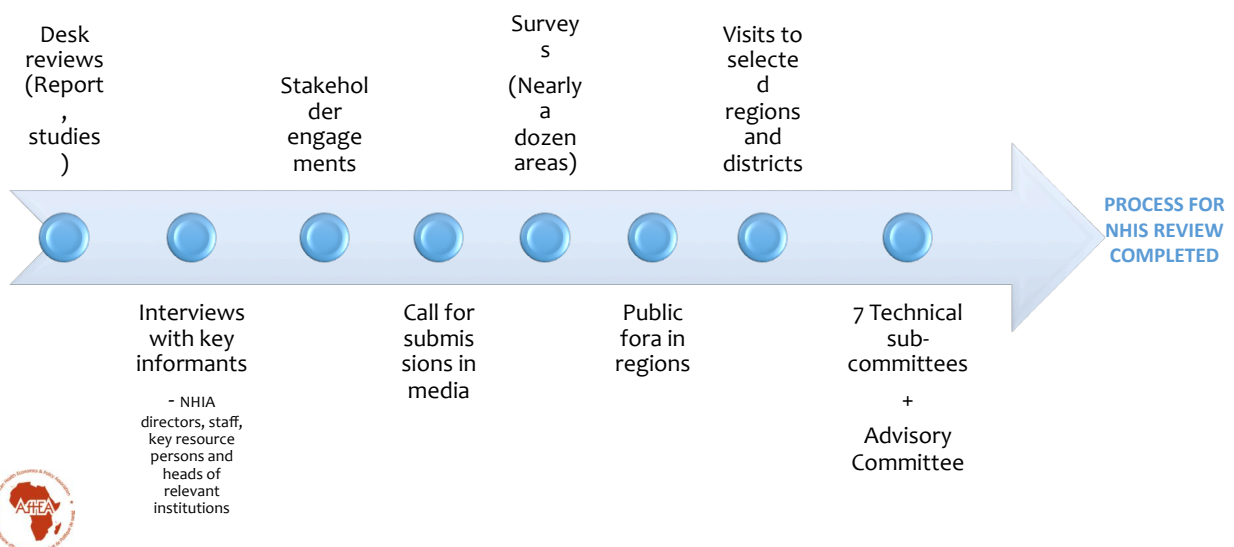
➔ Unfavorable media stories about NHIS ‘collapse’

TORs and Framework for the Review



* Aligning to broader sector goals is also a key efficiency factor, as well as touching on equity and user satisfaction

