ASSESSING SDG 3: ACHIEVING UNIVERSAL HEALTH COVERAGE IN GHANA

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DECLARATION

I, Nedra Amarkie Blaboe, hereby declare that this dissertation is the final product of my own studies under the supervision of Dr Daniel Dramani Kipo - Sunyehzi of the Legon Centre of International Affairs and Diplomacy (LECIAD), University of Ghana, towards the award of a Master of Arts (MA) degree in International Affairs. To the best of my knowledge, this dissertation is an original research work with the exception of references to other works which I have duly recognized. I also declare that this dissertation has not been submitted either in part or in whole for any degree elsewhere.

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(STUDENT)	**(SUPERVISOR)**
DATE……..	**DATE…….**

DEDICATION

I dedicate this work to Almighty God for bringing me this far. Without his grace, mercies, protection, favor and guidance, I wouldn't have made it. Also, to my dad, I say a special thank you for your immense support, sacrifices and encouragement. Finally, to my family, friends and loved ones who supported me during my period of study, I am forever grateful. God Bless you all.

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LIST OF ACRONYMS

ADB	-	African Development Bank
AIDS	-	Acquired Immunodeficiency Syndrome
ANC	-	African National Congress
CEO	-	Chief Executive Officer
CHF	-	Community Health Fund
CHPS	-	Community-based Health Planning and Services
CS	-	Caesarean Section
DANIDA	-	Danish International Development Agency
DDS	-	Direct Delivery Strategy
DfID	-	Department for International Development
DMHIS	-	District Mutual Health Insurance Scheme
DP	-	Development Partners
GDP	-	Gross Domestic Product
G-DRG	-	Ghana Diagnosis Related Grouping
GHS	-	Ghana Health Service
GIZ	-	Deutshce Gesellschaft für Internationale Zusammenarbeit
GPRS	-	Ghana Poverty Reduction Strategy
HFG	-	Health Financing Groups
HFGC	-	Health Facilities Governing Communities
HIV	-	Human Immunodeficiency Virus
ICC	-	International Criminal Court
IGF	-	Internally Generated Fund
IMF	-	International Monetary Fund
KOFIH	-	Korea Foundation for International Health

MDG	-	Millennium Development Goal
MoF	-	Ministry of Finance
MoH	-	Ministry of Health
NGO	-	Non-Governmental Organization
NHI	-	National Health Insurance
NHIA	-	National Health Insurance Authority
NHIF	-	National Health Insurance Fund
NHIL	-	National Health Insurance Levy
NNHIS	-	Nigerian National Health Insurance Scheme
NPP	-	New Patriotic Party
NSSF	-	National Social Security Fund
OOPS	-	Out-of-Pocket Spending
OPD	-	Out Patient Department
PCHIS	-	Private Commercial Health Insurance Scheme
PHIS	-	Private Health Insurance Scheme
PMHIS	-	Private Mutual Health Insurance Scheme
PMS	-	Performance Management System
PRO	-	Public Relations Officer
SA	-	South Africa
SDG	-	Sustainable Development Goal
SDSN	-	Sustainable Development Solutions Network
SHIB	-	Social Health Insurance Benefit
SMS	-	Short Message Service
SNHI	-	Single National Health Insurance
SSNIT	-	Social Security and National Insurance Trust

SWAp	-	Sector Wide Approach
THE	-	Total Health Expenditure
TIKA	-	Tiba Kwa Kadi
TNHIS	-	Thailand's National Health Insurance Scheme
UBC	-	Universal Benefits Coverage
UHC	-	Universal Health Coverage
UN	-	United Nations
UNDP	-	United Nations Development Program
UNHDR	-	United Nations Human Development Report
UNICEF	-	United Nations Children's Fund
USAID	-	United States Agency for International Development
USSD	-	Unstructured Supplementary Service Data
WBG	-	World Bank Group
WBPHCOT	-	Ward-Based PHC Outreach Teams
WHO	-	World Health Organization

TABLE OF CONTENTS

ABSTRACT

Health is a crucial economic and social asset, particularly for the working low- and middle-income groups in developing countries. However, effective access to health care seems to be practically impossible without a well-functioning system that adequately protects users of health care services against the associated financial risks, especially, at the time they need them. The implementation and goal of the Universal Health Coverage (UHC) policy by 2030 as part of the Sustainable Development Goals (SDGs), therefore, is to mobilize resources and to ensure equitable and sustainable financing of the health sector. The goal of this study is to highlight measures being put in place by Ghana as a country in order to provide universal access to healthcare for all citizens. Measures to achieve this goal include the development of a comprehensive strategy for mobilizing resources from all sources of funds; pursuing equity in health financing with special emphasis on risk pooling, targeting resources to services for the poor and vulnerable groups, and reducing catastrophic health expenditures. The study adopted a qualitative research method in order to enable the researcher access the views of respondents in their most original state. The research was carried out in Accra, the capital of Ghana where respondents expressed their views primarily through interviews. Meanwhile, secondary data were collected from relevant stakeholders to give more meaning to the opinions expressed. In sum, the research study revealed that Ghana is on the right path in fulfilling SDG 3.8 in terms of funding, human resource development, and infrastructure among others. Also, it was obvious that the NHIS has evolved since its implementation in 2003 and could boast of excellent coverage in Ghana with increasing membership in recent years. Finally, the NHIS is making and continues to make giant strides towards achieving UHC in Ghana. Nevertheless, the main challenge facing the attainment of this goal is the issue of finance which the NHIA is putting in utmost efforts to resolve in order to deliver the quality of healthcare the country needs.

It is obvious that the issue of finance serves as the root cause of the many problems faced by the smooth implementation of the NHIS towards achieving UHC. The study recommends that leadership and relevant stakeholders must make transparency and accountability its hallmark which will automatically translate to the resolution of other problems faced by the scheme.

CHAPTER ONE

RESEARCH DESIGN

1.1 Background to the Study

Since the establishment of the MDGs in 2000, it has been cited widely as the primary criterion for judging progress in international development efforts (Karver, Kenny, & Sumner, 2012). Its aim was to implement new initiatives to combat poverty, hunger and diseases while promoting education, gender equality and environmental stability worldwide (Sachs & McArthur, 2005). However, calls for additions and modifications have been made by various scholars, stakeholders and international bodies, as it is believed that the MDGs in spite of significant disparities in many developing nations, lacked strong goals and indicators for equality within countries (Deneulin, 2009). It focused mainly on donor performance rather than development success. An attack levelled against the MDGs was that it did not capture all the necessary elements to achieve the ideals laid down in the Millennium Declaration (Kabeer, 2010). However, India and China have been recorded as countries whose poverty population has been drastically reduced as a result of the MDGs (Besley & Burgess, 2003). Sub-Saharan Africa is believed to have benefitted significantly largely through agriculture, education, health care and disease control even though many scholars are of the view that the African continent was rather behind in achieving the targets set by the MDGs (Ahmed & Cleeve, 2004).

The inability of many nations to achieve progress on the Millennium Development Goals MDGs has called for subsequent agenda which is aimed at building up progress to sustain the post 2000 goals. This has led to the implementation of the SDGs in the year 2015 also known as the Agenda 2030. The SDGs comprises seventeen (17) goals with one hundred and sixty

nine (169) targets measured by two hundred and thirty two (232) indicators which include economic, social, environmental development issues such as poverty eradication, health, energy, water and sanitation and human settlement (Beisheim, 2015).

Governments in various countries have been tasked to translate the objectives into national legislation, carve out an implementation plan, set and allocate budgets as well as seek partners. However, developed countries have been tasked to support developing countries to ensure the targets are met by 2030 (Begashaw, 2017). The WHO in the year 1948 declared health as a fundamental human right of every individual (WHO, 1948). Achieving UHC is gradually gaining its grounds among nations with the aim of providing health services particularly for the poor in society (Besley & Burgess, 2003). The SDSN report suggests that "by 2030 every country should be well positioned to ensure UHC for all citizens at every stage of life, with particular emphasis on the provision of comprehensive primary health care services delivered through a well-resourced health system" (Fried et al., 2013).

According to WHO, UHC means providing all people with access to affordable, quality health care services in order to ensure that they obtain the health services they need without suffering financial hardship when paying for them (Kieny & Evans, 2013). It basically seeks to make health care services affordable and accessible to all. The government of Ghana as part of its GPRS, has implemented a policy to provide all Ghanaians, particularly, the poor and most vulnerable in society, with the needed healthcare services. This policy was aimed at eliminating the out-of-pocket payment system which makes health care almost inaccessible by a larger proportion of the populace.

The NHIS was established under Act 650 in 2003 under the NPP Kufuor-led administration in a quest to fulfill one of his many campaign promises. The law also required the formation of the NHIA to regulate the activities of the NHIS and ensure its smooth operation. The NHIS provides a comprehensive range of outpatient and inpatient services at authorized public and private health care facilities for both the formal and informal sectors (Mills et al., 2012). The NHIS is funded largely through taxation, donor funding, government funding as well as premiums among others (Awoonor-Williams, Tindana, Dalinjong, Nartey, & Akazili, 2016). However, the poor and vulnerable in society are exempt from making contributions to the NHIS (Kanchebe Derbile & van der Geest, 2012). The government of Ghana, in its quest to achieve UHC for its citizens and the implementation of the SDGs, has put the country on its toes to enforce policies to meet these targets by the stipulated times.

1.2 Statement of the Problem

Ghana's effort to achieve UHC and to improve upon health care has led to the implementation of policies such as the NHIS, and free maternal health care, among others. Ghana as a developing country seeks to provide accessible and affordable health care to its citizens. As a result, the implementation of the NHIS is aimed at serving this purpose and in the long run alleviating poverty. A number of scholars such as Irene Akua Agyapong, Angela Abroso and Sylvester A. Mensah have conducted research on the scheme since its inception and its reformation to suite the evolution of the scheme. However, the implementation of the SDGs has called for further research into this area especially on what measures Ghana should put in place in meeting the target set by SDG 3.8 towards achieving UHC in the country. This means that achieving UHC in Ghana seems to be in the implementation of the NHIS. What measures are put in place towards achieving the UHC is what the study seeks to thoroughly investigate, to determine whether Ghana is on the pathway towards achieving the UHC

through the implementation of NHIS in an attempt to fulfil the SDG 3.8 or the country is far from achieving the UHC.

1.3 Research Questions

- What mechanisms have been put in place to fulfill the SDG 3.8 in Ghana?
- What is the current state of NHIS since its implementation towards achieving UHC?
- What are the successes and challenges facing the NHIS in achieving UHC in Ghana?

1.4 Research Objectives

- To assess the mechanisms put in place to fulfill the SDG 3.8 in Ghana.
- To examine the current state of NHIS since its implementation towards achieving UHC.
- To analyze the successes and challenges of NHIS in achieving UHC in Ghana.

1.5 Scope of the Study

The study looks at the existence of the NHIS from the year 2011 to 2018 in Ghana. The SDG 3 is used with specific consideration of the target 3.8 which seeks to "achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all (Minas, Tsutsumi, Izutsu, Goetzke, & Thornicroft, 2015).

1.6 Rationale of the Study

This study is to identify the most effective way through which UHC can be achieved with the NHIS as a tool. It also seeks to bring to light the various challenges and successes achieved by the NHIS in its quest to achieve SDG 3.8. The study also seeks to enable government, the

UN, NGO's, think tanks, as well as stakeholders concerned to develop structured programs aimed at achieving UHC. As the policy is still in progress and gaining its grounds, the study also seeks to add to the body of knowledge since research in this area is limited.

1.7 Conceptual Framework

The conceptual framework considered for this study is the concept of human security. The UNHDR defines human security as "safety from chronic threats and protection from sudden hurtful disruptions on the patterns of daily life". It can be grouped under seven (7) main elements. Namely; economic security, food security, health security, environmental security, personal or physical security, community security and political security. However, the element of health security is the most relevant to my study. "Human security is not about states and nations but about individuals and people" (Bajpai, 2000). The concept of human security means ensuring the basic center of all humans live in ways that enhance human potential and human fulfilment (Tavanti & Stachowicz-Stanusch, 2013).

The UNDP's 1994 Human Development Report created by Mahbud Ul Haq focused essentially on the detailed and systematic approach to deal with human security by sketching out the new elements of the concept of human security (Bajpai, 2000). In this regard, two (2) main issues were outlined. The first school of thought, freedom from fear argues that it is the protection from unexpected and harmful disruptions in everyday life cycles, whether in households, employments or communities and the freedom from want that focuses on the wellbeing of severe threats such as famine, illnesses and violence. The purpose is to address human obstacles, abuse and discomfort. The second school of thought, freedom from want also argues that, addressing the real problem of human security would require an extended objective which would include poverty, illnesses and natural hazards. This is because, more

people lose their lives to these conditions than situations of conflict, extermination and terrorist acts put together. It places a strong emphasis on the development and safety over and above aggression.

