

# **The Implementation of the National Health Insurance Programme in Ghana – an Institutional Approach.**

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## *Abstract*

Ghana's Social Health Insurance scheme, introduced in 2003, aims to remove financial barriers to health care access and bridge the inequality gaps in health care. The scheme has been praised for its coverage, associated legal reforms, clinical audit mechanisms and for serving as a hub for knowledge sharing and learning within the context of South-South Cooperation. However, gaps and challenges have emerged in the implementation process and issues of universality, inadequate medical facilities and health care professionals, cost escalation and reimbursement of providers threaten the sustainability of the scheme.

The paper reports on a study of implementation in two local government areas in Southern and Northern Ghana. The research design has been informed by new institutional theory to help understand the roles played by the various actors in the formulation and implementation of the policy. The focus is on the institutional field, which has developed around the implementation of the programme. The paper will profile key actors, and draw on interview data with them in terms of their history, values and belief systems and examine whether these have been challenged by the insurance programme and analyse organizational processes in which actors engage.

## **Introduction**

Ghana implemented a social health insurance programme in 2004 as part of reforms aimed at “putting in place a mechanism that will ensure equitable access to an acceptable package of essential health services, without out-of-pocket payment at the point of service use for all Ghanaians” (Parliament, 2003) by removing financial barriers to health care. Prior to independence from Britain in 1957, access to health care was by the payment of some token fees mainly in the form of out-of-pocket payments at the point of service use (Arhinful, 2003; Agyepong and Adjei, 2008). Public and civil servants and their families within the colonial service were covered by the colonial government (Arhinful, 2003). At independence in 1957, the government of the Convention Peoples Party (CPP) of Dr Kwame Nkrumah abolished user charges in all government and public health institutions across the country. Healthcare was largely tax-funded and, therefore, people went to hospitals free of charge. Access to health services in the private sector, meanwhile, continued to be by out-of-pocket payment at the point of service use (Agyepong and Adjei, 2008). Following the overthrow of the CPP government in 1966 coupled with the growth in the population of the country and worsening economic conditions, much pressure was placed on the limited resources (Yevutsey & Aikins, 2010) as tax funding of health care was no longer sustainable. The government was forced to seek alternative and sustainable ways of financing health services.

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As an alternative, user charges were introduced in public health facilities across the country through a cost-sharing mechanism in 1969 with the enactment of the Hospital Fee Decree, (Yevutsey & Aikins, 2010). By the 1980s, however, shortage of essential supplies and equipments at the hospitals following the adoption of the IMF and World Bank structural adjustments programmes (SAP) by the Government in 1983 necessitated a review of the user charge policy. The SAP was adopted to cut down on government spending and ensure efficiency in public sector management. As part of the SAP, user fees at public health facilities were significantly increased (Osei-Akoto, 2004:13). The introduction of user fees was aimed at generating more revenue to finance the health sector and to discourage the frivolous use of health services. The 1983 and 1985 reforms succeeded in achieving the financial objectives to some extent but still fell short of expected revenue. The policy was subsequently, restructured in 1992, under what has become known as the “cash and carry” system in health care financing. The policy change aimed at full cost recovery by creating a policy of direct charges for usage of public health services in the country. At this stage, access to health care was based solely on ability to pay and, therefore, some people were being excluded from accessing health services. The drop in utilisation levels was sustained, particularly, in rural communities (Waddington and Enyimayew, 1989; 1990). There were reported cases of delays in seeking health care with often grave consequences (Shaw and Griffin, 1995; Oppong, 2001; Mensah et al. 2010) as the sick, unable to afford payment avoided attending hospitals, clinics and health centres. Sharing of prescription drugs became commonplace among households (Asenso-Okyere et al, 1997). The consequence of this was the emergence of new behavioural patterns, and health practices. These included delays in reporting sickness to health care providers, consultation at drug stores, partial purchase of prescription and sharing of prescription drugs with household members, self-medication by way of using other left over drugs (Asenso-Okyere et al, 1997:224). Some people also resorted to alternative methods of treatment such as traditional medicine, healing and prayers. Though the cash and carry system did achieve its financial objective and improved services in hospitals, the achievements were accompanied by visible inequities in financial access to basic and essential clinical services (Waddington and Enyimayew, 1989, 1990; Agyepong and Adjei, 2008; Gilson, 1997).

In the midst of the negative consequences of the cash and carry system, proposals for the establishment of a national health insurance emerged from national and international organizations and groups including: the World Health Organization (WHO); the European Union (EU); the International Labour Organization (ILO); the Ghana Medical Association (GMA) and Labour Unions such as the Trade Union Congress. On the basis of these proposals coupled with the success of existing community based mutual health organizations in the country, the government through the Ministry of Health (MoH) in the mid 1990s, created a unit to establish national health insurance as an alternative to “cash and carry” (Agyepong and 2008; Yevutsey & Aikins, 2010). A number of community based health insurance pilot projects were established as a precursor to the national health insurance scheme. Though the pilot projects were not particularly successful, the Social Security and National Health Insurance Trust (SSNIT) started planning for another centralized health insurance scheme to be run by a company called the Ghana Health Care Company (Agyepong and Adjei, 2008; Yevutsey & Aikins, 2010). This project failed to take off.

