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Building on Community-based Health Insurance to Expand National Coverage: The Case of Ghana



Mutual Health Organization Growth Meets a Big Bang National Reform

Executive Summary: Ghana’s National Health Insurance Scheme has captured the global health community’s attention as one of the most ambitious plans for universal health coverage in Africa. From modest growth of mutual health organization (MHO) schemes to a rapidly scaled-up and centralized national program, Ghana holds a wealth of lessons in ways to raise revenue, pool health and financial risk, and organize purchasing from public and private providers. These lessons include the politics of navigating health finance reform, limitations to scaling up from MHOs, and challenges to achieving and sustaining universal health coverage.

Box 1: Country Case Series

MHO schemes have been criticized for creating small risk pools, offering limited service coverage, and being vulnerable to bankruptcy. Debate remains, however, on whether and how community insurance schemes can be leveraged to expand coverage to poor and rural populations.

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Introduction

Enacted in 2003, Ghana's National Health Insurance Scheme (NHIS) is a prominent model for African countries striving to achieve universal health coverage. It is a uniquely ambitious model: the only one in sub-Saharan Africa that aims to provide a standardized, nearly comprehensive and portable package of health benefits to all residents, delivered by accredited public and private providers who are reimbursed from a single national fund with no fees at the point of service, and that collects 90 percent of its revenues from dedicated taxes (portions of value-added tax (VAT) and payroll). The NHIS is the product of a half century of health financing policy development, a decade of experimentation with community-based mutual health organizations (MHOs), and competitive democratic politics in response to public backlash against user fees. About one in three Ghanaians now benefits from the health and financial risk protection from NHIS enrollment [2], far greater than the coverage in 2003; however, the program faces major challenges of financial sustainability, quality, equity, and—still—basic coverage for the remaining two-thirds of Ghana's 25 million people.

The Ghana case holds myriad lessons for other countries striving to increase access to affordable health care, on concerns such as national-level financing and risk pooling, the merging of centralized authority with decentralized administration, and the purchasing of health service from public and private providers. Since the creation of the NHIS followed a proliferation of MHOs in the 1990s, this case study focuses on the opportunities and limitations that other countries could experience in trying to leverage community-based health insurance (CBHI) for national-level (universal) health coverage.

From MHOs to NHIS

Community-level and national-level health insurance are part of a 50-year history of health financing changes in Ghana, with influences tracing back (at least) to the country's independence in 1957. In the immediate post-colonial era, Kwame Nkrumah's government ended the pre-colonial practice of paying for health services at the point of use and provided some free services in public hospitals, health centers, and pharmacies—funded by general tax revenue. However, many geographical areas and populations had little physical access to care and the depth of care was quite limited. Nationally, in the 1960s, there were only approximately 0.8 hospital beds and 0.1 physicians per 1,000 population [4], mostly located in southern Ghana. Private care continued to require out-of-pocket payment. Economic stagnation led to the introduction of user fees in 1972 and increased reliance on such fees through the 1980s. By 1985, structural adjustment policies had led to increased public sector user fees known as “cash and carry” that intended to recover at least 15 percent of recurrent expenditure [5].

Cash and carry stabilized the finances of many facilities, but decreased access to health care, especially for the poor [6, 7]. The system was deeply unpopular and efforts to implement exemption policies for the poor were largely unsuccessful [8]. Accounts of patients being physically detained at hospitals for lack of ability to pay were not uncommon [9].

The Catholic diocese in Sunyani district is recognized as being the first to experiment with community-level health insurance to improve financial access to care, by piloting and then launching the Nkoranza Community Health Insurance Scheme at St. Theresa's Hospital between 1989 and 1992 [5, 10]. The Nkoranza scheme flourished and by 2000 had enrolled nearly 30 percent of the district's population [1].

While it had challenges, the Nkoranza scheme's growth helped inspire both the Ministry of Health planning for health insurance and the creation of other MHOs by faith-based groups, health providers, and geographic and employment-based communities—with increasing support from external donors. DANIDA and the USAID-funded Partnership for Health Reformplus (PHRplus) project played an especially important role in equipping and providing technical assistance (e.g., development of training materials) to the growing body of MHOs [5]. By 2001, a survey of MHOs recorded 47 schemes across 34 districts and noted that the inventory was not comprehensive [11].