However, the human security concept has been criticized for several reasons. Many critics of the concept claim it is vague and does not meet the criteria for recognition in international relations as an efficient conceptual analytical framework. According to Chandler (2008), the policy framework of human security has had little effect even though human security has been strengthened at various levels. He included that human security is empirical instead of prescriptive, considering the fact that human security implies what ought to be and not what is occurring. The places of attacks to human security are generally recognized as consolidated in developing countries; notably in Africa. As such, the concept has been overgeneralized. He emphasizes that theorists of human security are only considering expertise in the short-term instead of the long-term tactical alternatives to human security attacks. According to Owen (2004), there is no limit to the definition of the concept. However, concentrating mainly on individuals propagates the concept without adding any empirical significance.

On the other hand, Paris (2001) is of the view that the concept of human security has prompted some useful accomplishments to human welfare and cannot be regarded as pointless. He also points out that the decision to implement human security has resulted in the creation of institutions such as the ICC which guarantees that governments do not subordinate their citizens to abuse, agony and poverty.

Despite the criticisms levelled against this concept by various scholars, I am of the view that it is the most appropriate for the study. This is because, health security serves as an element

of the concept of human security. Also, it must be considered that access to quality health care is a fundamental right of the individual. The concept of human security stresses on the fact that governments especially those of developing countries must ensure maximum protection of their citizens from diseases and unhealthy lifestyles by UHC as an instrument. The health of the populace plays a significant role in the development of the economy.

1.8 Literature Review

This section of the study brings to light diverse views on the subject area by various scholars. It also enables me to highlight some gaps found in the literature as well as justify the relevance of the literature to my study.

In the article, Universal Health Coverage: necessary but not sufficient (Fried et al., 2013), the authors are of the view that despite the MDGs being unfulfilled in certain areas such as maternal and reproductive health care, there is more to be accomplished with regards to achieving UHC. Fried et al. (2013) emphasize that in achieving UHC, access to healthcare must be convenient, serviceable, and of good quality offered in a just and equitable manner. In general, UHC focuses heavily on guaranteeing safety for the less privileged in society who are unable to access healthcare services rather than focusing on providing accessible healthcare to everyone irrespective of financial status. Achieving UHC in the long run indirectly deals with issues of poverty alleviation in our economies.

In order to achieve UHC fully, the focus should be on providing quality healthcare for all irrespective of age, gender, religion and ethnicity, among others. Again, states and international bodies must be able to outline clearly the criteria for poverty so that its agencies can easily focus on these groups where priority needs to be given. Also, the implementation

and enforcement of a health protection policy is essential in order to address issues of stigmatization and discrimination due to poor health in our societies or inability to access health care. For instance, in Brazil, there are disparities in access to health care among adolescent and young pregnant women which should not be the case if the focus of the country is to eventually achieve UHC (Fried et al., 2013). Once more, this article, 'Universal health coverage: necessary but not sufficient; Fried et al. (2013), focus mainly on the health issues of women and children.

Universal health coverage: necessary but not sufficient (Fried et al., 2013) is relevant to this study because the WHO in 1948, declared health as a fundamental human right (WHO, 1948). As such, it requires all states to provide quality and accessible health care. In spite of the many hurdles they may face in its achievement, states must be ready and willing to deal with them in order to provide the best services to their citizens as the quality of their human resource would eventually affect the economic development and stability of the state.

Okebukola and Brieger (2016) work on; "Providing Universal Health Coverage in Nigeria" discusses the challenges facing the achievement of UHC as well as arrangements being put in place by the country in order to achieve the goal despite the launch of the NHIS twelve years ago. They observed that the out-of-pocket system covered a greater percentage in funding the health sector.

The researcher is of the view that for Nigeria to achieve greater coverage in terms of healthcare, the populace especially those of the informal sector need to be educated on the need to purchase the NNHIS. In addition, health care infrastructure and services must be improved upon to enhance quality of health care delivery. In terms of the management

structure, it needs to be decentralized to facilitate decision making as well as coverage. Nigerian states being regarded as autonomous need the government to implement a law which requires all states to join the policy as this serves as a major problem with regards to expansion of coverage. Also, to enhance the confidence of citizens in the health care system, private health care providers must be entreated to use the NNHIS to foster healthy competition for public health care providers which will eventually boost active registration of citizens and an improvement of the health care system in Nigeria.

Nigeria and Ghana face similar challenges in policy implementation and enforcement. Okebukola and Brieger (2016) provide the researcher with a better understanding of the health care system in Nigeria and keep the researcher abreast with the challenges and achievements in order to analyze and appreciate better the situation of Ghana.

Blanchet, Fink, and Osei-Akoto (2012) on 'the effect of Ghana's National Health Insurance Scheme on Health Care Utilization' highlights the evolution of health care financing since independence. It has evolved from a tax-funded, low user fees, the cash and carry and finally the cashless systems of the NHIS. The implementation of the NHIS has undergone many reforms over the years.

The primary aim of the NHIS is to provide accessible health care for the poor and most vulnerable in the society. In order to achieve UHC, the target population must include all citizens irrespective of their social status. Also, the NHIS has concentrated largely on women. The target population of the scheme should not be skewed towards a particular group if we seek to achieve quality health care for all. Again, with regards to funding, the government must implement policies to ensure the equitable distribution of funds to

appropriate organizations in order to facilitate the provision of health care services as funding appears to be a major challenge of the scheme. The inability of government to deal with the issue of funding is gradually diminishing the confidence enrollees have in the scheme largely because the purpose for which it was established is not being met. The NHIS excludes certain expensive procedures such as expensive drugs, treatments for certain diseases as well as surgical operations among others. However, if the issue of funding is adequately resolved, there is a need for government and relevant stakeholders to consider paying a quota of these services as they seem to be the leading cause of pre-mature death in the country. This is largely as a result of patient's inability to afford treatments.

Again, an essential aspect of recovery for enrollees is their ability to access prescribed drugs most of which the NHIS does not cover. The government must address this issue critically because providing access to quality medical examination without the necessary drugs does not result in recovery of health of the individual.

Blanchet et al. (2012) keeps the researcher abreast with the history, issues of funding and other relevant challenges being faced currently with the implementation of the NHIS with regards to achieving UHC in the country which serves as its ultimate goal.

According to Tangcharoensathien, Suphanchaimat, Thammatacharee, and Patcharanarumol (2012), on 'Thailand's Universal Health Coverage (UHC) Scheme, Thailand in its quest to achieve UHC has implemented three health insurance schemes aimed at reaching all its citizens irrespective of their social status. It has also worked to ensure the establishment of an efficient funding system through capitation. This has minimized out-of-pocket expenditure on health care which has subsequently led to a reduction of the poverty level in the country.

TNHIS is highly in favor of the elderly and children. Adolescents, and women must also be considered especially with regards to issues of maternal health care. Also, the capitation system is important because it helps to control cost and makes accountability easier since hospitals are reimbursed based on the number of patients they register. Another initiative Thailand must be applauded for is the ability to divide the scheme into sectors to enable its citizens gain full access to it depending on their social class. It also allocates premiums depending on the economic level of the individual. Tangcharoensathien et al. (2012) brings to light the measures that Thailand has taken to achieve UHC in its system. As such, it provides a clearer picture of initiatives that a developing country like Ghana can take in order to achieve its goal.

Agyepong et al. (2016) on 'The "Universal" in Universal Health Coverage and Ghana's National Health Insurance Scheme: Policy and Implementation Challenges and Dilemma of a Lower Middle-Income Country', assessed the various challenges affecting the enrolment of citizens into the NHIS and how the goal of achieving UHC can be fulfilled in the country. It was observed that the stagnation of enrolment on the NHIS was as a result of many factors which include policy arrangements, implementation and structures. The study took place in the Volta region of Ghana where the NHIS was undergoing phase two of its scale up.

In the researcher's view, the implementation of measures to ensure automatic renewal of membership will subsequently solve the issue of inadequate funding. Again, the government must implement policies that will enable enrollees to register easily and get access to their cards. In addition, there should be a clear-cut criterion for classifying who an indigent is. Also, it is assumed that pregnant women and children under 18 benefit largely from the scheme. Adolescents, men and the elderly should also be given equal attention. Another

factor discouraging citizens from enrolling on the scheme is the nature of customer service rendered by scheme workers. Workers need to be trained to be more receptive to enrollees of the scheme. Agyepong et al. (2016) is relevant to the study as it looks at a typical case study in Ghana and addresses the challenges facing stagnation of enrollment as well as provides practical information and a better understanding of the situations at hand.

Lagomarsino, Garabrant, Adyas, Muga, and Otoo (2012) in their work 'Moving towards Universal Health Coverage: Health Insurance Reforms in nine Developing Countries in Africa and Asia', analyze how some low-and middle-income countries at the early and intermediate stages of their reform and how they are raising funds towards achieving universal health coverage in their countries. It was discovered that most of these countries relied largely on revenues from taxation to fund the scheme whilst others relied largely on the collection of premiums from enrollees.

Lagomarsino et al. (2012) study is relevant to the study as It looks at the large informal sector enrollee's situation in Ghana and other developing countries efforts to generate revenue. As such, they should be considered for payment of premiums in raising funds for the scheme. Once the informal sector is engaged in economic activities, they should be able to contribute their quota towards attaining quality health care in the country. Consequently, the government and its agencies must find a way to implement taxation of economic activities in the informal sector. With regards to the receipt of subsidies for the poor and vulnerable in society, governments should be able to provide a clear-cut criterion so as to enable agencies classify them accordingly. In most of these developing countries, the focus of achieving universal health coverage has been shifted to a particular target population normally children and pregnant women, which should not be the case. In achieving UHC, there should be no

limitation with regards to the target population. Again, the policy should make provisions to include the private sector so as to ensure rapid transformation of the scheme.

Also, Lagomarsino et al. (2012) work is relevant to the study as the countries assessed have diverse ways of implementing the NHIS and can easily be compared for shortfalls as well as progress. In this respect, the study looks at both facilitating and inhabiting factors in enrolment of clients into Ghana's NHIS, its prospects and challenges.

Mills et al. (2012) on 'equity in financing and use of health care in Ghana, Tanzania and South Africa: Implications for paths to universal health coverage', analyze the best ways in which countries initiate to finance UHC notably in the informal sector who are largely classified as being unable to afford premiums or contributions. The countries understudied here are Ghana, Tanzania and South Africa. It was discovered that out-of-pocket as well as contributions from the formal sector is gradually declining in all three countries.

The reluctance on the part of citizens to purchase the health care scheme is as a result of factors such as no coverage for certain essential drugs, lack of awareness to certain entitlements, unskilled medical resource teams, poor service availability and poor equipment and facilities which these governments need to address. Mills et al. (2012) work is relevant to the study because the countries studied are all developing reforms to suit their health care systems in order to achieve in the long run, universal UHC.

1.9 Research Methodology

This study adopts a qualitative research design, in which data are collected using qualitative strategies. The rationale for adopting qualitative research design is to enable the research

reach out with respondents in their natural setting and for them to freely express their opinions, views and share their experiences on NHIS in Ghana.

This section outlines the strategies and processes used to gather and evaluate the data. Methodology pertains to the decisions we make about the areas we are researching, data gathering techniques and data interpretation forms when preparing and executing a research study (Silverman, 2005). It shows how a research is carried out and provides a basic foundation for the research. The design also places great importance on what is to be studied in order to generate comprehension rather than vague results (Kitchin & Tate, 2000). The researcher believes this qualitative research design is suitable for the work because it enabled the researcher have direct contact with the individuals, professionals registered under the NHIS and other policy makers and implementers working to ensure that the policy is well established as speculated by the law. It also enabled the researcher to have access to real life experiences and gave the researcher a better understanding of the situation at hand.

1.9.1 Sources of Data

The research was carried out from January to July 2019, and took place in the Greater Accra Region of Ghana where the capital is located and has a higher number of residents. Residents of the capital engage in both formal and non-formal economic activities as such, fall within the various criteria for registration with the NHIS. Data collection involves well-structured interviews with an interview guide. These face-to-face interviews were conducted with selected respondents with adequate expertise on the subject at hand, as well as enrollees of the program.

Both primary and secondary sources of data were employed in this study. The primary data sources consisted of well-structured interviews with medical doctors, hospital administrators,

nurses, and some enrollees of the NHIS program in the language best understood by them. One primary data source the researcher used is interviews. According to Kvale (1983), a qualitative research is one "whose purpose is to gather descriptions of the life-world of the interviewee with respect to interpretation of the meaning of the described phenomena". The face-to-face interview is the most popular form of interviewing correspondents despite the rise of technological advancements and social media. During face-to-face interviews, the interviewer can be provided with additional information that can influence the verbal responses of the interviewee. These include the interviewee's social indications such as body language, voice, intonation among others (Opdenakker, 2006). Again, face-to-face interviews allows the interviewer to receive sincere responses as the interviewee has little or no time to think through answering questions. As such, responses are spontaneous and usually honest (Opdenakker, 2006). Once more, face-to-face interviews can be tape recorded which enables the interviewer to have proper records that can always be referred to. The interviewer can also transcribe the conversation for future references and a more accurate report (Opdenakker, 2006). On the other hand, in conducting face-to-face interviews, the interviewee might be intimidated by the presence of the interviewer and as a result may not provide the interviewer with honest responses. Again, face-to-face interviews might be time consuming and expensive in the case where the interviewer is unable to access the interviewee in a timely manner and if it involves travelling. I preferred using face-to-face interviews for my study to enable me access non-verbal responses of my interviewees. Health is a delicate matter and individuals would normally express their emotions about the issues at hand especially when they have been victimized.