It was against this backdrop of several unsuccessful attempts that the New Patriotic Party (NPP) government, which had campaigned on the issue of replacing the cash and carry system won the general elections in 2000. In August 2003, the Government passed a National Health Insurance Act (ACT 650) that aimed to improve access and quality of basic health care services in Ghana by removing financing barriers through the establishment of

mandatory district level mutual health organizations (Yevutsey & Aikins, 2010). The NHIS is run nationally by the National Health Insurance Authority (NHIA), an autonomous body set up to facilitate, coordinate and regulate the health insurance schemes

Ghana has since made considerable progress with population coverage of 67.5% as of June 2009 (WHO, 2010). As of June 2010, total registered members consisted of 66.4%- an experience that is virtually unparalleled on the African continent. However, underlying these impressive gains in coverage are several challenges confronting the implementation of the NHIS. Indeed, even the coverage figures are disputed. An Oxfam report published in March 2011 put it at not more than 18%. The dispute about coverage figures were raised by a number of those who participated in the fieldwork for this study and their comments support the suggestion that coverage figures are lower than reported. This issue will be returned to later in the paper.

While policy makers, analysts and implementing officials and agencies point to a myriad of factors to explain the implementation challenges, far less attention has been paid to the characteristics of key actors and how they relate to one another. Yet, this is crucial to a nuanced understanding of the issues. Institutional theorists have long argued that as a regulative entity, institutions both constrain and empower social behaviour by enabling social actors and action, conferring licenses, special powers, and benefits to some types of actors (Scott, 2008). Thus, in the policy arena, powerful actors may sometimes impose their will on others through a number of mechanisms including use of threat of sanctions, and inducements to secure compliance. The institutional approach may provide a useful means of differentiating between the impact that different actors have on implementation of the NHIS in Ghana.

Di Maggio and Powell view the institutional field as: *“those organizations that, in the aggregate, constitute a recognized area of institutional life: key suppliers, resource and product consumers, regulatory agencies, and other organizations that produce similar services or products”* (1983:148). Actions and behaviours of actors are viewed as being dictated by norms and values. It is some of these values and norms that give rise to roles (conceptions of appropriate goals and activities for particular individuals or specified positions) within a particular institutional or policy setting (ibid.). In this regard, it could be argued that the roles of the various stakeholders in the national health insurance programme implementation might be dictated by the values and norms of each stakeholder’s institutional field. A clear understanding of the institutional field of the different stakeholders in the NHIS policy environment will help provide an insight into the role each of them played in the formulation and implementation of the policy and the relationships between various stakeholders.

## **Methodology**

The paper is based on a qualitative, comparative case study of the NHIS policy implementation process in two local government areas in Northern (Nanumba North Mutual Health Insurance Scheme) and Southern (Ashiedu Keteke and Osu Klottey Sub-Metro Mutual Health Insurance Schemes) Ghana respectively. The main aim of the study was to explore the role the different institutional actors played in the policy formulation and implementation process of the NHIS. Methodologically, two interlinked approaches have been employed in this paper:

- There was an extensive literature review of scholarly papers on the NHIS in Ghana from various databases including some unpublished but relevant data;
- The second methodological approach of the study involved in-depth interviews conducted with implementing Agencies and Institutions; Service Providers; Technocrats/Interest Groups; International Actors/NGOs; Politicians/Policy Elites; and Academics, Research Institutes/Think Tanks

These groups were included in the study because of the roles they played in the policy formulation and implementation process. The NHIA, its regional offices and the District Mutual Health Insurance Schemes are the frontline agencies responsible for implementation. The NHIA regulates and operate the national health insurance programme. The DMHIS are the local level implementing bodies that register clients, contract service providers for the clients, vet claims of providers and serve as link between service providers, clients and the NHIA. The service providers are the suppliers of health services to insured subscribers of the district schemes. Practical implementation is triangular with the DMHIS, the service providers and the subscribers. Their views are, therefore, indispensable to understanding the implementation process. The technocrats are the civil servants in the health ministry and the Ghana health service, who help in designing the policy and also assist in its implementation through training of DMHIS staff and advising the government on policy direction. They also conduct research on how to improve the programme. The International actors or development partners and NGOs were also included in the study because they provide technical and financial assistance to ensure efficient systems are put in place for the smooth operation and sustainability of the programme. NGOs, such as the Christian Health Association of Ghana also supply services through their health facilities. They also started the community based mutual health organizations upon which the current health insurance programme is based. The politicians or policy elites initiated the bill and continue to give direction to the national health insurance programme. Academics, research institutes and think tanks conduct evidence-based research into the national health insurance programme and propose policy recommendations.

Thirty three in-depth semi-structured interviews were conducted in the two local government areas between June 2011 to December 2011 and in February 2012. Prior to the main interviews, negotiation for appointments was sought by going to the offices and work places of the actors personally, through letters, emails, and phone calls. This was to acquaint the subjects about the study and secure their willingness to participate in the research. The table below shows the numbers of interviews by sector.

