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Promising Start, but bleak future? Progress of Ghana's National Health Insurance Schemes towards Universal Health Coverage

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Abstract
In 2003 the Government of Ghana, West Africa began implementing a National Health Insurance Scheme (NHIS) to improve health care access for Ghanaians and eventually as a cardinal strategy towards meeting the ideals of universal health coverage. After nearly a decade of implementation, this article attempts to examine the progress made in meeting the policy objective of ensuring that all residents of the country get an acceptable quality package of essential healthcare. The major finding from this study suggests that although the NHIS cover a wide range of services as well as absorption of remarkable proportion of healthcare cost , coverage of the scheme could best be described as low after nearly a decade of implementation as over 60% of the population are uninsured, and hence financially unprotected. In progressing faster towards UHC, the paper proposes some strategies for widening NHIS finance and recommends different strategies of expanding membership enrolment including a consideration of commission-based remuneration for NHIS registration staff.
Keywords: Ghana, National Health Insurance, Universal Health Coverage, health financing

1. Introduction

In the past few years, there has been a growing wave at the international level towards universal health coverage (UHC), although there is still less consensus in many countries on the best mix of financing mechanisms to protect poor people especially those outside the formal employment sector (Garrett, Chowdhury et al. 2009; Sachs 2012). The quest for universality, which currently remains one of the strong policy focus of the post-2015 Millennium Development Goals, is often argued as an essential way to reduce financial impoverishment caused by health spending. This is also to practically ensure that everyone including the rich and poor, men and women, ethnic or religious majorities and minorities obtain full and equal access to the key health services (Gwatkin and Ergo 2011). As Dr. Margaret Chan, the director of the World Health Organization (WHO) puts it, universal health coverage is “the single most powerful concept that public health has to offer...it is a powerful equalizer that abolishes distinctions between the rich and the poor, the privileged and the marginalized, the young and the old, ethnic groups, and women and men.” (Chan 2012). The past decade or so have therefore seen considerable interest among many nations and the international community on the potential of social or national health insurance (NHI) to increase access to and affordability of health care especially in low income countries—and consequently drive the ideals of UHC.

Ghana, West African country with a population of about 24 million began experimenting NHIs as a way of replacing out-of pocket fees at point of service use as well as a more equitable and pro-poor health financing policy in 2003 (Agyepong and Adjei 2008). The policy objective for the scheme was to ensure that within five years of implementation every resident of Ghana would belong to a health insurance scheme that would guarantee equitable healthcare access and adequately cover him or her against catastrophic expenditure (Ministry of Health 2004; Agyepong and Adjei 2008). Consequently, the Ghana National Health Insurance Scheme (NHIS) is seen as the cardinal strategy for achieving the principles espoused by UHC. After almost a decade of implementing the NHIS in Ghana, there is currently fragmented information in relation to the progress being made by the country towards UHC. Current scholarship attention on understanding the progress made by countries implementing NHI has focused largely on cross-country analysis (Lagomarsino, Garabrant et al. 2012; Mills, Ally et al. 2012), which offers useful insights for understanding the performance of insurance schemes in relation to UHC. Yet, in-depth analysis for progress on specific countries is very limited. The aim of this study is therefore to focus on Ghana’s experience to contribute to the growing body of knowledge that is examining how different countries are attempting to move towards universal coverage under the implementation of National Health Insurance Schemes. The paper does not aim to offer comprehensive evaluation of the NHIS as that would require robust empirical and quantitative exercise. Rather, the main objective of the paper is to shed light on the progress that Ghana has made towards universal health coverage under the National Health Insurance Scheme regime over the past decade of its implementation paying close attention to who and how many of the population is covered, what services are covered and what proportion of cost is covered.