The secondary data were collected from the NHIA and the MoH. These secondary sources include holistic reports, journal articles, internet sources and other relevant documents

obtained from organizations such as the WHO and the UN. Also, published books on the subject area was utilized as part of the secondary data sources. I also made some direct observations at hospitals and clinics during health service provision, to observe how the health workers relate with health insurance clients (insurance holders and non-members). The same direct observations were made in some selected health insurance offices in Greater Accra. The sample size for this study was at least fifty people.

1.9.2 Data Analysis

A qualitative method of data analysis was employed in this study. In particular context, qualitative research seeks contextual meaning into issues (Saks & Allsop, 2012). It offers an opportunity for researchers to obtain useful data by providing an in-depth understanding of people's thoughts and experiences, which are more valuable in meaning (Silverman, 2016). Also, with qualitative data analysis, large amounts of data cannot be processed at a time (Mayring, 2004). Again, the presence of the researcher which is inevitable during data collection may influence the responses of the subjects (Anderson, 2010).

Data analysis was done devoid of biased in this study by reporting exactly what respondents said on the study field. The recorded interviews were kept on a computer and transcribed verbatim from audio to text format to enable me easily classify the themes and make my analysis.

The secondary data sources such as books, journal articles, internet sources and reports were analyzed contextually. The information was analyzed alongside themes that were derived from the study. This was done to make the meaning of gathered data much easier to comprehend.

1.9.3 Ethical Issues

"In an age where technology is rapidly advancing and societal values and roles are changing dramatically, ethical issues are becoming increasingly more complex" (Rogers, 1987). As a result, ethical considerations were seriously taken into account and there was no form of deception in gathering data for this study. Interviewees were informed about the academic nature of the study while seeking their consent to participate in the exercise. Also, in response to the confidentiality codes, interviewees were assured of their privacy and anonymity.

1.9.4 Limitations of the study

The study has some limitations within which the findings need to be carefully interpreted. First of all, most of the target population who shared their opinions on the subject matter wanted their identities to remain anonymous. Secondly, others were not comfortable with the fact that their voices were being recorded for the purpose of the research.

1.10 Arrangement of chapters

The study is organized into four main chapters. Chapter one covers the research design. It introduces the subject and gives a brief background to the research area, outlines the research questions and objectives, scope and rationale of the study, the conceptual framework which guides the study, a brief literature review, sources of data, research methodology, as well as limitations of the study.

Chapter two provides the historical overview and analysis of the NHIS in some African states as well as Ghana since its implementation.

Chapter three provides an analysis of research findings of the NHIS towards achieving Sustainable Development Goal (SDG) 3.8 "Universal Health Coverage (UHC)".

Finally, chapter four presents the key findings of the study, conclusions, as well as offers some policy recommendations for the way forward towards achieving UHC and to some health policy makers and implementers and for further research.

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CHAPTER TWO

AN OVERVIEW OF UNIVERSAL HEALTH COVERAGE (UHC)

2.0 Introduction

This section presents an overview of UHC from the WHO perspective, the efforts made by some African countries to achieve UHC as well as initiatives put in place by the NHIA in Ghana to implement a policy that will eventually lead the country in attaining the SDG 3.8 towards achieving UHC.

2.1 World Health Organization (WHO) perspective of Universal Health Coverage (UHC)

A significant observation is that many of the world's 1.3 billion low-income individuals do not even have access to efficient and inexpensive drugs, surgeries and other procedures due to health funding system weaknesses (Carrin, Mathauer, Xu, & Evans, 2008). Projecting the outcomes worldwide indicates that around 44 million families experience serious economic distress and that 25 million households are driven into poverty every year merely because they need to use health facilities and pay for them (Xu et al., 2007). The WHO constitution of 1948 declares health as a fundamental human right (WHO, 1948). The UN General Assembly decision to achieve UHC aims at transforming health systems especially for the poorest and most vulnerable in the society (Campbell et al., 2013). In the quest to achieve this aim, the term UHC has been clearly defined to guide policy makers and implementers.

According to WHO, "UHC means that all people and communities can use the promotive, preventive, curative, rehabilitative, and palliative health services they need of sufficient

quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship" (WHO, 2017a).

This definition therefore places emphasis on equity in access to health services, the quality of the services available to patients as well as protection of citizens against financial risks. UHC is made up of two interconnected aspects: the complete range of good quality primary healthcare, and security against economic instability as a result of out-of-pocket healthcare services payment (Boerma et al., 2014). The most cost-effective and efficient way to achieve UHC is through primary healthcare. According to WHO, primary healthcare refers to "essential healthcare that is based on scientifically sound and socially acceptable methods and technology, which makes universal healthcare accessible to all individuals and families in a community" (WHO, 2019). It is simply an approach to health beyond the traditional healthcare system that focuses on health equity producing social policy (Starfield, Shi, & Macinko, 2005). The aim of shifting towards UHC is to improve the health system in all countries and reduce poverty. As a result, the WHO together with its partners such as the Health Policy and Systems Research, P4H Social Health Protection Network, European Union-Luxembourg-World Health Organization Partnership for UHC and Primary Healthcare Performance Initiatives are assisting nations all over the world to create, maintain and track progress towards achieving UHC (WHO, 2016). UHC is structured around a unique package of incentives for all members of a community with the ultimate objective of offering financial risk security, enhancing access to healthcare services and improving health results (WHO, 2010). The Director General of the WHO describes UHC as the "single most powerful concept that public health has to offer" since it unifies "services and delivers them in a comprehensive and integrated way (Matheson, 2015).

UHC has been accomplished in most nations through a blended financing model. Direct tax revenue is the main source of financing, but it is supported by particular levies, normally paid by individuals or employers in many nations whilst others opt for direct or optional insurance through private transactions for services uncovered or outside those covered by government schemes (Kutzin, Yip, & Cashin, 2016). On the contrary, out-of-pocket payments generate economic obstacles that stop millions of individuals from seeking and getting the healthcare services they need each year (Dror & Preker, 2002). A truly broad-based consensus on an accurate operational structure would make the accomplishment of UHC a process that is more inclusive and country-led, rather than one that is influenced by experts worldwide (O'Connell, Rasanathan, & Chopra, 2014).

2.1.1 The term "Universal" in Universal Health Coverage (UHC)

The term universal was described as the nation's legal responsibility to provide healthcare to all its citizens, paying special attention to guaranteeing the participation of all underprivileged and exempted groups (Kirby, 1999). On the contrary, the term universal excludes stateless individuals which includes illegal migrants, remote persons, refugees, or persons refused birth registry. They are usually considered by authorities as having no lawful right to healthcare due to lack of citizenry (Kingston, Cohen, & Morley, 2013). For lawful citizens there is an element of biased based on impairment, sexuality, belief, race, ethnicity, religious affiliations and political leanings (Kenya Human Rights Commission, 2010).

2.1.2 The term "Health" in Universal Health Coverage (UHC)

In terms of health, UHC requires the provision of sustainable possibilities for the greatest achievable mental and physical health standards such as work on health determinants (O'Connell et al., 2014). This view is heavily endorsed by civil society organizations that

require and promote domestic intervention on societal factors to reduce disparities and allow interventions outside the healthcare industry (Ooms et al., 2013).

2.1.3 The term "Coverage" in Universal Health Coverage (UHC)

Coverage serves to integrate an evaluation of efficient use of available services (Frenz & Vega, 2010). It covers the degree at which fairness can be improved, who to involve and cover for which services, and at what performance level (O'Connell et al., 2014). In order to achieve this goal, there are other linking factors that cannot be ignored. They include the quality of infrastructure such as roads, hospitals; especially in rural areas, pension plans, social welfare and urban development which influence access to healthcare services by citizens (Nabarro, 2017).

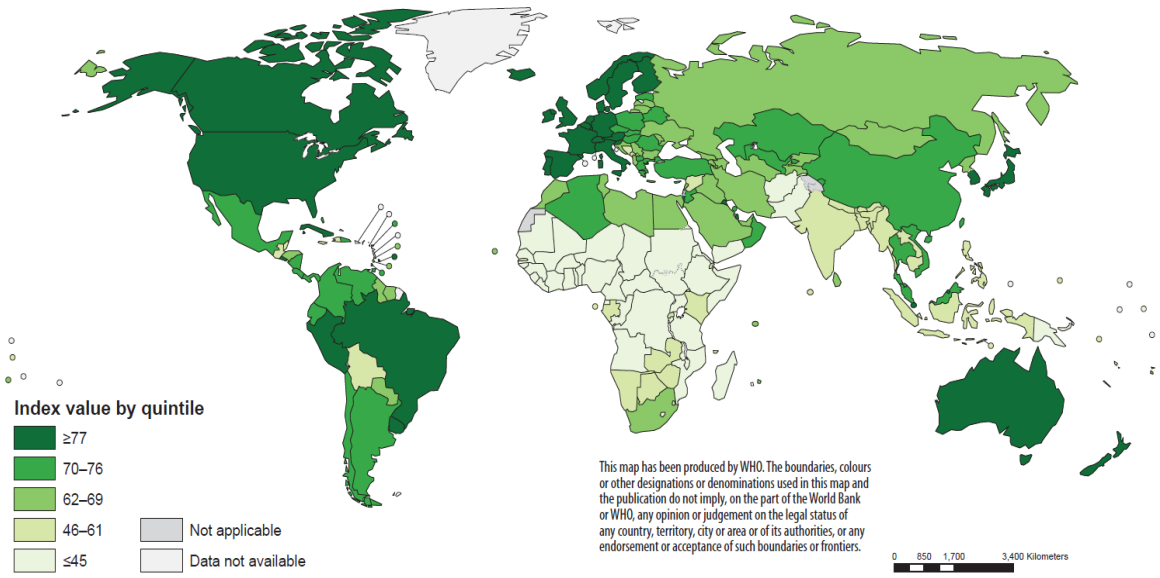
2.1.4 World Bank Group (WBG) and Universal Health Coverage (UHC)

UHC is also essential to achieving the combined objectives of the WBG to combat abject poverty and improve wealth and social stability. This has been the catalyst behind the WBG's investment in health and wellness (World Bank). However, over the past fifteen (15) years many nations have embraced UHC (Reich et al., 2016). The objective of the WBG is to assist nations in building safer and more balanced societies by enhancing their economic status as well as productivity. The WBG achieves this through research, and expertise generation at regional, country, and international level, technical aid, capital investments and international conventions (Kiss, Castro, & Newcombe, 2002). In order to assist nations monitor their performance and UHC outcomes, the WBG together with the WHO have created a surveillance structure to guide the international community (Sands, 2017). Health is crucial if absolute poverty is to be eliminated and development of wellbeing is promoted (WHO, 2002). Consequently, the international community is committed to investing in health in order to transform lives and livelihoods (Summers, 2015).

2.1.5 Can Universal Health Coverage (UHC) be Measured?

UHC's pivotal role in the Sustainable Development context and its rise in policy discussions has called for an effective and efficient surveillance of UHC. Monitoring UHC is a complicated and demanding process that involves a broad variety of operations from information collection and infrastructure to data conversion and evaluation that can guide and influence policy change (WHO, 2017d). This is to create a collaborative and valuable UHC statistic which would serve as a way of determining if people throughout the world are actually getting the services they need to live long and healthier lives (Fullman & Lozano, 2018). However, for many indices, there are presently information gaps that need to be resolved as an aspect of UHC surveillance, particularly in low-income countries (Boerma et al., 2014). Service coverage and delivery standards differ across and within nations. As measured by the UHC service coverage index, it is highest in East Asia, Northern America and Europe (with 77 on their index), followed by South Asia (53) whilst Sub-Saharan Africa has the lowest index value (42) as illustrated in figure 2.1 below (WHO, 2017b).

Figure 2. 1: UHC service coverage index by country, 2015: SDG indicator 3.8.1



SDG: Sustainable Development Goal; UHC: universal health coverage.