**Table 1**

<b>Sector</b>	<b>Number of Interviewees</b>
Politicians/Policy Elites	3
Implementing Officials/Sick Funds	13
Service Providers	5
NGOs/International Actors/Development Partners	5

Bureaucrats/technocrats/Civil Servants	3
Interest Groups/Professional Associations	2
Academics, Research Institutes/Think tanks	2
Totals	33

### **Context of Ghana's Social Health Insurance Scheme**

Six main contexts define Ghana's social health insurance programme implementation. These are: the cash and carry context; the political context; the socio-economic context, the context of non-consumption of health services; the context of existing community based mutual health organizations and the international context.

#### *The Cash and Carry system*

The major underlying context within which the national health insurance programme in Ghana finds meaning is the cash and carry system. The crises of cash and carry, which required upfront payment before treatment served as a barrier to health services. Sick people unable to pay were deterred from seeking medical care. The crises of user fees or full cost recovery had reached a point where politicians had to respond as utilisation levels dropped drastically in health facilities. Health insurance emerged as the best alternative and hence, the cost recovery policy played a part in the adoption of health insurance in Ghana. The argument that emerged, especially from the viewpoint of some stakeholders is that as a policy, the National Health Insurance Scheme is actually a natural development from the cost recovery policy with the scheme only replacing the payment at the point of service.

#### *The Political Context*

The major driving force that gave impetus to the adoption and implementation of the national health insurance programme is the political factor. As indicated earlier, after independence from Britain in 1957, Ghana financed health services in public health facilities mainly through general taxation. As the population grew from about 4.5 to 5 million at independence, coupled with the stagnation of the economy due to series of coups and economic mismanagement, funding social services including health services became difficult. Successive governments, both military and civilian experimented with various forms of financing healthcare ranging between free medical services and token fees or user charges. When Ghana returned to constitutional democratic rule in 1992 after twelve years of military dictatorship, civil society groups and other interests began making demands for reforms in the health sector. The cash and carry system, which was then in operation became the major political focus of debate in the 1996 and 2000 general elections in Ghana. Three political parties; the Peoples National Convention (PNC), the National Democratic Congress (NDC), and the New Patriotic Party (NPP) all promised to abolish the cash and carry system if voted into power. In 2000, on winning the election the NPP set up a ministerial health financing task force to design a national health insurance scheme. The political pressure to adopt a

national health insurance programme was intense and accounts for the establishment of a health insurance scheme being one of the first priorities for the NPP government. Thus, the political window presented itself for politicians to gain political capital, and they latched on to it and propelled the adoption of the policy.

### *The Socio-economic context*

Importance also has to be attached to the larger socio-economic context of pervasive poverty, especially in some regions and the rural parts of the country and widening health inequalities with regards to access and utilization of health services among the different socio-economic and demographic groups in the country. Given that majority of Ghanaians could not settle their bills at hospitals, clinics and community-based health and planning services (CHPS), the NHIS was adopted as the government's overall poverty reduction strategy so as to remove financial barriers to health care access. The national health insurance programme could be viewed as a poverty alleviating strategy given it aims to assist the poor gain access to affordable health care.

### *The context of non-consumption of health services (low utilization)*

Another context within which the NHIP germinated and blossomed was the non-consumption of health services due to the high rates of user charges and inability to afford out-of-pocket payments at the point of service use. The decline in the consumption of health care in the health facilities when maternal, infant and general mortality were increasing led to questions about non-attendance. The answer was simple - people could not pay. Access and utilization was, therefore restricted, not necessarily because of lack of essential drugs and other supplies at the facilities, but because of the financial barriers to health care. With money being the problem, policy makers saw health insurance as the right mechanism to remove that barrier by spreading risks and pooling resources in a fund.

### *Existing community initiatives (Activities of faith-based organizations)*

Prior to the adoption of the NHIS, communities themselves had taken up the challenge of access by establishing what is popularly called Community Based Health Insurance Schemes. They included sub-district schemes, work place schemes and faith based or religious groups' schemes among others. In all about 58 of them existed at the time across the country and the experiences of their operations were positive. With the potentially politically charged field, coupled with the many problems of the cash and carry system, these provided an example to politicians of an alternative. The government felt that it could replicate the successful management and operation of these smaller schemes on a national scale.

### *The International Context*

A year after Ghana implemented the NHIS, the World Health Organisation's General Assembly Resolution (WHA58.33) called on countries to adopt innovative health financing mechanisms as a way of making health accessible and affordable to all its citizens. The first two articles of the World Health Assembly urge member states: to ensure that health-financing systems include a method for prepayment of financial contributions for health care with a view to sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking care; and secondly, to ensure adequate and equitable distribution of good-quality health care infrastructures and human resources for health so that the insurees will receive equitable and good-quality health services according to the benefits package (WHO, 2005c).

Prior to the WHA Resolution, in 2001, African heads of states met in Abuja and pledged to set a target of allocating at least 15% of their annual budget to improving the health sector. Adopting and implementing innovative health financing mechanisms such as social health insurance was key to meeting this target. Thus, there was pressure at both global and African level to initiate more equitable and more effective health financing mechanisms. What was needed, therefore, was the political push, which was provided by the New Patriotic Party (NPP) government in 2003.