Despite proliferating to more than 140 schemes by 2002 and forming their own Network of Mutual Health Organizations of Ghana (GNEMHO), MHOs covered only about 1-2 percent of Ghana's population prior to the creation of the NHIS. Services covered for enrollees were also quite

limited, as schemes had to operate and pay for benefits entirely from members' very modest premium payments and registration fees. Benefits packages were thus quite limited, varied across schemes, and were not portable outside of the few providers with whom a given MHO contracted (or was based within, as in the case of the Nkoranza scheme—see Box 2). Community participation and sense of ownership among enrollees of MHOs tended to be high, however, and the GNEMHO certainly viewed itself as a foundation for organic growth and improvement of the community-based, autonomous schemes [10].

This period of experimentation and organic growth, however, ended with the relatively rapid drafting and legislative enactment of the NHI Act in 2003, certainly a “big bang” within Ghana's post-colonial health financing reforms. However, it was a big bang that had decades-old origins and that did leverage some of the MHO experience.

Box 2: A Comparison of Two pre-NHIS MHOs

Prior to the NHIS, MHOs shared some features but also varied in their structure and operations. The Nkoranza and Okwawuman schemes illustrate some of these similarities and differences.

The Nkoranza Financing Community Health Insurance Scheme was hospital based. It covered services at St. Theresa's Hospital, other inpatient care referred from the original hospital visit, prescriptions not available in the hospital, and outpatient visits for snake bites. The scheme was directly administered by the hospital, with hospital staff in charge of claims processing and provider repayment. “Community ownership” was virtually nonexistent [1]. Conversely, the Okwawuman Health Insurance Scheme was administered indirectly by individuals chosen by the board of trustees, which was in turn chosen by the entire community of enrollees known as the “General Assembly.” The Okwawuman scheme had more robust coverage, paying for inpatient care through contracts with two hospitals; outpatient care above a monetary threshold; cost of caesarian sections; cost of treating dog, cat, and snake bites; and treatment for referrals outside the scheme providers within a month of hospitalization [3].

Both schemes were financed primarily by annual premium payments. In 1998, the premium per person in Nkoranza was 5,000 cedis (former currency valuation), and the premium per person in Okwawuman in 2002 was 15,000 cedis—exemplary of the range of informal sector premiums that was then deemed feasible in the NHIS design. Both schemes tried to mitigate adverse selection by insisting on or strongly encouraging household enrollment, but neither was completely successful in enforcing that policy or eliminating such selection. Both schemes paid providers on a fee-for-service basis. In Nkoranza, because the scheme was integrated into the hospital, there was no independent authority to verify claims or protect the scheme against provider-side moral hazard/induced demand. The district director of health services in Okwawuman examined claims before paying the provider for services, creating at least one level of oversight within the scheme to combat claims fraud.

Nii Ayite Coleman, former director of policy, planning, monitoring and evaluation at Ghana's Ministry of Health (1998-2001), cites evidence that Ghana's Ministry of Health established a committee to study national health insurance as early as 1970, and that further planning occurred in the mid and late 1980s, with technical assistance sought from West Germany and office space requested for a National Health Insurance Project Management Unit [10]. As civilian rule with competitive, multiparty elections returned to Ghana in 1992, National Democratic Congress' (NDC) and National Patriotic Party's (NPP) routinely promised to address user fees and establish health insurance in their manifestos from 1992, 1996, and 2000. The World Health Organization and International Labor Organization assisted the Ministry of Health to study social or national health insurance, and government officials (NDC-led at the time) reported feeling "immense pressure to put the National Health Insurance Scheme in place soonest" (Ministry of Health letter from 1995 cited in [10]).