Source: (WHO, 2017b)

UHC does not have a one-size-fits all strategy and nations take distinct routes at various levels to achieve it (Agyepong et al., 2017). Measuring health equity will rely on whether mental health and psychosocial wellbeing are defeated only by levels of curable diseases and death or are widely included (O'Connell et al., 2014). Also, measuring UHC basically requires two (2) indicators namely to capture healthcare coverage for all citizens and provide financial protection against poverty. On the contrary, significant changes to indicator 3.8.2 implies that we cannot assess the number of individuals who face economic difficulties to pay for the medical facilities they need (Wenham et al., 2019). In order to enhance advancement towards the SDG and UHC, countries can use evaluated reports to define target

action zones so that the surveillance procedure of each country can be coordinated with the required preference fields (WHO, 2015)

2.2 Does Progress Towards Universal Health Coverage (UHC) Improve Population Health?

WHO as well as many scholars and analysts have championed advancement towards UHC on the basis of improving population health. However, UHC is a political process requiring agreements on the distribution of welfare advantages between distinct stakeholders in society, including who is eligible to pay for these advantages. With regards to UHC, the manner in which healthcare is paid for is of vital interest (Savedoff, Ferranti, & Smith, 2012). Further dependence on prepaid health expenditure and risk pooling system is considered to be an important indicator of advancement towards UHC (Moreno-Serra & Smith, 2012). A key goal is to decrease the economic obstacles that individuals face in order to obtain access to the needed healthcare due to expenses on healthcare or ineffective procedures owing to incapacity to pay (Baeza & Packard, 2006).

Good health is not only a result of economic development, but also a vehicle of it because healthier people can do more to promote economic growth through increased productivity, enhanced academic performance especially of children not forgetting increased innovation and entrepreneurship. Increased economic security for household from huge medical bills decreases the possibility of economic decline, thereby making properties and investments safer and more secured (Frenk & De Ferranti, 2012). The 2001 report of the Commission on Macroeconomics and health shows that “a 10% improvement in life expectancy at birth is associated with annual economic growth increases of 0.3 to 0.4%” (Konteos, Katrakilidis, & Sotiriadou, 2018).

Poorly addressed health issues result in decreased production, increased long term costs, and broken families as well as communities. Eventually, this may lead to lack of investment in the future generation resulting in even higher future costs. Lower cost on society is not only created by a life saved and given the opportunity to be productive but it also draws more value to it (Frenk & De Ferranti, 2012). UHC must be enforced by agencies within a nation and not rely on external sources such as foreign aid. In 2009, "the developing world recorded $410 billion as government expenditure for health from the country's own resources" This is sixteen (16) times larger than the total development assistance for health (Murray et al., 2011). Healthcare reforms in various countries makes it easier to accommodate local conditions thereby enhancing widespread political assistance (Frenk & De Ferranti, 2012).

In general, wider health coverage results in better exposure to needed care and enhanced population health, especially for the poor. In addition, a successful health system encourages human rights and makes it possible for everyone to realize their complete potential. There have been substantial financial advantages for families from the implementation of UHC technologies and the decrease of out-of-pocket spending (WHO, 2013).

In the next sections, I examined some healthcare systems efforts towards UHC in Africa.

2.3 South Africa's (SA's) move towards Universal Health Coverage (UHC)

The post second world war period saw the coverage of private medical care increasing rapidly in SA mainly among the working-class white population with a percentage growth from 48% to 80%. The entire white population had practically moved from the government's free health facilities by 1960. At this time, 95% of non-white remained dependent on the public service for healthcare (Seekings, 2002). In 1994, the assumption of power by the ANC saw the introduction of measures to tackle health inequalities in SA. This included the

implementation of free healthcare for all children below the age of six (6), along with pregnant and lactating females using public healthcare services (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). In 1996, the services were further extended to everyone using primary healthcare services at the public level, and in 2003, it saw an expansion of free healthcare to children above six (6) with mild and extreme disorders (Leatt, 2006).

The constitution of SA requires the state to advance towards the gradual realization of the right to health. However, over fifteen (15) years after democracy, the nation is still struggling with huge health disparities mainly caused by a skewed healthcare financing system (Heywood, 2009). South Africa's history has had a significant effect on its citizen's health, including the current healthcare policies and facilities. The government, financial and resource restrictive policies prior to 1994 organized society by race, gender, and age-based structures that significantly affected organizations of social interactions, healthcare facilities and availability of fundamental healthcare services (Coovadia et al., 2009). Today, SA is a multiracial democracy, where the black African majority (79.2%) of the population sits alongside minority groups that are white (9.2%), colored (9.0%) and Indian (2.6%). In the region of the South African Development Community, the health profile discovered four (4) concomitant pandemics with HIV/AIDS topping the chart (Bradshaw et al., 2003). Impoverishment-related diseases including communicable diseases, maternal mortality and malnourishment stay relevant whilst non-communicable diseases are increasingly burdened (Norman et al., 2007).

"South Africa spends almost 8.6% of GDP on healthcare, which is comparable to other middle-income countries. However, 4.1% of health expenditure as a percentage of GDP is spent on 84% of the uninsured population served in an over-burdened public health sector

whilst 4.4% is spent on 16% of the population covered by private medical schemes who mainly access their healthcare services in a costly private sector" (Bitran, 2014).

The health system in SA has been largely characterized by accelerating disease burden, economic resource management, health workforce and human resource planning and management difficulties, aggravated by weak governance, constraints in pharmaceuticals and technology, and also difficulties with regards to using data and information for policy making in the health sector. This has amounted largely to poor healthcare service delivery that has adversely affected healthcare quality and even poor quality of public healthcare facilities (Mnyembane, 2002).

The present government is still working to create a NHI scheme based on issues of disparities with regards to the national healthcare system which involves uneven access to healthcare among the various socio-economic communities in the county (Rusch, Amado, Christofides, & Pieters, 2012). For a long time, the health care system in SA has been defined as a two-tiered system which is arguably unfair and divided. Private and public health systems exist simultaneously in SA (Yamin, 2009). This has called for the implementation of the three (3) phased NHI scheme in line with the SDG. SA intends to implement the NHI over a fourteen-year period. The NHI will be funded largely by general taxes. NHI application and implementation is compatible with the international community vision of social welfare in healthcare (Weimann, 2013).

The implementation of the first (1st) phase took place over a five (5) year period from the year 2012/13 to 2016/17. Throughout the first phase, the healthcare systems in the country were facilitated with various projects in the eleven (11) NHI pilot districts (Mureithi, Burnett,

Bertscher, & English, 2018). This phase saw an improvement in the performance of health centers, administration and accountability of healthcare facilities, enhancing the planning and development of health workers, implementation of the e-health strategy, strengthening medicine and technology accessibility in healthcare centers and the registration of health patients (Di McIntyre & Gilson, 2002). This was achieved through the implementation of pilot programs such as the Operation Phakisa-Ideal Clinic initiative, the Quality Standards for Health, the WBPHCOTs, Integrated School Health Programs, District Clinical Specialist Teams, DDS among others (Madore, Yousif, Rosenberg, Desmond, & Weintraub, 2015).

The second (2^{nd}) phase of implementation began in 2017/2018 and will end in 2020/21. The aim of this phase is to approve the regulations of the NHI and create the NHI fund. The activities outlined during this phase will include reforms to other laws that will affect NHI most of which have been concluded on whilst others are ongoing, a modification of the Medical Schemes Act, procedures for population registration, accreditation of healthcare facilities and service providers, mobilizing extra funding to set up the NHI fund and the active continuation of healthcare systems employed in phase one (Braa & Hedberg, 2002).

The third (3^{rd}) phase is scheduled to begin in 2021/22 till 2025/26 and beyond. This phase will include activities such as the enforcement of initiatives already introduced in phase one and two, the adoption of the NHI specific taxes from qualified taxpayers by the National Treasury, and also filling up gaps of the previous phases at their implementation stages (Bah, 2009).

The NHI has sought to create a special fund in order to cater for emergency healthcare of refugees (Meyer, 2010). The focus of the NHI is to make healthcare accessible to those who

cannot afford it or whose conditions prohibits them from obtaining the needed services. This would also guarantee that individuals and families are protected from financial difficulties (Schaay, Sanders, Kruger, & Olver, 2011).

2.4 Tanzania's move towards Universal Health Coverage (UHC)

In a quest to enhance Tanzania's domestic economy, President Julius Nyerere in 1967 launched the Arusha Declaration, highlighting the values of Ujamaaa, his concept of social and economic policies (Hydén, 1980). This concept signaled the beginning of a sequence of healthcare initiatives in Tanzania with the ultimate aim of enhancing universal access of healthcare services to the poor and disadvantaged especially in the remote areas of the country. In order to achieve this, the government banned private-for-profit medical practice and shouldered the responsibility of offering free healthcare services in the year 1977 (Kolstad & Lindkvist, 2012). By the early 1990's, increasing healthcare expenses coupled with a failing economy put a burden on offering free healthcare services for all which eventually became apparent. As a result, the government introduced healthcare reforms that transformed the funding system from free services to a hybrid funding system, which included cost-sharing strategies (Therkildsen & Semboja, 1992). The cost-sharing strategies was implemented in four (4) stages in the form of user charges from 1993 to 1994 (Gilson & Mills, 1995).

Over the years, there has been an improvement in health budget distribution in Tanzania. For instance, the THE of Tanzania increased from "$US734 million in 2002/2003 to $US 1.75 billion (West-Slevin & Dutta, 2015). Tanzania's healthcare system was funded mainly by tax, foreign donors and households (Carrin, Waelkens, & Criel, 2005). However, healthcare financing has been facilitated by donor funding which is largely ascribed to the introduction

of the Global Fund for HIV/AIDS in 2001, as well as the SWAp (Dambisya, 2007). Furthermore, in spite of the high level of diversity of insurance schemes, there has been a commitment by the Tanzanian government to extend insurance coverage in the nation (Diane McIntyre et al., 2008). The plan to ensure universal access to healthcare in the country led to the establishment of four (4) publicly owned health insurance schemes of Tanzania which are the National Health Insurance Fund (NHIF), Social Health Insurance Benefit (SHIB), Community Health Fund (CHF) and Tiba Kwa Kadi (TIKA) (Kumburu, 2015).

NHIF was set up by Parliament Act No. 8 of 1999 and started activities in June 2001. The system was originally designed to cover civil servants. However, subsequent amendments of the Act has introduces the enrolment of private individuals (Humba, 2011). The fund is financed by 6% compulsory contribution from the monthly salary of all public sector officials and government (Borghi et al., 2013). This insurance scheme covers the employee, their spouse and a maximum of four (4) lawful dependents below the age of eighteen (18) (Kumburu, 2015). According to the NHIF report, Bultman, Kanywanyi, Maarifa, and Mtei (2012), the scheme covers about 6.6% of the total population of Tanzania.

The SHIB scheme was also introduced in 2007 as part of the National Social Security Benefits of Tanzania (Mtei & Mulligan, 2007). This scheme covered all employees of the NSSF through a registration procedure with one health facility of their choice. Both the public and private sector suppliers are certified by the scheme (Mchomvu, Tungaraza, & Maghimbi, 2002).

The CHF is the system targeting the larger population in the informal rural sector and voluntary participation. On the other hand, its partner TIKA caters primarily for individuals

of the informal sector residing in urban areas (Borghi, Mtei, & Ally, 2012). Both the CHF and TIKA are controlled and operated at the district level under the CHF Act 2001. The management and sensitization of the CHF is monitored by the council health service boards (Ellison, 2014). Participants pay a yearly membership which grants them access to basic medical care and drugs. As of March 2018, coverage under the CHF was 13,325,718 representing 25% of the population and HFGC at the district level (Djukanovic, Mach, WHO, & UNICEF, 1975). Nevertheless in 2009, the NHIF was awarded the national administrative position of the CHF (Borghi et al., 2013). "Until June 2018, the NHIF had registered 856 members whilst 446 of them had 3,918,999 beneficiaries, which is about 7% of all Tanzanians while 67% of Tanzanians were not registered with any form of healthcare" (Msikula, 2019).

Since 2015, UHC has become a significant political concern in Tanzania. The introduction of the HP+ project financed by the USAID has supplied technical support to ascertain the optimization of health funding projects in Tanzania, concentrating mainly on the levelling-up of health insurance (Mtei & Mulligan, 2007). In order to tackle the present divided and poor insurance coverage, the government has created a new SNHI system with the objective of decreasing out-of-pocket spending (Mtei, Makawia, & Masanja, 2014). The National Assembly of Tanzania tabled the health insurance cover in April 2019 which required the registration of all Tanzanians especially the poor and vulnerable in society (Ajuaye, Verbrugge, Van Ongevalle, & Develtere, 2019). Even though health insurance coverage is relatively low in Tanzania, this initiative is set to increase enrolment and guarantee access to primary healthcare by all citizens in the quest to play its role in achieving UHC.