Overall, Ghana's health insurance has historical antecedents to its development and implementation but these are not the main focus of this paper.

### **Overview of the Ghana Health Insurance Model**

The ACT (650) establishing Ghana's model provided for three types of schemes: the District wide Mutual Health Insurance Scheme (DMHIS); the Private Mutual Health Insurance Scheme (PMHIS) and the Private Commercial Health Insurance Scheme (PCHIS). The DMHIS is a state-issued or sponsored health insurance programme and receives subsidies from the government for payment of claims and reinsurance in case of distress. The major sources of funding include 2.5% VAT on goods and services or the health insurance levy; 2.5% SSNIT contribution of formal sector workers; premium from informal sector workers, investments, donations, budgetary allocations, and other funding from donor partners. There are 145 DMHIS currently operating in Ghana as companies limited by guarantee. Initially they had their own boards but these have been converted to what is called caretaker committees in an attempt to impose greater centralisation.

In terms of coverage, it is "mandatory"<sup>2</sup> for every Ghanaian resident to be enrolled onto one of the three schemes but in reality there is no enforcement. It has a minimum benefits package of about 95% of all common diseases affecting Ghanaians and including general and specialist consultation review; general and specialist diagnostic; Antenatal care; deliveries (normal and assisted); caesarean session; and emergencies. For a complete list of the benefits package and exclusion list, see the NHIS website<sup>3</sup>. Each scheme can increase the benefits package based on its financial ability. Also, although there is a fixed premium across the various socio-economic groups as determined by the NHIA, there are variations across the 145 sick funds. The flexibility in premium and benefits package is to cater for local environmental conditions. While the north is Savannah grassland, the south is coastal tropical forest and the disease burden is not the same across the country.

### **Policy Actors and Some Basic Attributes**

Table 2 below is an institutional map of the social actors within the NHIP implementation policy environment. It can be seen that each institutional actor has its own functions and roles unique to its environment. The norms, values, ethics and biases differ from one institutional context to the other. However, based on Scott et al's (2000) model, the institutional roles and functions of the various social actors that populate the national health insurance policy environment overlap. How do these roles and the relationships between the actors impact on the policy formulation and implementation of the NHIS?

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<sup>2</sup> It is mandatory in the sense that ACT 650 requires every resident in Ghana to be enrolled onto one of the three schemes but there is no way or measure to enforce compliance

<sup>3</sup><http://www.nhis.gov.gh/?CategoryID=158&ArticleID=120&print=1>

Policy Actors	Institutional Attributes, Roles and Functions	Functions in the NHIP Implementation
<p>Ministry of Health (MoH)/Government (Political)</p>	<p><b>-Norms:</b> Sets Policy Agenda; introduce bills and change policies; design policies with the aid of bureaucrats in the ministry; engage development partners and other stakeholder in the health sector.</p> <p><b>-Economic Calculations:</b> Seek to redistribute wealth between the have and have-nots; reduce government's health expenditure by getting the public to contribute</p> <p><b>-Rules:</b> Follows government laid down rules; sometimes, logic of consequentiality rather than logic of appropriateness underlie official procedures</p> <p><b>-Hierarchy:</b> Authority is in the hands of the minister who is a politician. The civil servants or the bureaucrats support the execution of the government policy. There is a wide power distance between the politicians and the bureaucrats with regards to authority.</p> <p><b>-History:</b> Implemented several healthcare financing mechanism since independence from free health care, partial cost recovery through to full cost recovery as part of government's attempt to ensure sustainable funding of the health sector.</p>	<p>Governance, oversight</p>

<p>MoH/ Ghana Health Service (GHS) (Bureaucracy)</p>	<p><b>-Norms:</b> Implement health policies; Assist government in developing and shaping health policies in the country; Charge with the responsibility of providing quality health care services based on international standards.</p> <p><b>-Economic Calculations:</b> Generate enough internal funds to supplement government subvention; Employees are motivated to save lives. Use their special status to secure better salaries and working conditions</p> <p><b>-Rules:</b> Ministry of Health and Ghana health service and internationally acceptable standards. Follows logic of appropriateness.</p> <p><b>-Hierarchy:</b> Ghana Health Service; Ghana medical Association and the Private Medical and Dental Practitioners Associations direct the affairs and activities of members. Members do not however, religiously follow directives of their leadership when it comes to welfare matters.</p> <p><b>-History:</b> Since independence, the GHS has always implemented government healthcare policies together with other partners</p>	<p>Governance, oversight and suppliers of services</p>
<p>Service Providers</p>	<p><b>Norms:</b> Provide health care services, maintain standards and quality of healthcare, discipline, and values of members</p> <p><b>-Economic Calculations, Hierarchy, Rules and History</b> are about the same as the Ghana Health Service and other service providers since they work under the various umbrella bodies</p>	<p>Supplying Services</p>
<p>Civil Servants</p>	<p><b>-Norms:</b> Execute government policies without question. Undertake research for effective formulation and implementation of government policies; and monitoring, coordinating, evaluating and reviewing government policies and plans.</p>	<p>Advise government on policy direction of the national health insurance programme</p>