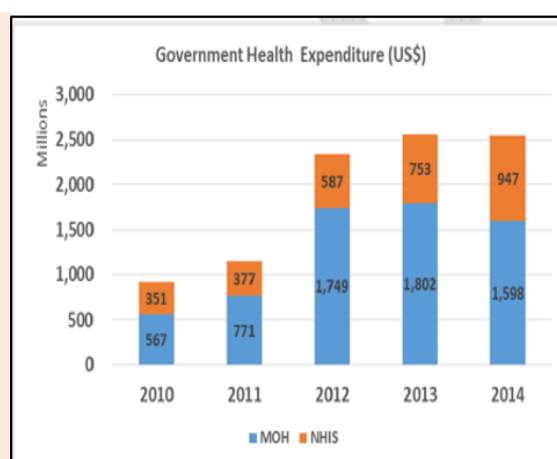
Process : Evidence-based review



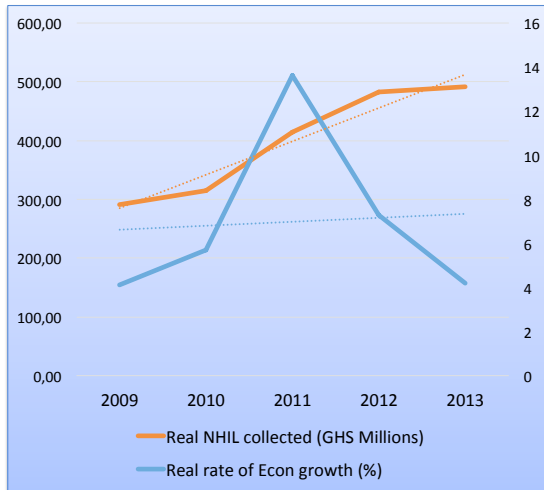
Key Findings of Review

Structural issues impacting sustainability

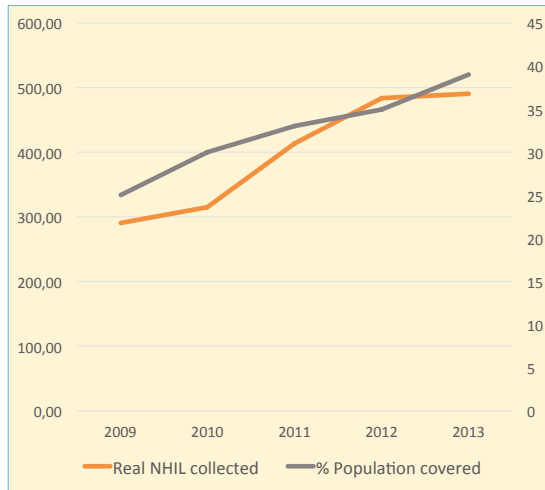
- ▶ 2.5% VAT as major funding source allows NHIS revenues to grow broadly in line with economic growth
- ▶ But does not enable NHIS income to be adjusted to expenditures or membership growth
- ▶ Graduation from LIC to LMIC
- ▶ Increasing reliance of health spending on NHIS, from other sources
 - The ratio between MoH expenditure and NHIF expenditure decreased from 2.9 in 2012 to 1.7 in 2014