In the mid-1990s, government policymakers believed that a single, national scheme was unlikely to be feasible, but rather contemplated (and planned pilot projects for) multiple schemes potentially to be underwritten by the Ghana Healthcare Company (GHC). The GHC was in fact incorporated in 1999 and was intended to "provide country-wide health insurance services... assist in abolishing the 'cash and carry' system, and also serve as a catalyst for the development of other insurance schemes" (GHC Corporate Statement, 2006, as cited in [10]). Despite pledges by the government to enroll its employees in the company and major capital investments by Ghana's Social Security and National Insurance Trust (SSNIT—Ghana's social security program for formal sector employees), the GHC never began operations and disappeared from the government's health insurance planning after the change in government in 2001 [11]. By the end of the 1990s,

despite these planning efforts for a national-level (with multiple schemes) health insurance system, government policymakers, including an individual given the title Director of National Health Insurance Scheme in 1998, encouraged regional health officials to support the burgeoning MHO movement, collaborating with local initiatives and DANIDA to support community-based and, increasingly, district-wide MHOs.

Following a campaign focused heavily on promises to abolish cash and carry and establish health insurance, the opposition NPP won the presidential and parliamentary elections in December 2000, ushering in the first democratic turnover of power of Ghana's Fourth Republic and leading directly to the NHIS's enactment. The post-2001 policy design phase of the NHI Act is detailed in several papers [5, 10, 12, 13], but the key developments were the following:

1. Technocratic-led early planning efforts by the Ministry of Health, with key public and private sector stakeholder representation, proposed building on existing MHOs iteratively toward a nationally regulated but still decentralized national health insurance system.
2. The minister of health chose new leadership for the first planning taskforce, and two subsequent planning teams were given three mandates that aligned with NPP political priorities. As Rajkotia reports, the mandates for the NHIS design were that "the policy had to:
 - ▶ Result in the establishment of a national system that could quickly be scaled up to cover the majority of the population;
 - ▶ Be publicly perceived as a new initiative, not merely as a continuation of previous government's efforts; and
 - ▶ Be formulated and passed through Parliament before the next elections in 2004." [13]

3. Ghana's districts (110 at the time) became the primary foundation for the planned implementation and rapid roll-out of the new NHIS, a choice that combined four influencing factors: (a) the growing MHO experience, especially a pilot district scheme in Ejisu; (b) the mandate for rapid scale-up of a clearly national program; (c) the ongoing decentralization of governance in Ghana; and (d) the district-based administrative structure of the Ministry of Health and the Ghana Health Service (GHS).
4. Increasing and earmarking Ghana's VAT to finance the NHIS is a major part of the MHO-to-NHIS transition and a critical feature for other countries to consider. The International Monetary Fund was recommending that Ghana increase its VAT in 2003, but the government resisted due to strong public opposition to the previous (Rawlings') administration's attempt to do so in the late 1990s. However, an earlier VAT increase specifically earmarked for education had passed without such opposition, which inspired the minister of finance to propose a similar financing mechanism for the NHIS [14]. This confluence of external pressure on the VAT, the need to address the "cash and carry" crisis, and the country's prior experience with earmarking a VAT increase would be difficult to replicate, but was (and is) vital for the NHIS's broad national scale-up. It is also consistent with the historical trajectory of health insurance expansion elsewhere, where state intervention is usually necessary to begin achieving universal coverage.
5. As the NHI Act legislation took shape, external donors raised major concerns about financial sustainability and losses of investments in MHOs; the network of MHOs, whose organizations would be forced (and ultimately were forced) to suspend operations or merge with new district schemes; the opposition party (NDC); and unions, who were concerned with effects on health providers and the

impact on pensions from the carve-out of social security taxes for the National Health Insurance Fund (NHIF). The opposition party ultimately boycotted the compressed debate on the NHIS legislation.

6. Thanks to Ghana's strong presidency, NPP's control of the presidency and parliament, and the limited ability of the opposition party to stop legislation in Ghana's unicameral parliament, the NHI Act passed in August 2003, followed by the more detailed Legislative Instrument in 2004. Actual operations began in late 2004.