	<p><b>-Economic Calculations:</b> Ensure government expenditure is manageable; resources are well distributed; plan and manage expenditure for the benefit of all</p> <p><b>-Rules:</b> Non-partisan, secure tenure of office, continuity; neutrality; integrity and fairness</p> <p><b>-Hierarchy:</b> Authority is bureaucratically through several channels from the top to the bottom</p> <p><b>-History:</b> Carried out research on the health insurance programme since the mid 90s through piloting of number of projects</p>	
Political Parties/Interest Groups	<p><b>-Norms:</b> Seek Political power and set policy agenda indirectly through their manifestoes and ideologies. Seek the interest of members and have the formal right to participate in policy formulation that is of interest to them.</p> <p><b>-Economic Calculation:</b> Generate funds through various means including membership dues to promote their interest. Improve economic conditions of members</p> <p><b>-Rules:</b> Constitution of Ghana and Electoral Commission Acceptable Standards. Code of conduct</p> <p><b>-Hierarchy:</b> Democratic and consensus involving key leadership and members</p> <p><b>-History:</b> Interest groups since the 1970s have often called for health insurance programme, while political parties made it an issue from the 1996 general elections in the country</p>	Oversight and purchasers of Services. Suppliers of services
Implementing Officials and Managers of Insurance Funds (NHIA, Regional Offices of the NHIA and the	<p><b>-Norms:</b> Initiation of policy reforms in the area of the NHIP. Monitoring and Evaluation; Management of the insurance fund, claims payment. Registration of clients; issuing of ID cards</p> <p><b>-Economic Calculations:</b> Generate</p>	Purchasers of services and pooling and bearing of financial risks

DMHIS)	<p>enough funds to purchase services; ensure sustainability.</p> <p><b>-Rules:</b> According to the principles of the NHI law</p> <p><b>-Hierarchy:</b> Decisions are taking by the CEO and his or her management in consultation with the Health Insurance Council. District Scheme managers take decisions in consultation the Boards (Caretaker committee). Semi-autonomous in nature. Authority is a bit muddy in terms of governance</p> <p><b>-History:</b> Set up from 2004 to assist the implementation of the health insurance programme</p>	
NGOs & Int. Actors	<p><b>-Norms:</b> Assist states and government in the formulation and execution of policies of interests to them through the provision of resources and technical expertise. Helping in capacity development and building.</p> <p><b>-Economic Calculations:</b> promoting growth through Poverty Reduction; Encouraging citizens' contribution to healthcare; Encouraging borrowing (World Bank) of member states. Seeking sustainability of the scheme.</p> <p><b>-Rules:</b> According to their individual rules and regulations. Work according to their different cultural norms and values</p> <p><b>-Hierarchy:</b> Country representatives in consultation with home governments or heads take decisions regarding their operations and activities.</p>	<p>Supplying Services;</p> <p>Providing financial and technical support to the National Health Insurance Authority</p>
Academics, Think-Tanks and Research Institutes	<p>Provide analytical and research reports in specific policy areas on a consultancy basis.</p>	<p>Oversight</p>
Users	<p>Consumers of services.</p>	<p>Consumers of services</p>
Mass Media and other Civil society Organisations	<p>Throws light on government policies and makes input to policies through various channels</p>	<p>Oversight</p>

While the government through the ministry of health sets the national health insurance policy agenda, it requires the parliamentary committee on health and the bureaucrats in the ministry of health, development partners and other stakeholders to shape and frame a policy acceptable to the population. This requires consensus and effective control over the “street level bureaucrats” (district mutual health insurance schemes and health facilities and or service providers). Resources are also required from other sources such as development partners. However, the values of these different stakeholders are not always the same. There is also some blurring of responsibility and autonomy. For example, under ACT 650 (2003) DMHIS are semi-autonomous and only responsible to their boards as body corporate. Thus, when it comes to controlling them, they can assert their authority by pointing to this autonomy but when issues of paying claims arise, they look to the centre for financial subsidies. There are also clear challenges in trying to exert regulatory control over health professionals. Evidence suggests this control is resisted with health professionals going on strike to lever salary increases and better conditions of service from the Ghana Health Service (GHS) or the Christian Health Association of Ghana (CHAG). Thus, the professional status of the health workers can be used to challenge the rules when it comes to implementation of the programme. At the time of writing (February 2012), some accredited private service providers under the scheme withdrew service provision in the Ashanti region of Ghana because of the piloting of capitation (rather than the current Ghana Diagnostic Related Group payment method) under the programme as a cost containment measure. The impasse has, however, been resolved after several meetings with the service providers

The National Health Insurance Authority is the regulatory body and operator of the National health insurance programme with the assistance of the regional offices. The regional offices main functions are to act as monitoring and evaluation agencies over the district mutual health insurance schemes and the service providers. The structure in terms of authority of the NHI programme, however, constrains and challenges the authority of the regional offices. . One interviewee observed that: “they choose as and when it suits them to be autonomous”. At the national level, though the NHIA by law is an agency of the Ministry of Health and supposed to be answerable to the minister in its operations, it is noted that “*the chief executive is supposed to report to the Minister of Health (MOH) but in practice what happens is that the CEO deals directly with the presidency. The MOH may just get a report but most of the day to day discussions are direct with the presidency*”<sup>4</sup>. This situation tends to undermine the civil structures put in place for the implementation of the programme.