2.5 Kenya's move towards Universal Health Coverage (UHC)

Kenya held a national referendum in August 2010, implementing a new constitution to decentralize the government (Akech, 2010). Kenya is ruled by one (1) national government and forty seven (47) country governments (Boone, 2012). The 2010 Kenyan constitution provides a useful framework to insure a comprehensive rights-based approach to delivery of healthcare services (Kramon & Posner, 2011). It further involves rights to reproductive health and offers that each individual has the right to the greatest achievable health status. It also states that the government will provide valuable social security for citizens who are unable to support themselves and their families. Citizens will also be provided with the necessary emergency medical treatments they need (Kenia, 2013). Kenya made provision for the Kenya Health Policy which took effect from 2014 and is expected to undergo a reform by 2030, in line with achieving UHC, a primary aim of the SDGs (Tsofa, Goodman, Gilson, & Molyneux, 2017). The Kenya Health Policy 2014-2030 aims at guaranteeing a substantial decrease in the overall health issues of the Kenyan citizenry by attaining at least 48% reduction in deaths attributed to communicable and non-communicable diseases, including accidents to a less level of public health importance without loosing concentration on developing situations (Kinyanjui, Kimani, & Kinyanjui, 2016). The identification and creation of policy goals and guidelines was centered on a thorough and crucial assessment of the patterns, conditions and accomplishment of health goals in the nation between the year 1994 and 2010 execution era of the past health policy structure (Jenkins et al., 2010). The healthcare system in Kenya is organized in a hierarchical manner that starts with primary healthcare and further accelerates to complex instances relating to greater healthcare stages (Karuri, Waiganjo, Daniel, & Manya, 2014).

The policy is intended to be detailed, balanced and consistent in order to attain its objective. It also seeks to minimize financial barriers to services which is largely driven by UHC and

Social Health Protection principles (Lagomarsino et al., 2012). By the end of the policy, the health delivery mechanisms will gradually evolve from the present six (6) levels into a 4-tier system via regular evaluations every five (5) years in compliance with values and regulations. The 4-tier system will be made up of the community, primary care, secondary referral and tertiary referral. Community services will concentrate on developing adequate demand for services, while primary care and referral services will put more emphasis on meeting this demand (Ndung'u, Thugge, & Otieno, 2011). National and country governments are primarily responsible for offering the funding needed to fulfill the right to health. This will be achieved by ensuring equity, productivity, transparency and accountability in the mobilization, distribution and use of resources. Initiatives are being put in place to create a viable political, national and community commitment to achieve and maintain UHC through enhanced and varied domestic funding options (Akin, Birdsall, & De Ferranti, 1987). The Kenya Health Policy 2014-2030 will be incorporated by a five (5) year National Strategic Plan, Multi-year Country Sectoral plans and yearly plans whilst adopting a multisectoral approach which will include stakeholders such as state actors, client, regulatory bodies, professional associations, non-state actors, development partners, health worker unions at both the national and country levels (Munge, Mulupi, & Chuma, 2015). Advocating the execution of this policy means the national ministry will set up and promote an organizational and leadership framework to monitor and handle the implementation at the domestic level of the constitutionally established health policies and systems. The Kenyan Health Policy will be monitored and evaluated through a number of financial and non-financial targets and indicators used to document the implementation of the policy yearly at both national and country levels (Barasa, Nguhiu, & McIntyre, 2018).

2.6 Ghana's move towards Universal Health Coverage (UHC)

International actors such as Christian missionaries, European colonists, the World Bank and IMF have strongly affected the development of healthcare in Ghana (Twumasi, 1981b). In pre-colonial Ghana, the primary cause of morbidity and mortality was infectious diseases (Agyei-Mensah & Aikins, 2010). Moreover, democratic change in Ghana prompted healthcare reforms in an effort to tackle the existence of infectious and non-communicable diseases that ultimately led to the creation of the current NHIS (Carbone, 2011). After the second World War, it became progressively apparent that a global health policy needed to be reinforced as the global transportation network had been enhanced (Twumasi, 1981a). Incentives and support to supplement western medical practice in Ghana were delivered by organizations like the WHO and the UNICEF (WHO, 2006). These Organizations provided economic and technical help for the eradication of diseases and the enhancement of health standards (Higazi, 2005). Nevertheless, traditional priests, clerics and herbalists continued as significant healthcare providers particularly in remote rural areas where healthcare centers are prevalent (Berry, 1995). Ghana gained its independence in 1957, electing Dr Kwame Nkrumah as the first president. In order to increase access to healthcare, Dr Nkrumah concentrated on curative healthcare and employed a strategy to public health concentrated primarily on outbreak and disease control (Agyei-Mensah & Aikins, 2010). These health programs were funded completely by general taxation but Ghana discovered an economic struggle with free public healthcare and huge state spending. In the wake of the increasing HIV/AIDS epidemic, the Rawlings-led administration adopted provisions for improved social policies such as education and healthcare (Agyei-Mensah & Aikins, 2010).

In 1981, the WBG and IMF urged the government to reduce public expenditure by introducing structural adjustment programs. In 1985, the government passed the Hospital Fees Regulation leading to the implementation of the Cash and Carry system which

subsequently led to higher out-of-pocket fees in order to cater for the medications and required resources by the healthcare system (Carbone, 2011). This excluded many citizens from public healthcare as they could barely afford the charges and were highly discontent with the services as many Ghanaians belonged to the lower- and middle-class groups. The government however, believed it was the only way to foster economic development in the country (Agyei-Mensah & Aikins, 2010). A medium-term health strategy was adopted in 1996, which meant a transition from resource-limited, constrained initiatives to a more comprehensive approach that would assist the public health sector grow better (Carbone, 2011). A subsequent launch of the Health Fund in 1997 did not resolve the issue. In the year 2000, the Kufuor-led NPP administration assumed power and launched the NHIS in 2003 as a fulfillment of their campaign promise (Carbone, 2011). The NHI Act sought to provide universal healthcare to all Ghanaians.

The state provides most healthcare in Ghana and is mainly administered by the MoH and GHS. There are five (5) categories of suppliers in the healthcare sector. They comprise the health posts, health centers and clinics, district hospitals, regional hospitals and tertiary hospitals. Health posts for rural communities are the first (1^{st}) level of principal care. These initiatives are financed by the Ghanaian government, financial credits, the Internally Generated Fund (IGF) and the donor's -pooled Health Fund (Canagarajah & Ye, 2001). In 2005, Ghana spent 6.2% of GDP on healthcare implying $US30 per capita. Of that, approximately 34% was government expenditure (WHO, 2005). Ghanaian citizens form 97.5% of the total population in Ghana. In 2010, 5.2% of Ghana's GDP was invested in healthcare and availability of primary healthcare was accessible by all citizens (Odeyemi & Nixon, 2013).

The NHIS serves as the UHC structure in Ghana and remains the first countrywide social benefit program in Sub-Saharan Africa to include the remote and agricultural communities (WHO, 2011). The NHIS has undergone many reforms since its implementation and continues to go through it in order to provide better services to meet the needs of its citizens. Moreover, the success of Ghana achieving UHC depends to a large extent on government leadership in promoting its key initiatives of community-based healthcare and services (Lagomarsino et al., 2012).

2.7 Conclusion

In sum, the chapter brought to light the WHO perspective of UHC, including policies implemented by some African countries such as South Africa, Tanzania, Kenya and Ghana towards achieving UHC and fulfilling the SDG 3.8. The policy of the WHO is that health is a fundamental human right of every individual and countries must endeavor to meet the health care needs of their citizens. Health is essential for every country as a healthy population leads to economic growth in the country. The countries considered in this study have made and are still making significant efforts to provide primary healthcare which also involves the coverage of certain drugs. Even though they are all faced with the issue of funding, they are putting in measures to generate the needed funds for running the health care policies they have implemented.

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CHAPTER THREE

AN ANALYSIS OF RESEARCH FINDINGS OF THE NATIONAL HEALTH INSURANCE TOWARDS ACHIEVING SUSTAINABLE DEVELOPMENT GOAL (SDG) 3.8

3.0 Introduction

This chapter presents an analysis of data gathered from the interviews conducted with stakeholders of the NHIA and its agencies, beneficiaries and healthcare service providers of the NHIS in order to address the objectives of this study based on the research questions. I also employed the use of secondary data.

The NHIS is the result of National Health Insurance Act 650 amended on 31st October, 2012 to Act 825. Its purpose was to create a NHIA, whose mandate is to ensure that a NHIF is created to cater for the healthcare needs of its scheme members. The amended Act of the NHIS requires every Ghanaian to be enrolled on the scheme. The establishment of the NHIA has led to the fulfillment of many objectives set out by the legislature in terms of meeting the health care needs of residents which has been highly beneficial.

3.1 Mechanisms Put in Place to Fulfill the Sustainable Development Goal 3.8 in Ghana

The SDGs requires that by 2030, all UN member states have been able to achieve UHC, in the fulfilment of its global agenda. What this means is that about 95% to 100% of residents should be able to access quality basic healthcare for free. Achieving UHC under the SDG is a broad spectrum which covers three (3) main areas. Namely population coverage, financial coverage and UBC. As it stands, the NHIS is making significant strides towards achieving UHC. The NHIS is doing their best on is UBC. The NHIS has a very generous benefits package which is the same for registered members of the Scheme. An active member of the

Scheme is guaranteed unhindered access to the benefit package without any form of co-payment, co-insurance nor deductibles as it is the case in some insurance systems. The UBC covers more than 95% of all diseases in the country.

In terms of population coverage, the NHIS has only been able to cover about 36% to 40% (MoH, 2018) of the population. In the area of finance, the card subscribers are entitled to grants which gives them access to primary, secondary and tertiary care at no cost once it is included in the list.

3.1.1 Funding

One of the biggest issues confronting the NHIS is funding. With this issue resolved, all other things are set to fall in place since the funds serve as the driving force of the scheme's activities. For a very long time, the NHIS has used various payment methods such as reimbursement, and is reviewing the Ghana Diagnosis Related Grouping which has been tested in certain parts of the country.

According to an NHIA finance officer:

> I*n the quest to implement mechanisms geared towards UHC, the scheme has introduced the capitation system for a certain level of care as practiced in SA.*

Capitation is a method of payment largely recognized in the international system. It is a provider payment mechanism in which providers in the payment system are paid, typically in advance, a pre-determined fixed rate to provide a defined set of services for each individual enrolled with the provider for a fixed period of time. The amount paid to the provider is irrespective of whether that person would seek care or not during the designated period. The capitation system has been introduced for the primary level of outpatient care which serves as

the fundamental base of healthcare systems in the country. This system will ensure that the amounts paid will cater for selected OPD primary cases.

The NHIA finance officer reiterated that:

> *The introduction of capitation as a mode of payment will improve the allocation and preparation of budget by the NHIA, eliminate the problem of paying claims and also reduce administrative and staff cost during the preparation of claims.*

The NHIA has also set out a financial risk strategy meant to consolidate the position of the NHIS as the preferred financing mechanism for reducing financial barriers to healthcare in Ghana, through a social health insurance scheme that reflects social protection.

3.1.2 Governance Systems Strengthening and Human Resource Development

To achieve universal financial access to quality healthcare, the NHIA intends to develop strong governance systems and improve its human resource. This called for some organizational reforms. Three (3) Deputy Chief Executive Positions were created and appointments made for finance and investments, administration and human resource and operations according to the NHIA Act, 2012. Regional directors have also been appointed for the various regions while the appointment of District Directors is in the process. The NHIA also established a fully functional human resource department to handle all HR issues within the scheme. Subsequent to that, all HR functions of the then DMHISs were brought under the HR department.

A human resource manager of the NHIA stated that:

> *As part of human resource capacity development, a number of staffs are being sponsored to pursue various health insurance-related master's degree courses.*

The Authority also commissioned consultants to undertake a job evaluation exercise to enable management place staff on their appropriate levels in order to be remunerated accordingly. To ensure that employees give off their best for the achievement of corporate goals and objectives, a PMS was instituted in 2011.

The manager further mentioned that:

> *Staff Performance Appraisal System had also been developed and all supervisors and staff across the country trained accordingly. Employee remunerations and promotions are based on their performance.*

3.1.3 Information, Education and Communication

The communication strategy within the NHIS system includes internal and external communications within the Authority. The internal communication is between Authority and its staff across the country and external communication is with the stakeholders. A situational analysis of NHIA communication system highlighting the strength, weakness, opportunities and threats has been done. Key stakeholders identified were NHIS staff, providers, corporate institutions, local authorities, subscribers and the general public. Some of the key threats to NHIA communication include politicisation of the NHIS, change of management and direction upon change of Government, bad press reportage, poor quality of care by providers and delays in payment to providers.

The NHIA, however, recognizes that the successful implementation of the NHIS and UHC requires collaboration among all stakeholders. In this regard, the Authority is working towards improving involvement and participation of all major stakeholders in its activities in order to get their buy-in at all times. The Authority is also committed to encourage a two-way communication between itself and its public. To achieve this goal, the NHIA set itself the

task to develop contacts database of key stakeholders that would facilitate mailings to them on important developments in the NHIS, appoint "Relationship Managers" to serve as the single interface for resolving client issues, irrespective of their nature, appoint monitoring and evaluation managers for claims and provider services and monitoring evaluation managers for membership in the ten (10) regional offices to serve as the main contact and information bank. Through this, other divisions would relate to providers, subscribers and other stakeholders and organize at least two fora per annum to interact with service providers in order to help the development and implementation of relationship protocols for continuously addressing issues through the relationship managers.