NHIS Today

The current NHIS is very different from the MHOs that preceded it, but some influence of the MHO era remains (Annex A, Table A.1). The NHIS is managed by the National Health Insurance Authority (NHIA), a centralized government agency with headquarters in Accra. The NHIA licenses and regulates the district mutual health insurance schemes (DMHIS), which each District Assembly was required to help establish by the NHI Act. (District assemblies are district-level government authorities, with locally-elected and presidentially-appointed representation.) The NHIS also accredits public and private providers, reimburses DMHIS for claims submitted or processes claims directly, and is generally responsible for policy and overall operations. DMHIS, which are legally autonomous corporate bodies, were originally intended to be governed by locally-elected boards and managers (following the spirit and practice of MHOs), but governance has been increasingly centralized and local boards disbanded since 2008.

Contrary to the MHO model, the NHIS is financed on a national basis from a single NHIF—a national risk pool. Revenue sources include the NHI levy (VAT) of 2.5 percent on most goods and services (about 75 percent of NHIS revenues), a

2.5 percentage point diversion of SSNIT payroll taxes into NHIF, NHIF investment income, donor funds, and only about 5 percent of revenues from informal sector members' premium payments. Individual enrollment is technically mandated by law but not enforced. The majority of the population is exempted from paying premiums (under 18, over 70, SSNIT members, the “core poor,” and pregnant women), but others must pay annual premiums of about US\$8–12. The benefit package is standardized nationally, portable, and far more generous than the MHOs' benefit packages were. It is intended to cover 95 percent of disease conditions in Ghana and includes primary, secondary, tertiary, and pharmaceutical goods and services. There are no copayments or other fees at the point of service. NHIS enrollees may access benefits at NHIA-accredited public and private providers.¹ Public providers are led by the Ministry of Health and GHS and organized by national, regional, district, and sub-district facilities. Private providers vary from thousands of chemical sellers and pharmacies to secondary-level hospitals, the Christian Health Association of Ghana, and other faith-based providers [15].



¹ Public providers received automatic accreditation when NHIS started, but now follow the accreditation renewal and post-accreditation monitoring process with private providers.

Impact

Dozens of studies have evaluated the impact of the NHIS. Several key findings are highlighted below.

Utilization

The clearest finding is that NHIS enrollees use health services more than non-enrollees overall and are more likely to use formal care services [16-19]. Measuring the true effect of NHIS on utilization is complicated by voluntary selection into the scheme, but studies that control for such bias have still found higher utilization among enrollees, including for visits to outpatient clinics and hospitals, pharmaceutical usage, prenatal care, delivery in facilities, and other maternal health services [19-23]. The impact of NHIS on non-enrollees' utilization is unclear.