The findings of this paper draw extensively on available scholarly literature and official publications and reports

by the National Health Insurance Authority (NHIA), the Government of Ghana, the Ministry of Health of Ghana and other multilateral institutions such as the World Bank.The data sources for which this study relies on cover the period 2003 and 2012. The national data sources were analysed thematically, focussing on the main dimensions for assessing universal health coverage –the breadth of coverage, height of coverage as well as depth of coverage. This was supplemented by a review of published and grey literature on Ghana's NHIS through databases such as *Sciencedirect, MEDLINE* and *Google Scholar* using key words "Ghana NHIS" and "national health insurance". Although the search produced a large volume of materials on the subject, only those that comprehensively discuss issues of national coverage (rather than specific sub-national case studies), benefits covered under the scheme and out-of-pocket issues were given attention. The key challenge with this approach relates to the non-availability of official publication for some of the years covered in the study (e.g coverage for 2013). Nevertheless, this did not significantly affect the key issues and arguments raised in this paper. This assessment of the progress made towards UHC is very useful so as to offer some useful lessons to policy makers of both Ghana and other countries implementing National Health Insurance programmes as a means of attaining universal health coverage. The paper is structured as follows: after this introduction, the next section gives an overview of the national health insurance scheme of Ghana. The next two sections further discuss the analytical framework for the study as well as a sketching out of progress made towards UHC. This is followed by a discussion and implications as well as set of recommendations before tying the discussion together with a conclusion.

2. The Ghana National Health Insurance Scheme: An overview

In an attempt to address the widely documented perverse problems of full-fledged user fees (known locally as "cash and carry" system), the government of Ghana passed the National Health Insurance Act (Act 650) in August 2003, after extensive consultations and debates on the model to be adopted. This was followed by the passage of a Legislative Instrument (LI 1809) in 2004 to provide the regulatory framework for the NHIS (Government of Ghana 2004). The law made provisions for three categories of insurance: a public-supported District Mutual Health Insurance Schemes (DMHIS), Private Commercial Health Insurance Schemes, and Private Mutual Health Insurance Schemes. In 2012, a new National Health Insurance Act (Act 852) was passed to bring the operations of all the district mutual schemes under the National Health Insurance Authority. While there is a large volume of literature on the DMHIS/NHIS, the contribution and information on subscribers of the private commercial and private mutual schemes has received less academic and research attention to date—partly because of its minimal share of the population accessing these categories of scheme. This paper thus focuses largely on the NHIS/DMHIS tiers of the scheme.

When the NHIS was introduced in 2003, the policy objective set out for the scheme was to ensure that within five years of implementation every resident of Ghana would belong to a health insurance scheme that would guarantee equitable healthcare access and adequately cover him or her against catastrophic expenditure (Agyepong and Adjei 2008). As a way of ensuring regular flow of funds for the scheme, the law governing the scheme earmarked funds for non-salary recurrent spending by creating the National Health Insurance Fund (NHIF). Consequently, the main sources of finance for the NHIS are: (a) 2.5% value-added tax on goods and services known as the National Health Insurance Levy (NHIL), (b) Payroll tax from Social Security National Insurance Trust (SSNIT), at 2.5 percentage points, and which covers largely the SSNIT contributors deducted at source from formal workers (c) individual contributions/ premiums (paid directly to District Health Insurance Schemes), which cover largely the informal sector and (d) other funds from investment returns, Parliamentary allocation, or donors. Non-SSNIT enrolees pay differential annual premiums ranging between GH¢ 7.20 (about $4.80) and GH¢48 (about $32.00) depending on their socio-economic status. Ghana therefore operates a hybrid social health insurance model comprising (i) annual contribution/premium-based financing elements to non-SSNIT contributors and (ii) tax-revenue financing to cover, or at least partially subsidize, informal workers, the poor and non-wage earners. At the beginning of 2011, the NHI levy has consistently been accounting for around 75% of the total income for the scheme while the premium from the informal sector has not exceeded 5% of the total income of the NHIA (National Health Insurance Authority 2011; Akazili, Garshong et al. 2012).

In addition to SSNIT contributors, there are number of groups who are exempt of paying premiums although they are required to pay for a registration fees which would entitle them to a subscriber ID card. These exemption groups are: all formal sector workers contributing to SSNIT and their dependants, staff of the Armed Forces of Ghana and the Ghana Police Service, children under 18 years (previously with at least one of their parents contributing), persons above 70 years and SSNIT pensioners and “core poor (i.e. indigents),” defined as those being unemployed with no visible source of income, no fixed residence, and not living with someone employed and with a fixed residence (Government of Ghana 2004).