The international actors or development partners (DANIDA, World Bank, WHO, Dutch Government support through the Dutch Embassy) and the NGOs see their role as ensuring that there is a sustainable means of financing for the health sector. The health insurance programme is, thus, a project in that direction and hence their support for the programme. In terms of norms and values, culture, economic calculations and other attributes, however, there are some differences, which challenge the process. The World Bank is a strong advocate of people contributing to healthcare financing. The Dutch government and DANIDA are greatly influenced by their egalitarian principles of equality and fairness in society, while the WHO seeks to ensure innovative and sustainable means of financing healthcare by providing technical assistance and advice to the government. The WHO leads the development partners in the health sector working group where inputs and advice are made towards ensuring the efficient running of the scheme. However, the basic challenge is

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<sup>4</sup>Interview with a stakeholder in Ghana

that sometimes the suggestions and advice of the group are ignored by the politician, who has different norms, values and orientation of doing things.

Academics, think tanks and research institutes conduct evidence-based research and advice government on how to proceed with regards to the programme. One such organisation is the Centre for Health and Social Services (CHeSS), has recently carried out research on the health insurance programme.

### **Challenges to Implementation**

This part of the paper seeks to present some of the impediments or challenges to the successful implementation of the NHIS and uses data from the interviewees with key stakeholders. Though generally regarded as a success in Africa, especially, in terms of coverage, and one of the best and widely accepted policies in Ghana since independence, stakeholders admit there are still serious challenges to the smooth implementation of the programme. Indeed, in the two local government areas, Nansumba North District Assembly and Accra Metropolitan Assembly, not all the same challenges pertained due to variations in local conditions; it is, however, the configuration of some of the factors presented below that militate against the effective implementation of the scheme.

#### *Capacity Development Weaknesses or Managerial Inability*

Since the inception of the programme, a major impediment to successful implementation has been the lack of capacity development or managerial ability. Empirical evidence from the two case studies in the study attests to the fact that the lack of capacity or managerial ability is not only peculiar to the sick funds or mutual schemes but also on the part of service providers to render quality service to the people. Though those employees who began the schemes way back in 2004 were giving some sort of training, the change in government in 2009 saw most of these management staff at the sick fund level either dismissed or transferred to the regional or national levels. Few of the management staff at the mutual scheme or sick funds level has any background in the operation of insurance or health economics. They have no basic medical background but regularly have to deal with health professionals to purchase services for their clients. Likewise, claims managers do not have basic medical background it is often difficult for them to challenge the medical professionals about prescriptions and billing of the schemes. There has also been a question about the relevance of the criteria (including lack of emphasis on insurance or finance) for recruitment of personnel into the district mutual health insurance schemes, the regional offices of the National Health Insurance Authority (NHIA) and the Authority itself. The Political nature of appointments was noted by an interviewee: *“once you have politics; and you appointed people; and you set up so many mutual schemes with management, who have no idea, people who were given appointments for political reasons, you have these kinds of problems we are facing now”*.

As argued by a technocrat in the Ghana Health Service, service providers neglected fundamental issues regarding their own role in organising their facilities during the setting up of the schemes. Questions such as how many facilities would be required to cope with anticipated increased in numbers, what equipment and personnel would be needed in those facilities with the implementation of the NHIS were all relegated to the background. The outcome of this neglect is now glaringly obvious across the country and can be seen in the pressure on resources, the lack of health facilities and the lack of expansion. Another challenging issue is the service providers' lack of capacity and capability regarding claim management and the technological and specialist knowledge needed for this. Indeed, to most of the service providers, health insurance is a new area. Training of personnel in all these

areas is costly and sometimes because of the lack of the requisite personnel to vet and submit claims as early as possible, it takes time to get reimbursement. A service provider observed that: *“we do not have enough trained personnel who are into claims. We are now taking people and training them and the prescribers, some are not filling the diagnoses and you have to go through every form”*. Other service providers concurred that this is a big challenge to them.

### *Spatial Distribution of Health Facilities and Personnel*

The challenges outlined are exacerbated by the spatial distribution of health facilities across the country. In the two local government areas in this study, the impact of the skewed distribution of facilities and health personnel is glaring. The Greater Accra Region alone as at 2008 had 320 health facilities while the Northern Region had 237. During the same period, the Greater Accra region accounted for 4,599 hospital beds with 1,310 in the Northern region. There is less difference in the doctor to population ratio in the two areas. The population in Greater Accra is far bigger than in the North but the Northern Region is the biggest administrative region in the country and one of the poorest as well with communities sparsely located. In the Northern region certain areas or communities have no access to even Community-based Health Planning Services (CHPS). The Ghana Health Service law stipulates eight kilometres for access to health facilities, yet on the ground, some patients have to make over 24 kilometres before they can access health services. While in most parts of Europe or America travelling such a distance would take relatively little time, in Ghana, it might take about three hours. Thus, the skewed and spatial distribution of health facilities and personnel is a serious hindrance to the implementation of the health insurance programme as subscribers can hold cards without being able to access health care because of the non-availability of facilities. Besides, the accreditation criteria by the NHIA require that every district hospital should have at least three doctors, ultra sound machines and many other types of equipment. On the ground, however, this is not the case as evidenced from one of the facilities in one of the two local government areas. The district hospital has only one non-resident doctor, who comes every Tuesday, and leaves on Friday morning or evening. Thus, patients do hold health insurance ID cards but no access to doctors. There is also evidence of two kids being admitted to the same bed presenting a very high possibility of cross-infection.