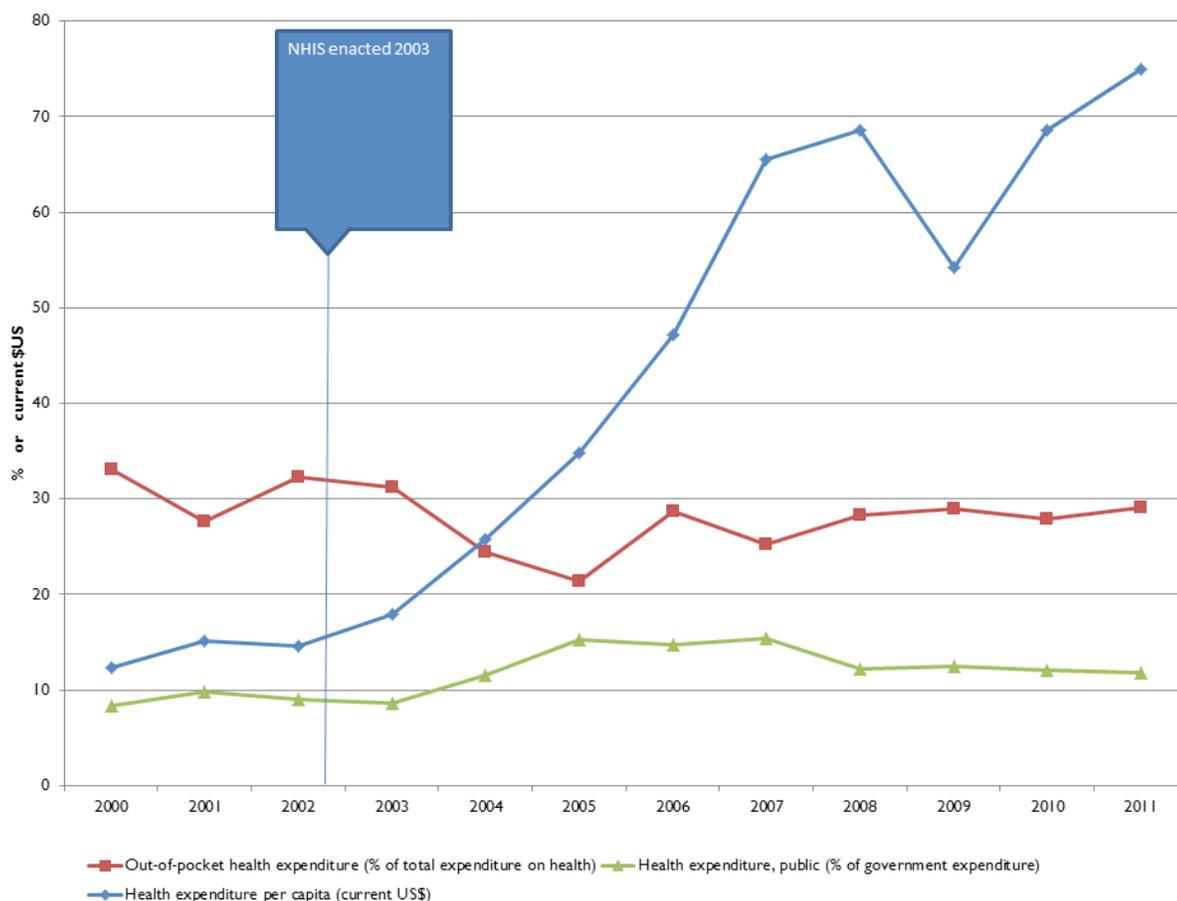
Financial risk protection

One of the original goals of the NHIS was to reduce Ghanaians' exposure to financial risk, and results have been mostly positive for enrollees. Alatinga and Fielmua found that the insured pay about half as much as the uninsured for services [16]. Health Systems 20/20's analysis showed that insured patients paid less out of pocket than the uninsured for outpatient services, hospital payments, and maternal services [19]. Nguyen et al. found that the insured were less likely to have catastrophic health care payments [24], but Brugiavini and Pace found NHIS enrollment only slightly correlated with lower out-of-pocket spending [25].

Quality of care

The evidence on NHIS's effects on quality of care is inconsistent. In an analysis of household data, measures such as waiting time at health facilities, perceived attitude of health professionals toward patients, and general satisfaction with services did not vary between insured and uninsured populations [16]. In the 2008 Citizens' Assessment

Figure 1: Health Spending in Ghana Before and After NHIS



Source: World Bank Databank, World Development Indicators 2012

of NHIS, about one-third of respondents indicated that waiting time at health facilities, perceived attitude of health professionals toward patients, and quality of inpatient care improved when they joined NHIS, though these results varied by geographic region. Of those insured by NHIS, over 92 percent indicated that they were satisfied with overall NHIS performance [26].

Health status

Improving the health of the Ghanaian population was and is an ultimate goal of the NHIS, but health status impacts are difficult to measure and take

the longest to occur. Saleh evaluated Ghana's recent progress with respect to the Millennium Development Goals, finding that Ghana is likely to meet nutrition and communicable disease control targets, but unlikely to meet child and maternal mortality goals by 2015 [27]. The only randomized controlled trial to date of the effect of NHIS enrollment on health status found increases in utilization consistent with prior studies, but no statistically significant effect of NHIS coverage on the studied health outcomes (moderate and severe anemia among children, often a consequence of untreated malaria) [17].