The legal and regulatory framework of the scheme also created the National Health Insurance Council (now Authority) to among other things oversee the implementation of a national health insurance policy that would ensure access to basic healthcare services to all residents. The responsibilities of the NHIA include issuing licenses and regulating district-level mutual health insurance schemes (DMHISs), providing accreditation to service providers and also determining premium levels together with other stakeholders. As at the beginning of 2011, there were about 145 district schemes and almost 3000 health facilities accredited to provide the minimum benefit package recognized by the law (Seddoh, Adjei et al. 2012). Over the years, the NHIS has chalked a number of notable achievements including being able to provide premium-free health care for nearly 70 per cent of its total registered membership; its ability to contribute significantly (about 85%) to all internally generated funds (IGF) of all government and missionary health institutions; and engagement of more than 3,200 healthcare service providers. In 2010, the NHIA won the UN Award for Excellence and Leadership for its role of sharing lessons from the scheme across the globe. But to what extent have these achievements contributed to the ideals of UHC. This is the focus of the remaining sections of this paper.

3. Analytical Framework Of The Study

Universal health coverage, is defined primarily as ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services (WHO 2013). Universal health coverage (UHC) has therefore become a cardinal goal for health reform in many countries and a priority objective of the World Health Organization (WHO). This understanding of UHC thus embodies hree related objectives: (i) quity in access to health services - those who need the services should get them, not only those who can pay for them; (ii) that the quality of health services is good enough to improve the health of those receiving services; and (iii) financial-risk protection - ensuring that the cost of using care does not put people at risk of financial hardship.

While different frameworks of Universal Health Coverage are emerging, this study draws on the three-dimensional approach of the World Health Organization (World Health Organisation 2008), which has been the commonest framework to assess progress towards universal coverage. This framework conceptualises progress to UHC as encompassing three key dimensions which need to be fulfilled: breadth of coverage, depth of coverage and height of coverage. The **breadth of coverage** component primarily focuses on the proportion of a country's population, especially the poor, who are having access to healthcare. The dimension of **depth of coverage** looks at the range of services that are available to meet the health needs of the population while the **height of coverage** concerns itself with the proportion of the total cost that is covered through pre-payment arrangements. In the long term, the height of coverage seeks to minimise catastrophic out-of-pocket payments especially for poor category of the population.

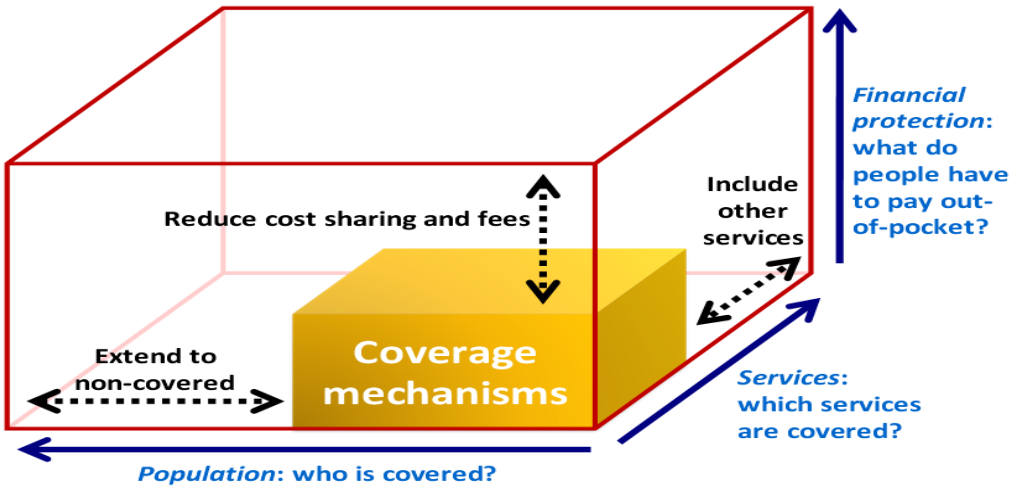

Figure 1: Analytical Framework for assessing progress towards universal coverage
Source: WHO (2008)