### *Take- up of Membership Cards*

While there is some evidence of growth in registration in the two case study areas, the actual take up of membership cards at the districts and sub-metropolitan offices is much less. One of the interviewees noted:

*“If you go to any of the schemes, ask you will see that they have a box of these cards sitting there and they are not able to send them back to their owners. What is happening there is that on the register, the membership is high but when it comes to card holding, there is that difference”*.

Some of the schemes explained the problems with the distribution of membership cards. During the registration process, registration points were created all over the districts or sub-metros to enhance proximity and facilitate enrolment. Agents were also recruited on commission to go to the various communities in each district to register people. Other agents visited some communities on market days and registered subscribers. Now the cards are being kept at the district and sub-metro and municipal offices without any attempt to go and distribute them where they were registered. This problem is compounded by deficiencies in

the address system in the country. There is also the argument that those in the hinterland areas see no point in collecting the cards if they cannot have readily available access to facilities. A myriad of factors, therefore, play into the inability to distribute the cards to their owners, which in turn questions the coverage levels as some cards are never picked up until they expire - even though they are still counted.

### *Sustainability*

There is no doubt that Health Insurance has brought a lot of relief to families who could not afford to pay for their medical bills. Concerns have, however, been raised about the continuous operation and successful implementation of the programme in the long term. Clinical audits instituted in 2009 revealed massive fraud and corruption both on the part of the schemes and the service providers. Facilities got reimbursement for caesarean operations on men while scheme managers acquired so much wealth and property in no time. Again, there were reported cases of rural community clinics with no caesarean surgeons and no capacity for caesarean delivery being reimbursed for such services. At other times, monies were found to have been paid to non-existing facilities. In addition, there is an abuse of the gatekeeper systems by the providers, which is putting further strain on the financial sustainability of the scheme.

The following statements from an academic and a labour unionist respectively point to the level of fraud and corruption that has engulfed and is threatening the financial sustainability of the scheme:

*Many scheme managers have built houses, many health care providers have built houses, many pharmacists have built houses in no time because there are too many loopholes in the system that people can tap in. I can treat you for one disease and bill you for something else that I deem fit; there is no way you would know...If I am in the same house with you, you are sick, and you do not have a card, I would take your sickness ... and go and describe it as much as possible, bring the medicine to you. If it is a child, the woman whose child is sick who is not insured would go with the woman who is insured whose child is not sick, then she would just swap the child.*

*We are told, for instance, that the depth of the fraud was so much that some people with the cards even when they were not sick were going to collect medicines either for their relatives or for other sick people who are not registered. You find out that somebody will be coming almost every day complaining sickness just because somebody wants a particular medicine and he wants to help them out.*

Due to fraud and lack of risk management mechanisms, as well as the ambiguity of the Ghanaian health insurance model, the managers of the NHIS invest resources from the health insurance fund in areas that are not health related or purchasing of services. An actuarial study conducted estimated that if additional funding sources are not explored to support current funding, the scheme could collapse by 2014. The initial actuarial calculation showed that by the year 2014, if nothing was done to address the income source of the health insurance, it would run into a deficit<sup>5</sup>. A contributing factor to the problem of sustainability is the low rate of premiums. They are not based on any actuarial calculations – and the benefit package is very broad. At the inception of the scheme, only about four million people were registered but now over sixteen million are registered and the premiums and health insurance levies are still the same. Delay in reimbursement of service providers could be

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<sup>5</sup> Interview with the Ghana Health service and a former minister of Health

attributed to this lack of adequate funding. Though the World Bank has put in place \$15 million to assist the scheme, concerns have been raised about the way funds are utilized. Besides the financial sustainability, there are also concerns about political sustainability. Almost all interviewees agreed that no political party would attempt scrapping the health insurance programme. However, political interference in terms of appointment of the CEO, day-to-day management of the scheme, recruitment at scheme level as avenue for job for party members all go a long way to affecting successful implementation.

#### *Client Shopping or Facility Shopping*

An interesting revelation that came up as one of the major impediments against the smooth operation of the national health insurance programme is what stakeholders described as client or facility shopping. This is a process where an insured patient moves from one health facility to the other with the same sickness within a short period of time with the aim of securing medicine which they then can sell. Even though mechanisms have been put in place to check for abuse, the fact that medical facilities are not networked makes it difficult for service providers to tell whether a patient has been to a particular facility earlier or the previous day and what medicines have been prescribed. One respondent laments thus: *“there is a leakage in our system where a client can move from one provider to another within a day. He or she collects drugs here in SDA hospital, move to Central Hospital, collects drugs, go to Teaching Hospital collects drugs, put the drugs together and sell it to a quack doctor or a quack chemical store and make money. That kind of thing, client shopping, they are shopping, using it to make money. That is our difficulty we are facing and is threatening the scheme”*. The perception is that a majority of people see government facilities as a place where people make free money and this could account for this kind of behaviour.