Presently, provider contact database has been established and series of fora organised to interact with providers. Recommendation had been made to management for the appointment of monitoring and evaluation managers in charge of provider relations and membership management at the regional levels. These recommendations had been taken into consideration in the revision of the NHIA organogram which took effect in early 2013. However, appointments are yet to be made.

The PRO official at the NHIA head office indicated that:

> *With regard to media engagements, the NHIA is to deploy the services of various directors, deputy directors and managers in the communication process. The strategy is to allow them to disseminate information in their areas of expertise through radio and television interviews. Senior editors in the media are also to be briefed quarterly to equip them with current happenings within the scheme for accurate reportage.*

Furthermore, the capacity of PROs in the districts and regional offices is to be enhanced to enable them play active roles in mainstream communication and public education at the

district and regional levels. By the end of 2030, the NHIA seeks to organize a series of fora with editors and the media in general while PROs at both the district and regional offices are being given some training.

3.1.4 Development Partners Coordination and International Relations

Since inception, the NHIS has attracted the support of Ghana's Health Sector DPs. The support has been in various forms, including capacity development of staff of the Scheme, especially at the district level, provision of technical advisors for specific projects and funding for projects. The NHIA is currently enjoying various forms of support from five (5) of the DPs. They include DANIDA, The Royal Netherlands Embassy, USAID, and DfID, KOFIH, ADB, and GIZ.

According to an official from DANIDA,

> *The organization is currently supporting the NHIA with an embedded Senior Strategic Planning, Monitoring and Evaluation Advisor to provide technical advice in the development and mainstreaming of a Monitoring and Evaluation system within the NHIS. DANIDA is winding up its support for Ghana as the latter has now become a middle-income country.*

The USAID had, on its part, concluded initial discussion with management of NHIA to support the NHIS with multiple projects in the areas of accreditation system, Monitoring and Evaluation policy, development and training of a core staff in Monitoring and Evaluation, NHIS communication strategy development, clinical audit system strengthening and claims management system. Currently, the USAID has signed a memorandum of understanding with the NHIA to move forward with the projects agreed upon. It is also working through the HFG

of the Results for Development to develop management dash-board system for monitoring performance by the Executive management.

The Royal Netherlands Embassy is also considering a proposal to implement an E-claims project as well as a Health Insurance Knowledge Centre to be established in Ghana. The Knowledge Centre will be jointly owned by Ghana, the supporting partners and other sister African countries that may express interest in the project.

The British Department for International Development's initial assistance to the NHIS ended in 2012. Following discussions on further areas of co-operation, DfID, in 2014, provided a grant of 1,700 pounds to support improvement of NHIA's financial management system.
The ADB and the GIZ of Germany had equally expressed their willingness to support the NHIA in various areas of development.

The KOFIH from South Korea has expressed interest in assisting the NHIA to undertake comparative research studies of both the Ghana and South Korea health insurance schemes in order to share ideas on how best to move both countries' health insurance forward. KOFIH provided an amount of $340,000.00 to fund the project. Subsequently, an amount of $55,000.00 was released to fund a joint research project in Ghana. KOFIH pledges to continue its support for the NHIA in 2015 and beyond.

3.2 The Current State of the National Health Insurance Scheme (NHIS) Since Its Implementation Towards Achieving Universal Health Coverage

The NHIS popularly known as health insurance in Ghana has been in existence for over fifteen (15) years. It is the single largest purchaser of healthcare services. What this means is that, it is the only entity that is able to cater for the healthcare needs of its subscribers at no

cost. The NHIS is a social health insurance introduced by government. That means, it is a pro-poor intervention. Meaning before anything else, the NHIS is supposed to take care of the poor and vulnerable in society who otherwise cannot afford healthcare. The NHIS is a household name in Ghana. However, the knowledge of the NHIS varies from one person to another. In some healthcare facilities, the first question you are asked when you get there is whether or not you are a subscriber of the NHIS which helps to increase its popularity among residents.

Presently, there is a need for every Ghanaian resident to be enrolled on the NHIS as it provides financial risk against health through the coverage of healthcare services and drugs at a minimal cost. The categories of NHIS subscribers are mainly grouped into two (2). That is, the informal sector on one hand, and the exempt groups on the other. The NHIS is largely funded by the NHIL through the MoF at a 70% to 80% rate; 2.5% from SSNIT contributions, premiums paid by the informal sector subscribers and returns on NHIF investments (NHIA, 2019).

In order to access services provided by the NHIS, residents must subscribe through a registration process which requires an interview to determine the category the subscriber belongs to. Exempt group categories need evidence of exemption before they are adequately placed in that category. The registration requires the provision of personal information such as the name, age, date of birth, marital status, contact number and residential address of the subscriber. After which the biometric capturing takes place. This is to ensure that the identity of the subscriber can easily be determined and there's no chance of duplicating identities.

According to some NHIS subscribers,

contributions and premiums paid to the scheme is made yearly and ranges from ¢27 to ¢48 cedis depending on one's location. In the case of exempt categories, such as children, SSNIT contributors and pensioners among others, they are only required to pay an amount between

¢5 to ¢8 cedis which only caters for the provision of the card, whilst further exempt groups do not pay anything at all.

A typical example of further exempt groups is children below three (3) months and pregnant women.

Upon registration, the subscriber receives the NHIS card after a one (1) month period. In the case of new subscribers, the card can only be accessed after a waiting period of three (3) months. This case is exceptional to expectant mothers and children under the age of five (5) who can access the card immediately.

A research officer at the MoH emphasized that:

Today, the NHIS covers 517 medicines on its drug list. That is to say, it provides medicines for almost every treatment which represents about 95% of coverage. Currently, the NHIS is visible in every region of the country with the presence of district and regional offices who ensure the delivery of good customer service at the various service points. The authority has a total of 166 district offices and 10 regional offices. The NHIA works in conjunction with many healthcare service providers which include CHPS, Maternity Homes, Clinics, Pharmacies, Health Centers, Licensed Chemical Shops, Diagnostic Centers and so on.

Private Health Insurance Schemes (PHIS) are inevitable in the country. As such, the NHIA Act 852 requires the regulation of PHIS in the country. The authority is mandated to enroll,

monitor, and oversee PHIS activities in Ghana. So far, there are two (2) main PHIS in Ghana. Namely, Private Mutual Health Insurance Scheme (PMHIS) and Private Commercial Health Insurance Scheme (PCHIS). A PMHIS is a health insurance system that operates solely for the welfare of its members. It can be formed by any recognized group. Membership for instance could be community, occupational or religiously based and through a non-corporate organization.

A PCHIS on the other hand applies to a health insurance company operating on the basis of business values for revenue. These companies are usually owned by shareholders. Premiums are paid depending on the calculated risks of subscribers and organizations signing up for it.

The methods of payment currently used by the NHIS is the reimbursement with fee-for-service payments and the G – DRG. Under this system, the tariffs for various services, medicines and diagnosis has been agreed on by the NHIS and its healthcare service providers, making payments made fixed, based on the number of subscribers that are attended to or are treated every month. The G – DRG is currently under review and would shortly be implemented as the main source of financing once it is able to resolve certain challenges confronting the scheme.

A Senior Research and Policy Manager at the GHS stated that:

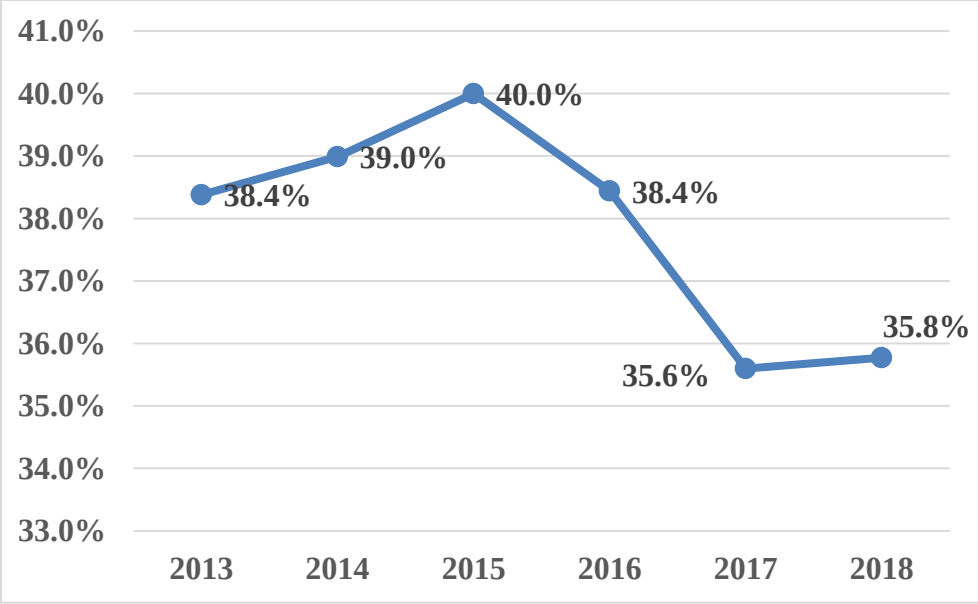
> *The NHIS is the catalyst of UHC in Ghana. It is still growing and public interest is increasing. UHC is not a quick thing. It doesn't happen in the twinkle of an eye anywhere. It is a slow, deliberate and very gradual process. As such, the NHIA must be given the chance to keep improving upon itself and put in place the right systems in order to truly make residents experience UHC.*

3.3 Successes of National Health Insurance Scheme (NHIS) Towards Achieving Universal Health Coverage (UHC) in Ghana

3.3.1 Access to Healthcare Services by Populace

The main purpose of introducing the NHIS was to provide access to healthcare services especially for the poor and vulnerable in society. To a large extent, this aim has been achieved through significant efforts made by the appropriate authorities. The trends in population coverage of NHIS in Ghana are illustrated in figure 3.1.

Figure 3. 1: Trend of NHIS Population Coverage



Source: (MoH, 2018)

Figure 3.1 shows NHIS population coverage from the year 2013 to 2018. It is evident that the trend reached its peak in 2015 at a 40% rate. However, there has been a steady decline since

2015 to 2017. The year 2018 has recorded a gradual increase from 35.6% to 35.8%, showing a 0.2% increase in total population coverage. The researcher tried to find out from NHIA officials what factors accounted for the rise and fall of the coverage of NHIS in Ghana. This was what one of the officials said:

> *The law that established the NHIS made provision for a liberal exemption regime to ensure that various categories of the society considered to be poor and or vulnerable get access to free healthcare through the scheme under certain circumstances. The exempt category as prescribed by law include SSNIT contributors and pensioners, children below age eighteen (18), pregnant women, differently-abled persons and indigents among others.*

Since its inception, about two-thirds (2/3) of all beneficiaries have been found in the exempt category as shown in the figure 3.2 below.

Table 3.1: Proportion of NHIS Exempt Categories

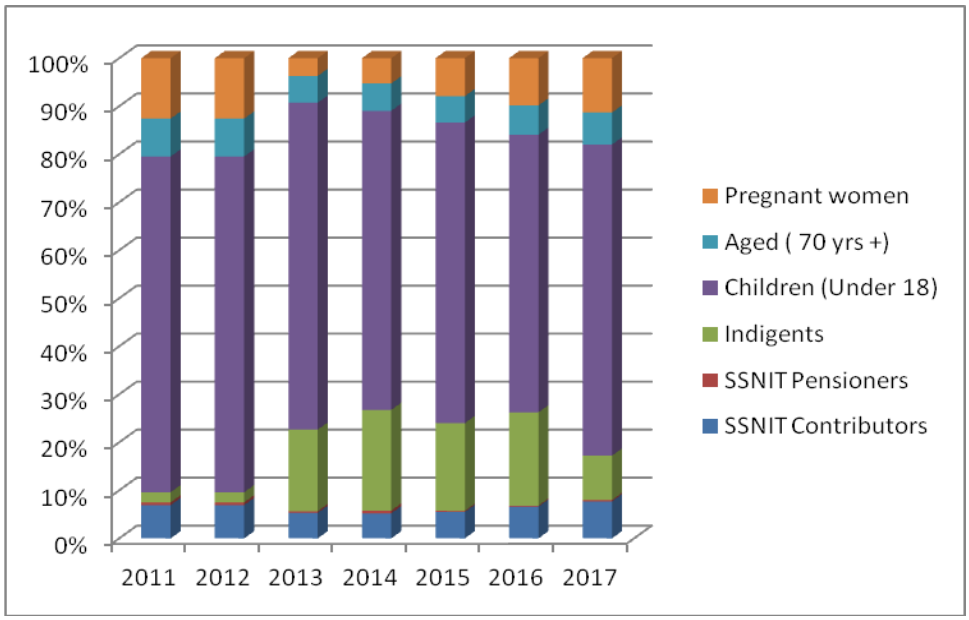
	Total Active members	No. Exempt	(%)
2013	10,144,527	7124364	65.3
2014	10,545,428	6924700	65.7
2015	11,058,783	7401158	66.9
2016	11,029,068	7,898,196	71.6
2017	10,476,542	7,415,773	64.7%

Source: (MoH, 2018)

The situation is not different in any of the years between 2013 to 2017 which recorded a gradual increase from 65.3% in 2013 to about 71.6% in 2016. After which there was a steady decline with about 65% of net beneficiaries belonging to the exempt category. In

spite of the sudden decline, the number of exempt groups still belong to a greater portion of total NHIS members.