Real economic growth rate vs NHIL real income growth

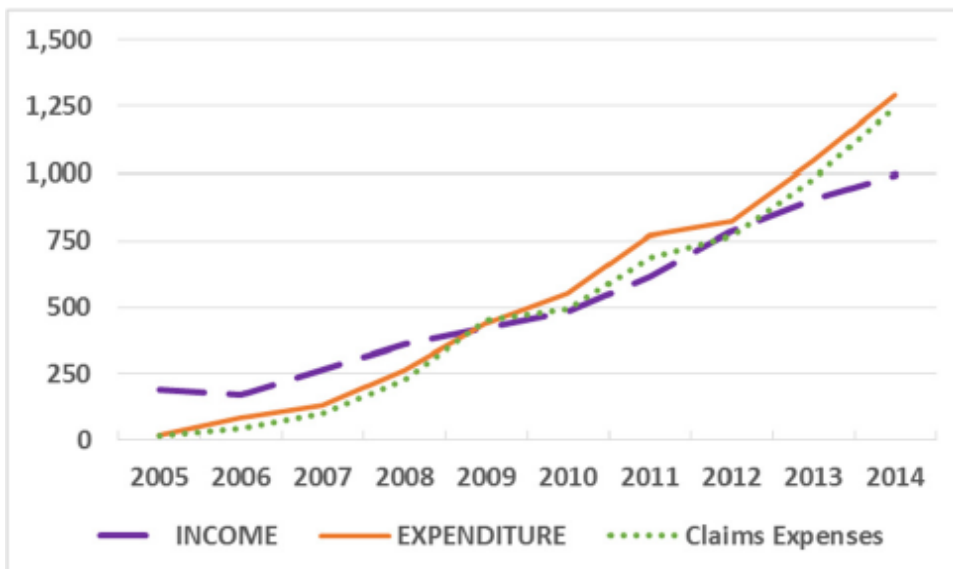


NHIL collected (real terms, GHS millions) vs % total population covered



Source: NHIA data; author's calculations

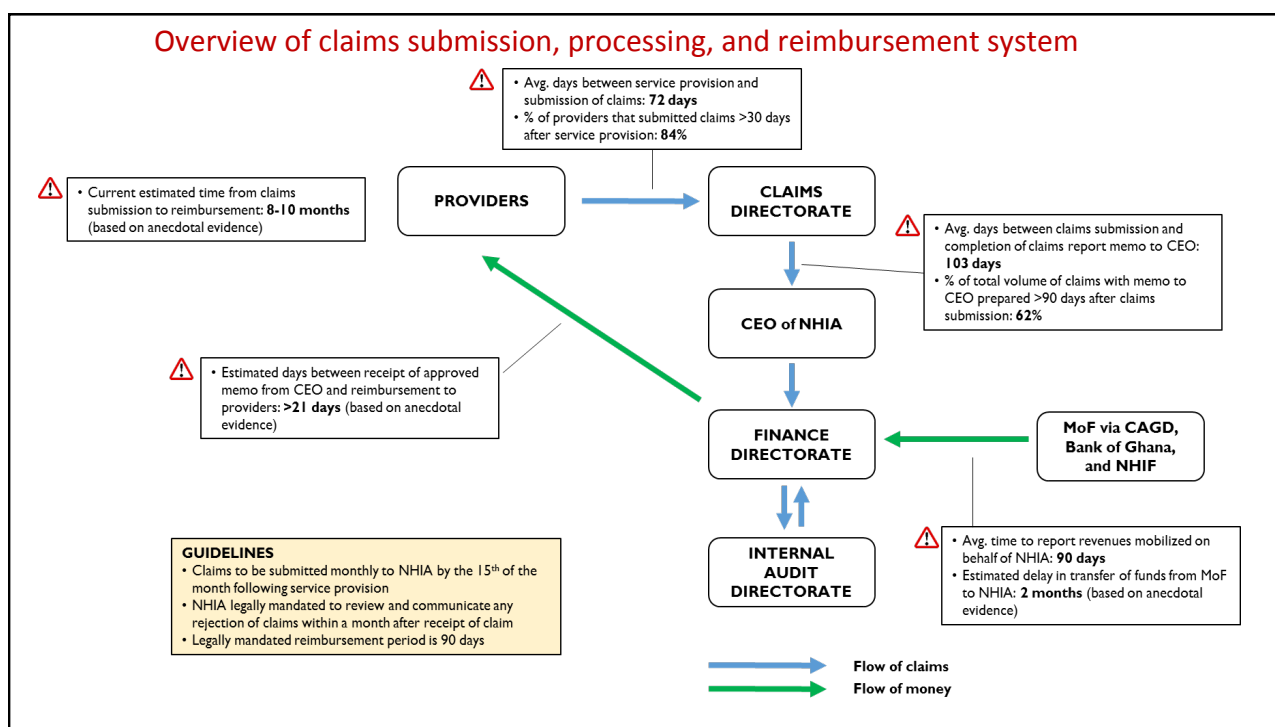
NHIS income and expenditure, 2005-2014: Sustainability trends



Sources of inefficiency

- ▶ Year-round design of open, voluntary, individual not family, enrolment favours adverse selection, despite 1 month waiting period
- ▶ Un-empowered membership is a key source of inefficiency
 - Members not incentivised to behave responsibly or see NHIS as ally or protector
 - Lack of adequate info about consequences of certain behaviours including diet, life styles and choices
- ▶ Operational inefficiencies arise from
 - Weak capacity of the purchasing agent in crucial dimensions
 - Lack of strategic purchasing and hence susceptibility to fraud and abuses
 - Manual claims processing, emphasising vetting but not expenditure management





Additional sources of inefficiency

- ▶ Facilities expected to deliver spectrum of services (both preventive and clinical), but they only have autonomy over NHIS payments and OOPs
 - incentivizes facilities to direct efforts towards curative services
- ▶ NHIS pays higher tariffs to private facilities, while highly subsidized public facilities appear under-utilised
 - The Review team was able to observe this in some regional visits; World Bank study notes same
- ▶ NHIS claimed to offer generous package, but that package excludes cost-effective preventive services and quality of care delivered
 - NHIS essentially paying for consequences of under-performance of public health programs



Inefficiency of benefit package

- ▶ The top twenty cases seen at the OPD constitutes on average 70 percent of total OPD seen at all the health facilities in Ghana. The diseases seen can be grouped into three major groups as follows:
 - Infectious diseases – Malaria, Upper respiratory infection, diarrhoeal diseases etc
 - Non-communicable diseases- Hypertension, Diabetes, Injuries, Rheumatoid joint diseases etc
 - Pregnancy related complications
- ▶ But NHIS not funding investments to tackle causes of infectious diseases and NCDs, or to act on the causes of high maternal and child mortality



KEY INDICATORS UNDERMINING HEALTH PERFORMANCE

Indicator	Value (Ghana)	Value (LMIC)
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

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

Efficiency – Medical loss ratios over time

ideal ratio: 95/5

Year	Medical loss ratio
2008	92/8
2009	85/15
2010	75/25
2011	72/28
2012	77/23
2013	77/23