National health financing

New funding sources for NHIS, especially the National Health Insurance Levy (2.5 percent VAT) and portion of social security taxes, have improved the consistency of health financing and resulted in higher levels of total and government spending on health (Figure 1). Ghana has also experienced remarkable economic growth since the NHIS was passed—an average of 7.29-percent annual gross domestic product growth from 2003 to 2012 [4]. Total health expenditure per capita, at US\$75 (current U.S. dollars) in 2011, aligns with countries of similar income levels and is just under the sub-Saharan African average of US\$85. Out-of-pocket payments represent 29 percent of total health expenditures, somewhat lower than pre-NHIS levels and the sub-Saharan African average of 32 percent. Ghana’s government health expenditure as a share of total government expenditure was 12 percent in 2011, slightly below the Abuja target of 15 percent [4, 27]. The NHIS faces major challenges to its own financial sustainability, however, as expenditures on claims are growing far faster than revenues.

Lessons Learned

Ghana’s NHIS is often studied for its revenue mobilization, national risk pool, combination of centralized authority with some district-level autonomy, and more. This case focused on the transition from MHOs to the more centralized NHIS, and the following are lessons that other countries may consider for the question of whether and how to leverage CBHI for universal health coverage.

1. MHOs facilitated NHIS scale-up. The MHO experience in Ghana eased the transition to national health insurance in several significant ways. The decade of experimentation brought valuable

benefits to select populations—benefits that were well-publicized and likely enhanced the country’s experience with prepaying for health. Two groups are important to note for this demonstration effect: the general population, who began to see the value of prepaying for health; and policymakers, who began to realize that prepaid insurance was indeed possible even for Ghana’s large rural and informal sector [14]. The community ownership aspect of MHOs was extremely valuable in this introduction of the concept of prepaying for health services that may not even be needed. Ultimately, however, such ownership had to be diminished as the program was scaled up. The learning-by-doing approach taken by many schemes, and the technical assistance provided by DANIDA, USAID, and other partners also helped build the capacity needed to administer the district-based schemes in the early roll-out of NHIS. Some of this “leverage” was quite concrete, including the use of training manuals developed for previous MHOs, the replication of locally-accountable governance structures (at least in NHIS’s early years), and the direct hiring of former MHO staff as managers and employees of the new district schemes under NHIS [28-30]. Finally, the previous MHOs offered several field-tested templates for how to organize population groups for health coverage (faith-based, profession-based, community-based, district-based), with the district being chosen as the most viable model for rapid scale-up and integration with Ghana’s health delivery system.

The MHOs also demonstrated the feasibility of two other important changes for Ghana’s health financing. First, they showed that money could follow patients’ actual use of services, through reimbursement to providers for services actually delivered, rather than solely through historically-

and input-based budgeting. Second, the MHOs showed that a single pool of prepaid funding could be used to purchase services from, and create competition between, public and private providers. Both of these are key features directly incorporated into the design of the NHIS.

2. MHOs had substantial limitations. Despite the decade of growth and proliferation of over 100 MHOs by the early 2000s, the MHO movement failed to expand coverage beyond 1–2 percent of the population, compared to nearly one-third of the population covered by NHIS after only five years of operation. Undoubtedly this limited coverage was linked to other MHO constraints, including extremely limited sources of revenue (premiums), limited benefit packages, lack of portability, and lack of wide choice of providers. Ultimately MHOs did not relieve the population's dissatisfaction with cash and carry. The NHI Act of 2003 borrowed key elements of the MHO experience, but it also represented clear ruptures with previous policy.

3. In launching NHIS, politics trumped technical planning, with mixed results. The particular path health insurance reform took in Ghana was heavily influenced by politics and, in particular, the competitive electoral pressure that caused the NPP to offer an ambitious and immediate break from the prior government's more iterative approach. It is very unlikely that the NHIS would have been created in its current form without meaningful electoral competition. Political expediency led to particular advantages and disadvantages. On the positive side, the political pressure for rapid national scale-up likely led to arguably the single most important innovation of the NHIS—the choice and successful passage of the VAT-based National Health Insurance Levy as the major source of financing. The NHI Act also set political precedents in Ghana that have yet to

be challenged by either major party: that funding raised and pooled at the national level should be used to reimburse providers for health services that patients receive, which both creates a single pool for the sharing of health and financial risk and allows money to follow the user of services. This political consensus stands in stark contrast to the recent health reform experience in the United States. However, the politically-beneficial promise of a comprehensive benefit package with no cost sharing and fee-for-service reimbursement has also created major financial sustainability problems for the NHIS, leading to urgent new policy development (e.g., capitated purchasing) to control costs.