Figure 3. 2: Distribution of proportions of exempt categories



Source: (MoH, 2018)

Figure 3.2 above shows the distribution of exempt categories according to their various social categories. SSNIT contributors increased from 3.9% in 2013 to 5.4% in 2017. These contributors by law, are not expected to contribute to the NHIS although they are beneficiaries provided, they can remain in good standing through registration and renewal of membership cards. The figure also records children as the exempt group with the largest number constituting about 45% of the group, followed by pregnant women and indigents and finally the aged. NHIS members belonging to these categories have testified to the benefits they enjoy as being part of these exempt categories during the interview process. Pregnant women, the aged and children in particular attested to the fact that they received healthcare

services, and maternal care at no cost at all.

Another GHS official revealed that:

> *A major achievement the NHIS can boast of in terms of access is its ability to register non-citizens on the scheme. This is unpopular in countries such as Kenya and Tanzania who have implemented health insurance schemes. Consequently, this initiative demonstrates a giant step towards achieving UHC in the country irrespective of nationality, religion, gender, age or ethnicity. Once an individual is a resident in the country, they qualify fully to enjoy the benefits of the NHIS.*

3.3.2 Reduction in out-of-Pocket Spending

Another important milestone made by the implementation of the NHIS is the reduction in out-of-pocket spending of scheme members.

Many medical doctors and beneficiaries interviewed reiterated the fact that:

> *Enrolling on the NHIS has reduced out-of-pocket spending to an extent since the scheme covered consultation, certain drugs, common laboratory investigations and subsidized admission bills and some surgeries.*

A beneficiary of the NHIS confirmed that:

> *Upon undergoing surgery which was billed at two thousand five hundred Ghana cedis (¢2500), I was only made to make a payment of one thousand Ghana cedis (¢1000) whilst the NHIS covered the balance of one thousand five hundred (¢1500) Ghana cedis.*

These initiatives by the NHIS has also reduced self-medication in the country resulting in a reduction of mortality rates as healthcare service providers are readily available to citizens at all times to provide them with the necessary primary healthcare services they need. In about six (6) districts where teenage pregnancy is on the rise, NHIS has initiated free family

planning for scheme members. This move is in conjunction with GHS to reduce maternal and infant mortality, unwanted pregnancies and abortion usually among the youth. The NHIS considers family planning as a way of reducing poverty and spacing children among the youth (GNA, 2018b).

3.3.3 Early Diagnosis and Treatment

The introduction of the NHIS has enforced early diagnosis and treatment of various ailments among scheme members. The NHIS has given active members the room to conduct periodic check-ups at no cost. This therefore enables healthcare service providers to detect impending ailments on time thereby enabling them to start early treatment. In case of emergencies also, patients have access to the necessary healthcare services irrespective of their financial status.

3.3.4 Introduction of Digital Technology

The NHIA and its agencies are geared towards the introduction of technological innovations in today's global village. Even though these services are unpopular among its beneficiaries, it has been designed to make the NHIS more accessible to its beneficiaries and also to improve upon the financial management of the scheme (GNA, 2018a). This includes the NHIS Mobile Membership Renewal Service through an USSD code *929#. With the NHIS number, beneficiaries get access to check the validity of their policies, renew membership, check benefits package, including the medicine list of the scheme. This service is available on all mobile networks in the country. At the same time, scheme members have access to a customer service center via the short code 6447 on all networks.

An officer at the corporate affairs directorate of the NHIA revealed that:

The introduction of the mobile renewal has led to a reduction in operational costs

linked to membership renewals and increase in membership awareness on the NHIS benefit packages, saved time of beneficiaries, increased revenue and is attracting more members to the scheme. It has also led to a reduction in revenue leakages in the quest to fight against corruption within the authority. The introduction of the biometric registration of beneficiaries to ensure that there is no duplication of identity has been essential in keeping adequate records of scheme members. Currently, members are being authenticated non-biometrically at healthcare facilities after which a SMS interactive prompt feature confirms attendance. These innovations are aimed at bridging the gap between stakeholders and beneficiaries and also to address their grievances.

3.4 Challenges of National Health Insurance Scheme (NHIS) Towards Achieving Universal Health Coverage (UHC) in Ghana

Despite the many successes achieved by the implementation of the NHIS in Ghana, there seems to be many barriers confronting the sustainability and functions of the scheme. These constraints are due to a variety of factors which will continue to pose various challenges to the smooth implementation of the NHIS if not properly managed.

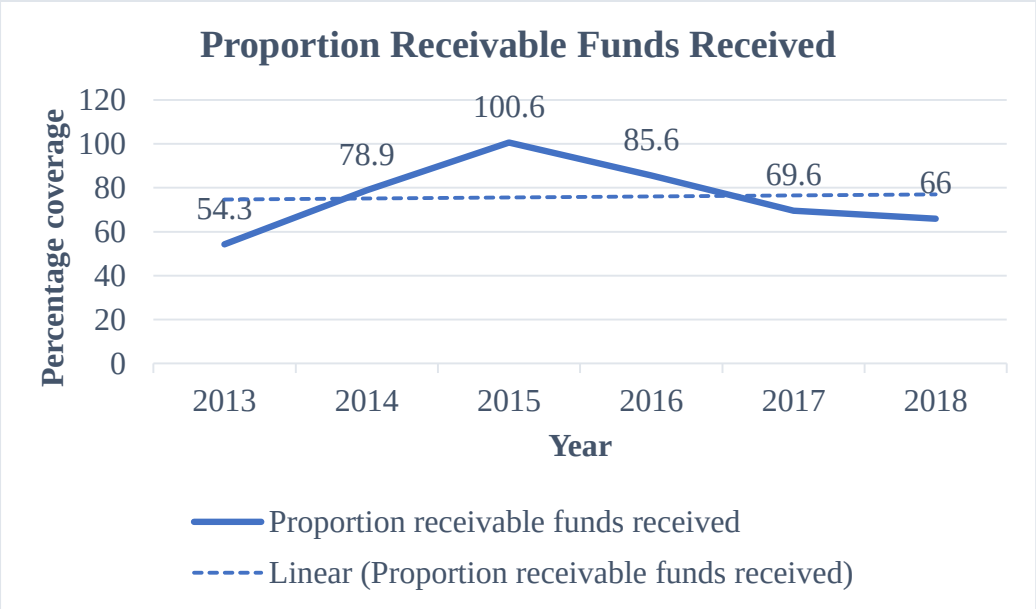
3.4.1 Funding

The NHIS is funded mainly through the NHIF from the NHIL, taxation, SSNIT contributions from formal sector employees, payment of premiums from informal sector contributors, returns on investments and donor funds. However, with the informal sector, poor and vulnerable in society which make up a larger portion of the population and exempt groups, contributions towards the NHIS has increasingly become complex.

Figure 3.3 shows the proportion of receivable funds received by the NHIS from the year 2013

to 2018. It shows a steady rise in funds received from contributors between 2013 to 2015 from 54.3% to about 100%. On the contrary, funds received begins to decline from the year 2016 to 2018 from 85.6% to 66%. This decline has caused a major setback in the operations of the NHIS.

Figure 3. 3: Proportion of receivable funds received by the NHIS



Source: (MoH, 2018)

The inability of the NHIL to accumulate enough funds for the scheme has subsequently led to delay in payment of claims which affects payment of salaries and suppliers of various clinical products.

Many healthcare service providers attested to the fact that:

NHIS debt to health facilities is on the rise.

They confirmed that:

Since August 2018, no payment had been made to many facilities.

Again, the inability to pay funds on time has generated the unauthorized charging of fees by NHIS approved healthcare facilities. This is to enable these facilities raise funds for their management. However, due to the inability of patients to bear the cost, many of them abscond after receiving treatment. Also, the insufficiency of funds does not give the scheme the room to cover certain critical health conditions and surgeries which is prevalent among the population these days and are highly costly to treat. For instance, the scheme does not cover treatment of cancer, kidney and liver problems. Even though pregnant women are found in the exempt category, the scheme does not cover CS. As a result, mothers who undergo these surgeries and cannot afford the cost end up spending days, weeks and sometimes months at healthcare facilities till their families are able to raise the needed funds for their discharge.

3.4.2 Administrative Issues

The inefficacy of the NHIA to address administrative issues that face the authority has caused a disinterest in the scheme mainly by beneficiaries and healthcare service providers making the scheme unpopular in recent times.

According to some beneficiaries,

long queues are unavoidable at the various registration centers mostly due to network issues. At certain locations, registration agents have to be tipped off before incoming beneficiaries can be registered.

Some beneficiaries confirmed that:

Upon registration, the membership cards take about a month or more to be released. This waiting period seems to be too long a time for those of us who need urgent access to healthcare services and cannot afford it.

With regards to the healthcare facilities, it has been observed that priority is given to patients seeking out-of-pocket medical treatment over NHIS card bearers. Again, many administrative issues have risen with the completion of the form 'J' which is a health insurance form issued by healthcare officers for clients, used for the purchase of drugs by patients using the NHIS. On the contrary, many issues have cropped up with the issuance of the form 'J' due to the complexities it comes with.

A medical officer revealed that:

> *The prescription given to patients by doctors must be rewritten on the form 'J' because patients on the NHIS need both to enable them purchase drugs from the pharmacies. Also, when a mistake is made whilst filling the form, it cannot be cancelled. As such, a new form must be filled all over again. In addition, when writing the prescription on the form, it cannot be completed if the patient's folder is not available because there is a part on the form which requires the patient's folder number. The doctor who writes the prescription must be the same person filling out the form 'J'. If the doctor is unavailable, no other doctor can fill the form in their place. Again, there are some drugs that are written in short hand and understood by both doctors and pharmacists but the form 'J' requires it to be written in full. Considering the number of patients doctors have to do that for, it becomes very frustrating on our part. Furthermore, certain drugs need to be taken once every day but the insurance only issues one each day to patients. Meaning, for the number of days the patient has to take the drug, the doctor has to fill out a new form every day whereas it can be purchased at a pharmacy where patients can get access to the normal dose of about three or four pieces of the drug to cover the entire treatment.*

This can be tedious for both the patient and doctor since they would have to visit the healthcare facilities as long as they are undergoing treatment and have to get the same doctor

to fill out the form.

In terms of renewing contracts for healthcare facilities by NHIA, many healthcare service providers affirmed that the process of renewing the NHIA license was cumbersome. According to the contract which had to be renewed every three (3) years, healthcare service providers are to put in a demand for the renewal of the contract five (5) months ahead of time in order to allow for the inspection of healthcare facilities and finally the authorization by the provision of the renewed license. On the contrary, this renewal process seems to exceed the five (5) months allocated period. In the end, healthcare facilities need to follow up on the request for a backdated letter due to delays in order to put in claims for their delayed funds which also goes through a longer process due to inadequate record keeping by the NHIS.

3.4.3 Quality of Service

The quality of healthcare services provided by accredited NHIS healthcare facilities is another critical area that needs redress. The main issues here are differential treatment delivered to NHIS card bearers in terms of waiting times, the quality of drugs covered by the scheme and the quality of facilities available.

Many healthcare service providers reiterated the fact that:

> *The tariffs provided by the NHIS for drugs and services rendered are relatively low. As such, we have been forced to use generic drugs for patients which is the cheapest on the market.* Some beneficiaries also stated that:

In cases where we were given drugs to purchase out-of-pocket, we realized the drugs were relatively cheaper in pharmacies outside than at the healthcare facilities.

Others were of the view that:

> *Drugs administered through the NHIS are only meant for the purpose of first aid.*

The NHIS has been unable to furnish healthcare facilities with the needed equipment for the smooth execution of healthcare services. Consequently, patients complain of inadequate beds when put on admission, payment for injection syringes, laboratory equipment, scanners as well as other modern essential equipment needed to run various tests to promote the healthy lives of scheme members. Scheme members end up going to private hospitals where they have to pay out-of-pocket in order to get access to certain services.

A claims officer at a healthcare facility added that:

> *The availability of healthcare services to scheme members has also encouraged rampant hospital attendance by beneficiaries which in turn puts pressure on healthcare facilities as well as service providers thereby resulting in the delivery of poor quality of service.*

3.4.4 Poor Education and Training

The NHIS has been able to innovate various ways of reaching out to its scheme members in order to meet their needs but it has failed in creating public awareness and education of these mechanisms that have been put in place considering the fact that people do not understand the principle of insurance in the country. These include the introduction of the mobile renewal to reduce long queues, the USSD codes to educate subscribers on the benefit packages, the NHIA membership handbook which contains a list of drugs covered by the scheme. Many interviewees had no idea of these initiatives and have been stuck with the manual methods of doing things.