4. Ghana's Progress on Universal Health Coverage

4.1 Breadth of coverage: Who is covered?

Enrolment figures have been one of the key determinants in assessing the breadth of coverage in terms of progress towards UHC. Enrolment figures of the NHIS have been very contentious in Ghana and needs to be treated with caution. As at 2005, when the NHIS has fully become operational in all the ten regions, coverage of the scheme was calculated at about 1.3 million of the population (then estimated to be about 20 million). By 2009, coverage figure was reported to have encouragingly reached about 10 million, which is about 53% of Ghana's population (National Health Insurance Authority 2011). But a controversy regarding the coverage began emerging. The most well known is that which came from a group of civil society including OXFAM. These groups heavily criticized the (cumulative) method used for calculating the enrolment figures which did not take care of double registration, people who have died or migrated and those holding 'valid' but 'expired' cards making it possible for the figures to be bloated (Apoya and Marriott 2011; National Health Insurance Authority 2011). By NHIS regulations, although ID cards are valid for 5 years it must be renewed annually. For subscribers who are unable to renew their cards, they are still unable to use the cards to access services although the cards may be valid. After series of heated debate, the NHIA later acknowledged these inherent challenges and revised its methodology for obtaining coverage figures of which they officially reported that 'active' members was 8.16 million at the beginning of 2011, representing 34% of Ghana's population (National Health Insurance Authority 2011). A public statement issued by the NHIA in September 2013 as part of preparations to celebrate the 10 year anniversary of the scheme mentioned that coverage of the scheme now stands at about 9 million. This represents about 36.5% of Ghana's 24.6 million population (Dapatem 2013). With the change in methodology, this cannot necessarily be said to be a drop in the coverage. However, for a scheme that sets a target of covering almost 100% of the population within five years, the progress is certainly far from satisfactory. At a civil society conference held at the Kama Conference Centre on 31st October, 2013, a representative of the NHIA stated that the private and the other mutual insurance tiers account for less than 6% of the population, thus bringing the total population insured to about 40%. Table 1 gives a trend of the population covered by the NHIS.

Table 1: Trend of coverage of the NHIS

Year	2005	2006	2007	2008	2009	2010*	2011	2012
Active Population covered	1,348,160	2,521,372	6,643,371	9,914,256	10,638,119	8,163,714	8,227,823	9,000,000
Percentage of total population**	6.74%	12.6%	33.2%	49.5%	53.1%	34%	34.2%	36.50%

Source: (National Health Insurance Authority 2011; National Health Insurance Authority 2012; Dapatem 2013)
*Change of methodology

4.2 Depth of coverage: Which services are covered?

The range of services covered by insurance schemes is of primary importance in relation to their ultimate effect on population health and financial protection. Benefit packages have been one of the dominant means to assess the range of services covered under health policies—which is the depth of coverage under the analytical framework. Encouragingly, the scope of the basic benefits package (BBP) of Ghana's NHIS is very broad with as many as 95% of the burden of diseases covered (National Health Insurance Authority 2011). Irrespective of whether subscribers sign up for private or national schemes, the legal framework for the scheme guarantees minimum benefits package under the NHIS including general out-patient and in-patient care, normal and assisted maternity care, oral health, eye care, diagnostic tests, generic medicines and emergency care. There is therefore no doubt that Ghana's scheme offer comprehensive preventive, hospital, and (in some cases) drug benefits. Empirical research into whether subscribers/clients/ actually receive all of these services or otherwise however remain scarce. But there are anecdotal evidence suggesting that some services which were free for subscribers at the beginning of the NHIS in 2003 are no more free, at present including laboratory tests as well as diagnostics (Ministry of Health 2009; Ministry of Health 2010) ,

4.3 Height of coverage: What proportion of cost is covered?

The proportion of costs covered by an insurance programme give some indications on how well people are protected from catastrophic expenditures and impoverishment caused by health costs. Some widely acknowledged indicators of progress therefore include a country's overall out of-pocket spending as a percentage

of total health spending as well as reductions in out-of-pocket spending achieved since reforms were implemented. Available information on the proportion of cost covered by patients under NHIS shows that, Ghana has made good progress in reducing out-of-pocket spending for subscribers of the scheme. Using reported data from the WHO global health expenditure database, Lagomarsino et al (Lagomarsino, Garabrant et al. 2012) argues that out-of-pocket spending (calculated by comparing out-of-pocket spending just before initiation of reforms with most recent available data in 2012) for subscribers of the scheme has gone down by 4 percentage points at pre-NHIS levels. Although the general situation is improving overall, Ghana could still do better. Indeed, in spite of the reported general reductions of OOP, household out-of-pocket spending is responsible for between 27-37 percent of total health spending (Lagomarsino, Garabrant et al. 2012; Saleh 2012), a figure which is in excess of WHOs suggested 15-20 thresholds for adequate financial protection (World Health Organisation 2010). Household health spending burden thus remain quite high which needs to be checked. There are further inequitable issues. A recent World Bank comprehensive review also noted that while burden of health payments appears to be relatively low in Ghana, households in the poorest quintile allocate around 3.2% of their household expenditures on health care as compared to the rich quintiles who spend 0.5% of total expenditures on out-of-pocket payments for health services (Schieber, Cashin et al. 2012). Studies by Nguyen et al (2011) also show that it is not just those who are not insured that incur out-of-pocket payments. Thus, despite that the benefit package of the NHIS is generous, insured people still incur out-of-pocket payment for care from informal sources and for uncovered drugs and tests at health facilities.