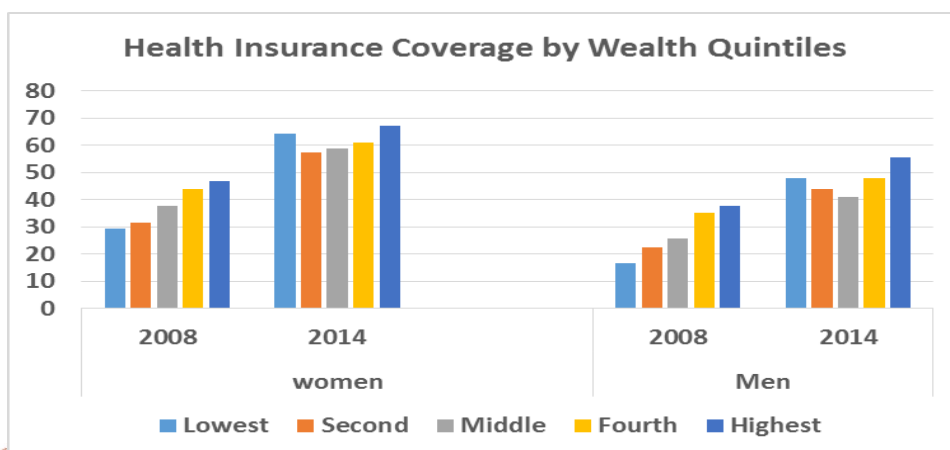
Compare some best practice examples

- ▶ Since 2007, the Estonian EHIF's operating expenses have not exceeded **1%** of its budget.
- ▶ 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 show only **4.4%** of total expenditure was spent on administration as at 2013



Equity

Equity in access has improved



Source: World Bank, Ghana PER, 2016



But several inequities in remain in NHIS

- ▶ Between insured and non-insured
 - Not acceptable for a publicly funded scheme
- ▶ Availability of the benefit package
- ▶ Quality of care and choice
- ▶ Bias against PHC and preventive services



Key Recommendations

Building consensus around objectives

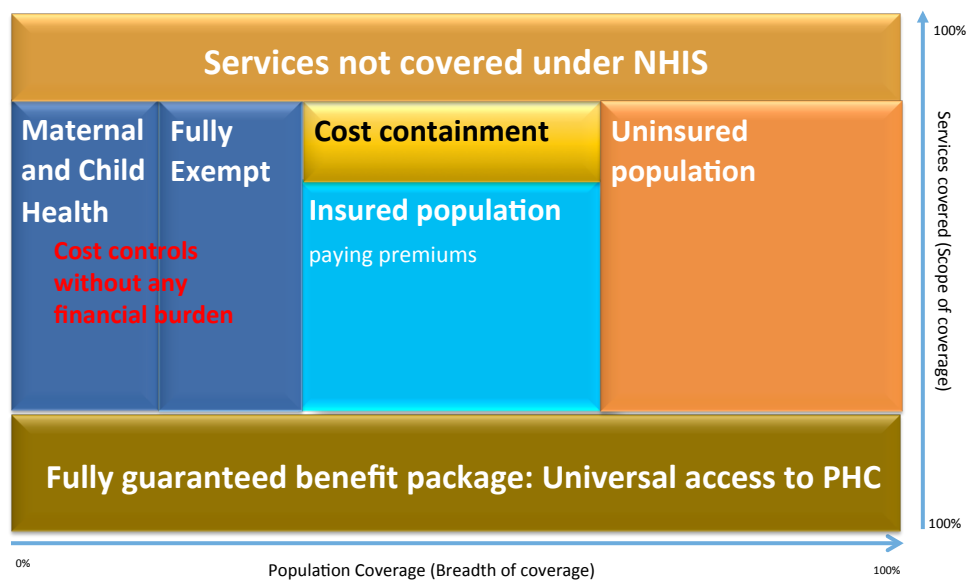


KEY FEATURES OF PROPOSED REDESIGN

- ▶ PHC and MNCH services at public and mission facilities to be guaranteed at 100% with no user fees on such health services for all the population (ie automatic coverage)
- ▶ Including private facilities in underserved areas or where no other option within realistic reach (ie 5 km radius)
- ▶ Based on VAT and SSNIT contribution. So not 'free' service: payment of VAT by general public confers entitlement
- ▶ NHIS card will not be a condition of primary health care but identification will still be required as an eligible resident; should piggy back on other ID systems in place
- ▶ NHIS becomes a strategic purchaser of these services for the Ghanaian public
- ▶ **“Coverage for all but not coverage for everything”**



PROPOSED COVERAGE RECONFIGURATION



Other recommendations

- ▶ Actuarial study of universal, capitation-based, primary care package
- ▶ Institutional reforms
 - National Health Commission
 - Patient Protection Council
 - Provider networks
- ▶ Medical loss ratio and minimum reserve requirements
- ▶ Role for MOF in strategic purchasing and technical assistance for financial management, modeling etc



Some process lessons of the review

- ▶ Extensiveness of consultations
- ▶ Being open minded and in listening mode
- ▶ Identifying the strongest stakeholders and key individuals
- ▶ Making use of country's talents and expertise
- ▶ Process of consensus-building
- ▶ Political neutrality
- ▶ Defining the problem first
- ▶ Attribution and distribution of ownership



THANK YOU

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