4. There is no “right” answer. In sum, other countries should consider several pros and cons with iterative building on CBHI, “big bang” centralized reform, or a Ghana-like combination. The NHI Act helped open a major new revenue stream (VAT), rapidly increased coverage, and set the important political precedent that health care should be financed and organized publicly and nationally and delivered by public and private providers. However, the rapid design, adoption, and scale-up of the NHIS would likely not have been possible without years of lower level experimentation, learning, and awareness-raising. Most importantly, the MHOs showed the following: health funding could follow patients' use of services, both public and private providers could compete for this demand-driven funding, at least modest premium payments from informal sector workers were possible, and benefits would also need to be limited without major new sources of funding. Finally, some of the NHIS's current threats may not have developed so seriously with a more iterative approach of building on previous MHOs.

Methodology and Acknowledgments

The authors conducted a literature review of the history of MHOs and the NHIS in Ghana, plus impact evaluations of the NHIS. Peer-reviewed journal publications were prioritized, but the authors also accessed reports and unpublished working papers from known policymakers and scholars of health financing in Ghana. All references are available upon request. Given more limited literature on the transition from MHOs to NHIS, the authors conducted four key informant interviews with Dr. Chris Atim (former researcher for the PHRplus project in Ghana), Mr. Collins Danso Akuamo (former manager of the Okwawuman district health insurance scheme), Ms. Helen Dzikunu (former program officer for DANIDA), and Dr. Sam Adjei (former director general of GHS). We gratefully acknowledge all of their insights on the key question of whether the early NHIS leveraged the experience and resources of existing MHOs. We also greatly acknowledge Dr. Francois P Diop (COP Senegal Abt Associates Inc.) for his valuable contribution as reviewer and quality advisor of this case study.

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Annex

Table A.1: The Legacy of MHO Policies and Practices in NHIS

	Maintained from MHOs	Changed for NHIS
Financing (revenue mobilization)	Premium payments and registration fees by informal sector enrollees (but very small proportion of NHIS revenue)	NHIS funded at national level rather than scheme level, including 2.5% VAT (provides majority of revenue), 2.5 percentage-point carve-out of social security payroll tax (among some formal sector employees), investment income from NHIF, and other funds from Parliament. Single national funding/risk pool.
Enrollment	Early NHIS policy only gave under-18 exemption when both parents enrolled, similar to some attempts by MHOs to control adverse selection through household enrollment Membership cards with photo ID	Individual NHIS enrollment mandatory (but no enforcement).
Exemptions		In NHIS, those under 18 and older than 70, pregnant women, SSNIT contributors, and the poor are exempt from premium payments. Registration fee still applies.
Benefits package	Inpatient care, some outpatient care	Nationally standardized and broad—covers 95% of all disease conditions and >200 medicines on NHIS drug list.
Delivery	Use of public and private providers (but far more limited than NHIS)	NHIA-accredited public and private facilities across country.
Provider payment	Claims-based fee-for-service	More complex, nationally-standardized and DRG-like fee-for-service, plus fixed price list for drugs (negotiated with industry).
Organization/governance	Pre-2008 NHIS adopted some local governance boards/committees from MHOs Many MHO staff rehired	Centralized governance under NHIA with implementation decentralized to district-level (not community-based) schemes.
Accountability		The National Health Insurance Council (NHIC), made up of government stakeholders and appointees, oversees NHIA. Controls budget and works with Parliament to pass budget. CEO of NHIA appointed by President.

**Characteristics of MHOs varied across schemes. This table is based primarily on a review of Okwawuman and Nkoranza schemes as examples of a district-wide and a hospital-based scheme that existed prior to 2003. Categories to track adapted from Witter and Garshong's 2009 overview of NHIS [31].*