3.4.5 Poor Monitoring and Evaluation

The inability of the NHIS to put in place periodic monitoring and evaluation mechanisms is

causing more harm than good to the scheme. This has led to massive corruption among employees of the scheme especially during the registration process of scheme members which many beneficiaries brought to my knowledge during the interview process and the delivery of claims.

According to a legal practitioner of the NHIA:

> *The punishment meted out to persons found to have made fraudulent claims against the NHIS is not harsh enough to deter other miscreants from engaging in similar acts. Also, the judicial service delays in dealing with corrupt cases linked to the scheme and its officials which is another contending factor. The legal department of the scheme has not been tasked with prosecuting issues of crime. As such, crime against the scheme is treated like any other crime in the country.*

Again, in case of emergencies, scheme members who do not have their cards in their possession are unable to access treatment via the NHIS. Meaning, they have to fund their bills out-of-pocket.

3.4.6 Membership

The PRO of the NHIA confirmed that:

> *The current membership of the NHIS stands at about 36 to 40% of the total population. But for UHC, everyone should be on it. That is, coverage should be 100%. People enroll, but they don't use the card. They don't find the need to renew their cards either. However, in achieving UHC, active numbers and renewal is very essential. Some of the barriers to enrolment and renewal is distance. People have to travel to the district offices in order to register or renew the card. Another is that, people don't really appreciate the principle of insurance. They pay the premium; at the end of the year they*

don't use the card and they want their money back but insurance doesn't work that way.

3.5 Conclusion

To conclude, in defiance of the successes cropped by the NHIS, the challenges seem to be overwhelming. Thereby, hindering the progress of the scheme's activities. This is mainly because the authority is mandated to deal with issues being faced by the scheme itself, that of government, healthcare service providers including beneficiaries. There is still more work to be done with regards to enforcing sustainable measures needed for the achievement of UHC. From the observations of the researcher, the NHIA is dedicated towards the achievement of Agenda 2030 and in little or no time, Ghana is on the verge of becoming one of the first African states to declare UHC in the international community.

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CHAPTER FOUR

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

4.0 Introduction

This chapter puts together the summary of findings based on the objective of the research. It also makes conclusions and gives recommendations based on the empirical findings discovered during the study from the opinions of beneficiaries, healthcare service providers, stakeholders including data from secondary sources.

4.1 Summary of Findings

The study has revealed that currently, Ghana has joined hands with the international community in order to attain UHC by 2030. The NHIS is being used as a tool to attain this objective in fulfilling the SDG. The main priority of the current CEO of the NHIA is to increase membership and coverage within the country which is in line with the SDG agenda. The scheme has made adequate provisions for every resident to be registered on the scheme at a very low cost whilst giving priority to exempt groups. Meaning, there is a dare need for every resident to enroll on the scheme. These findings agree with Fried et al. (2013) who emphasizes that achieving UHC is very essential for every country and the populace must trust in the reliability of the services provided. It further states that achieving UHC is the gateway to poverty alleviation in today's world.

These findings are also in agreement with Okebukola and Brieger (2016) who reiterated the fact that the implementation of UHC in various countries is a step in the right direction towards the elimination of out-of-pocket spending among residents and serves as protection against healthcare expenditures for the poor and vulnerable in society. According to

Tangcharoensathien et al. (2012), in the case of Thailand, three different public health insurance schemes have been implemented in order to meet the needs of everyone depending on their social class. But Ghana has only one public NHIS which serves the needs of all residents irrespective of their social class.

In terms of the mechanisms put in place, the study further revealed that the NHIS policy has been implemented to provide financial risk against the health of Ghanaian residents. This includes coverage of five hundred and seventeen (517) drugs and provision of medical services. The benefits package which the NHIS is doing better at has been grouped into about six (6) categories which covers more than 95% of diseases in the country. These are out-patient services, emergency services, in-patient services, eyecare services, maternal services and oral health services. The scheme has also adopted the capitation method of payment which is still under review and will be fully implemented in no time. Also, it is putting in place the necessary measures to improve upon the quality of its human resource to develop their capacity for its development.

These findings agree with Blanchet et al. (2012) who highlights the reforms and evolutions of the NHIS in Ghana. This is important if we wish to see the NHIS evolve into a much better scheme, and adequately serve the healthcare needs of residents.

The NHIS can confidently boast of many successes with its main goal achieved. This is providing access to healthcare for the populace irrespective of their social class. In recent times, it has taken up the development of technology through for instance the mobile renewal service to make access to its services easier for all residents.

In identifying the challenges, it is evident that the NHIS is struggling financially which. With the issue of finance resolved, every hindrance to the smooth implementation of the scheme can equally be eliminated. The NHIA hopes to engage government and stakeholders to review the financial model of the scheme. The authority has proposed some sources of funding which includes revenue from the newly discovered oil resources, imposition of higher taxes on certain goods such as sugar, alcohol, tobacco etcetera. This is because the consumption of these products are the leading cause of various illnesses in the country. This initiative is to deter residents from its consumption.

This study found that lack of political will and low resources are key inhibiting factors towards achieving UHC in Ghana. These findings agrees with Agyepong et al. (2016) who highlighted the many challenges affecting policy implementation, funding and the appropriate structures
needed in place for the fulfillment of Agenda 2030. Also, the research study of Lagomarsino et al. (2012) showed that many countries in Asia and Africa relied mainly on taxation to fund their health insurance schemes thereby leading to instability in their health insurance policies. However, in the case of Ghana, the NHIS relies on other sources of funding aside taxation and this has helped to generate more revenue considering the number of people being catered for by the scheme and the low cost of contributions required of them.

The underlying theoretical framework, which is human security in chapter one emphasizes that good health is an essential need of every resident in the country agrees with the findings whereby the government is using the NHIS as a tool in Ghana to provide the needed basic healthcare for all its citizens. The NHIA receives support from the government through the NHIL, taxation, premiums and contributions of scheme members in order to facilitate its

activities. It was discovered that there is a need for every Ghanaian resident to enroll on the NHIS because healthcare is a necessity of life and since sicknesses are unforeseen circumstances there is a need to protect residents against it, as well as put in place measures to receive first hand access to basic healthcare in times of emergencies.

Despite the many hitches, the NHIA has been able to achieve many successes. It is ineludible that the primary objective of the NHIA which is ensuring primary access to healthcare by all scheme members across the country especially for the poor and vulnerable in society has been met. The authority is also making use of technological advancements to make operations and access to the scheme more flexible for its employees and clients in order to boost their confidence and gain their support in the drive towards achieving UHC by 2030.

4.2 Conclusion

The study disclosed that the NHIS is not an insurance company in the traditional sense. So, to be able to enroll about 70% of its members belonging to the exempt category is truly a step in the right direction. It is obvious that the entire establishment is making sure that the poor and vulnerable especially are given the chance to be provided for at the point of service. Notwithstanding the many challenges facing the smooth running and implementation of the NHIS since its inception, the NHIA is constantly reviewing its policies in the best interest of its subscribers and service providers. There is therefore the need for the whole country, Ghana to rally behind the NHIA to fulfill its UHC Agenda. It must always be remembered that a healthy population results in a better economy.

4.3 Recommendations

These recommendations are proposed based on the findings from the research and suggestions made by respondents during the interview process.

4.3.1 Recommendations to Government

- **Funding**

The NHIA is a very important organization in the country and must be treated as such. The government must endeavor to increase the proportion of the national budget to the scheme. Also, the reimbursement of the scheme must be made on time to prevent accumulation of debt.

- **Political Interference**

Government must enforce the provision of the law which requires registration of all citizens on the scheme. Again, issues that has to do with the NHIA should be devoid of political interference especially when there is a change of government to enable the scheme function independently and meet the needs of citizens.

4.3.2 Recommendations to NHIA

- **Finance**

The NHIA must endeavor to lobby with the government to increase its budget so as to enable the scheme increase its tariffs with regards to drugs and provision of healthcare services to motivate healthcare service providers to work harder. Also, the authority should consider the categorization of subscribers. That is, there should be a category that allows subscribers to pay more in terms of premiums and contributions provided they can afford it. The more a subscriber pays, the more benefits they gain from the scheme. Again, more drugs must be

added to the drug list to reduce out-of-pocket payments. Payment of claims to healthcare service providers must be made on time to facilitate the smooth running of the scheme.

- **Administrative issues**

The NHIS must make deliberate efforts to follow up timely on records, reports and claims submitted by healthcare service providers. The authority can introduce sanctions meted out on healthcare service providers who do not honor deadlines per the contracts signed with service providers. Also, renewal of licenses by the authority should be done promptly to enable service providers execute their duties.

- **Accessibility**

In cases of emergencies where patients do not possess their cards and have to be rushed to health facilities, the NHIA must put in place measures to ensure that they access basic healthcare provided they are registered on the scheme. Provision should be made for NHIS agents at healthcare facilities where cards can be renewed and accessed immediately in case of emergencies or when the subscriber is unaware that their card is expired. In addition, more surgeries should be included on the scheme to increase accessibility by subscribers.

- **Communication and Education**

The residents of Ghana must be communicated with and educated to understand the essence of enrolling on the scheme. They must also be made aware of the SDG and the need to achieve UHC so that they can easily cooperate with initiatives introduced by the scheme. For

instance, more awareness needs to be created on the newly introduced mobile renewal system.

- **Quality of service**

The NHIA must ensure that it's staff and healthcare service providers are receptive towards subscribers irrespective of their social class during registration and when they seek to access healthcare. The NHIA must consider setting up a foundation whose purpose would be to generate extra funds to provide hospital equipment, beds, laboratory tools etcetera which are needed to improve the quality of healthcare provided by health facilities. Also, the quality of drugs covered by the scheme is subpar and needs to be improved upon.

- **Technological innovations**

There is a need for the NHIA to introduce more innovative methods of executing its business. For example, the authority could consider the electronic monitoring, issuance of electronic receipts, claims and payments, online processing of membership cards, online access to folders by healthcare service providers in a single database, online processing of the form 'J' among others. These innovations are geared towards making work easier and faster for everyone. Again, the authority should take it upon itself to prompt subscribers of expiration dates of cards via text message to increase its active membership and promote accessibility.

4.3.4 Recommendations to Healthcare Providers

- **Submission of claims**

Healthcare service providers must make deliberate efforts to submit claims within the ninety (90) day stipulated period per the contract. It has been observed that delays in the submission of claims further affects the prompt execution of payments.

- **Loyalty to NHIS**

Healthcare service providers must serve as the backbone of the NHIA and desist from collecting unauthorized fees from subscribers so as to boost the confidence of residents in the scheme make it popular among Ghanaians.

4.3.5 Recommendation to Subscribers

- **Record keeping**

Subscribers must ensure that they keep appropriate records of expiry dates and strive to renew their membership on time to prevent any challenges faced at healthcare facilities.

- **Reception to Innovation**

Subscribers must endeavor to be receptive towards the innovations made by the NHIA and also put in concrete efforts to familiarize themselves with it.

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APPENDICES

Appendix I

INTERVIEW GUIDE

BENEFICIARIES

1. How did you know about National Health Insurance Scheme (NHIS)?

2. How long have you been enrolled on NHIS?

3. How much do you pay as contribution and at what interval?

4. Are you familiar with the NHIS registration process?

5. Have you renewed your health insurance card?

6. If yes, how was the renewal done?

7. Do you ever face challenges when using the NHIS to seek medical care?

8. How successful have you been in using the NHIS to seek medical care?

9. Would you recommend NHIS to others?

10. Are you enrolled on any form of health insurance aside NHIS?

11. Has your enrollment on NHIS reduced out-of-pocket spending?

12. In your opinion is NHIS living up to its expectations?

13. What recommendation can you give to improve upon the NHIS?

Appendix II

HEALTHCARE SERVICE PROVIDERS

1. What do you know about NHIS?

2. How does your medical facility benefit from NHIS?

3. What are the challenges that come with accepting NHIS cardholders at your facility?

4. In your opinion, is the implementation of NHIS geared towards achieving Universal Health Coverage in Ghana?

5. In your opinion has out-of-pocket spending reduced at your facility since the implementation of the NHIS?

6. Is the NHIS geared favorably towards exempt groups?

7. In your opinion what are some achievements made by the implementation of the NHIS?

8. In your opinion what challenges does your facility face with the implementation of NHIS?

9. What recommendations would you give to ensure the services of NHIS is improved?

Appendix III

NHIS STAKEHOLDERS

1. Is NHIS popular among Ghanaians?

2. Is there a need for every citizen to enroll on the NHIS?

3. What are the challenges facing the smooth running and implementation of the NHIS?

4. What successes has NHIS made since its implementation?

5. What do you know about the Sustainable Development Goals (SDG) and Goal 3 specifically Universal Health Coverage (UHC)?

6. What mechanisms are being put in place to ensure the fulfillment of SDG 3 in Ghana using the NHIS as a tool?

7. Is the NHIS particular about enrolling exempt groups in Ghana?

8. Is the NHIS particular about enrolling every Ghanaian and other persons' resident in Ghana?

9. What is the current state of NHIS since its implementation in 2004?