#### *Anticipating Developments (one off payment)*

Membership enrolment has been praised but in fact membership renewals have been very poor and going down both in the urban and rural areas – including the two case study areas. Many subscribers want a one-time premium payment that would bring entitlement to health care access for life. Others fear that such a move could collapse the scheme and are thus reluctant to renew their memberships or even register at all. Change expectation is thus one major factor that has affected the operation of the scheme on the part of both the clients and even scheme staff. The operations of the scheme are constrained in a way because of the lack of direction to scheme staff. Schemes are semi-autonomous by ACT 650 but over the last few years, this autonomy is gradually being taken away. Recent developments demonstrate clearly that the NHIA is moving towards a central role. This in the view of the scheme staff ought to happen quickly to help alleviate the negative impact of uncertainty. This uncertainty is one thing that serves as a challenge and it affects almost everything. One scheme staff asserts: *“it affects the community, it affects the morale of the scheme members, it affects service delivery to clients. It affects the image of NHIS itself and if something is done quickly to get all of us to sing with one voice to be doing the same thing at the same time, I’m sure it will go a long way to help”*.

#### *Reimbursement Blues*

Facilities pre-finance the treatment of health insurance card bearing members before submitting claims at the end of the month for reimbursement from the NHIA through the DMHIS. Indeed, health insurance has guaranteed funds and ensured that funds do not get lost through corruption and embezzlements as the money is paid directly into the accounts of the facilities. But the delay in reimbursement, of often three or four months has created difficulty.

The mutual schemes maintain that part of the problem is due to late submission of claims by the facilities. For their part, the facilities counter that according to the NHIS Law, invalid claims do not measure up to 10% of what is submitted for reimbursement. The impact of the reimbursement delays as evidenced from the interviews as claimed by some providers is that the long waiting period has forced them to reserve about 40% of monthly treatment to cash paying patients so as not to go broke. Some also prefer cash paying patients where they can take their cash for supplies and equipments, which for some time now are no longer being provided by the Ministry of Health but from the internally generated funds.

## **Discussions and Conclusions**

The implementation of the National Health Insurance Programme in Ghana has increased financial access and utilisation of health services to the majority of residents in the country. However, many challenges still abound as seen above. Besides the basic norms, values and core roles; hierarchy; economic calculations, rules and history, the implementation of the programme as a new policy has reconfigured roles, structures, and incentives, thus changing the array of costs and benefits to implementers, direct beneficiaries, and other stakeholders (Brinkerhoff, 1996). By helping to shed light on the nature and dynamics of the key stakeholders, knowledge of the institutional field could help an understanding of how to build consensus among the various actors and minimise challenges in the implementation process. A former manager of a district mutual scheme observed that: *“from the Authority to the scheme level, we are not health professionals, we are just administrators and so the health professionals have an advantage, very huge advantage over health insurance staff... You sit down before the doctor, he starts mentioning his medicines, he starts mentioning his scientific things, and he gets you confused. You might attempt challenging but you will be defeated and so whatever they send to you to pay, certainly you have to pay ... Even if you send it to Accra to the Head Office, you still have to pay the bills... So you as a layman, you are a little bit handicapped to challenge him on his professionalism”*. The special status, skill and knowledge of the health profession thus make this group of actors more prominent and influential over other actors. Buttressing the need for understanding the institutional field of the various actors, another scheme staff notes that: *“the Authority still needs to do some training for the staff at the scheme level because most of the time what happens is that we are dealing with finance; and we are dealing with medical people”*. The special training especially, of the medical personnel tends to empower them over the mutual schemes in the implementation process. However, the claims’ vetting and clinical audit process by the mutual schemes strengthen their hand in dealing with the providers. This sometimes results in conflict and tension between the providers and the schemes.

In similar manner, while the government seeks to redistribute wealth and share risks through the National health insurance programme, donor partners, especially the World Bank aim at ensuring sustainability of healthcare financing in the country through citizen’s participation. According to a bureaucrat, the Oxfam Report, which puts the coverage figures at not more than 18%, is indicative of a conflict between UK ideas (the promotion of free health care) and World Bank ideas - which favour US thinking. The World Bank wants countries to take a more business approach with loans so they are in business. These examples demonstrate the need for a nuanced understanding of the institutional field of the stakeholders if effective implementation of the programme is to be achieved.

Thus, as institutionalists argue, to the extent that each of the actors has their interests and preferences to protect in the health insurance programme, there are bound to be challenges as the more powerful ones seek to impose their will and desires on the less powerful ones. What

is important is that the stakeholders within the programme environment will have to compromise their institutional positions somehow and adjust to their new roles imposed on them because there is a relationship between successful implementation and the existence of dense networks of local organizations that enables communication flows among parties with different interests at the various level of the implementation chain.

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