5. Towards Universality: Issues, Implications and Recommendations for policy making

Universal Health Coverage is gaining increasing attention and popularity for its systemic perspective for addressing equity issues rather than the narrow focus of specific elements of health systems (e.g. just allocating public sector resources through needs-based formulae or user fee exemption mechanisms) that had characterised international debates on health financing and health equity in the past (Mills, Ally et al. 2012). For many low income countries such as Ghana, National Health Insurance Scheme has become the cardinal driver towards ensuring financial protection and achieving the ideals of UHC. Having implemented the NHIS for nearly ten years, this present study had sought to examine the progress of Ghana towards UHC by paying attention to who has been covered, what services are being covered, and what proportion of costs are covered.

While the range of services as well as the proportion of cost borne by subscribers of the scheme is commendable, coverage of the scheme could best be described as low after nearly a decade of implementation of the NHIS. It is generally known that almost 95% of diseases are covered and that there is virtually no cost-sharing for subscribers (at least on paper) but to the extent that just around 40% of the population enjoy this generous package—to the exclusion of over 60%--should give some cause for concern for policy makers. This coverage figure could therefore mean that there are more than half of the Ghanaian population who are still living the 'cash and carry' system---because they are not covered presently by the scheme. Of course Universal health coverage is generally expected to be pursued typically in an incremental manner rather than immediate but current picture should send signals for policy makers to fashion out more efficient strategies of increasing enrolment. The NHIA has publicly announced in September 2013 that the scheme has registered some 22 million subscribers since its inception in 2003 of which 9 million (or 36.5% of the population) remain active subscribers (Dapatem 2013; Mahama 2013). The critical questions to ask are: Why is it that only about 9 million of the cumulative 22 million people are active? What is preventing the inactive subscribers from not renewing their membership so as to become active subscribers? Why are they unable to renew their cards? How then do these over 60% of the population access healthcare? Answers to these critical questions are important as efforts are made by policy makers to progress to UHC. What is even interesting is that The Act 650 technically requires all Ghanaians to enrol in the NHIS or in another health insurance plan but this has been difficult to implement in practice largely due to the requirement for the payment/renewal of annual premium. Policy makers therefore need to identify and design strategies to remove the economic, geographic, political and cultural barriers (Asante and Aikins 2008) that affect enrolment. Some studies have shown that factors such as the perceived high amount of the premium, inaccessibility to registration, cost of transportation to the registration centres do affect enrolment of the scheme.

Beyond the low coverage, there also appears to be inequity in the general enrolment and utilisation trend which should also engage policy attention as Ghana moves towards a universal coverage. In one study by the Research and Development Division of the Ghana Health Service, it was discovered that whereas 52% of households in the top wealth quintile were enrolled in the NHIS, only 18% in the poorest quintile were enrolled (Ghana Health Services 2009). In a recent study by the World Bank (Saleh 2012; Schieber, Cashin et al. 2012), it was discovered that while 29 percent of the top wealth quintile was enrolled in the NHIS, only 17 percent of their

counterparts in the lowest wealth quintile were enrolled. This is particularly worrisome considering the rather extensive premium exempt eligibility groups which include the poor. It is therefore pitiful that while the NHIS was designed to benefit poor people, many of those who are currently enrolled belong to high income category (Akazili, Garshong et al. 2012). Although the NHIS legal framework exempt very core poor people from paying premium, identifying them and applying this law has been very difficult in practice. In 2008 for instance, only 1% of the total population were holding NHIS cards as *indigents* as against 28% of the population who are living under the poverty line (Ministry of Health 2009). These findings therefore indicate that there is the need to reassess and strengthen the premium exemptions for the poorest socioeconomic groups while the NHIAs enrolment strategies such as the increasing sensitisation and communication, outreach and special days for registration need to be stepped up to get more low income group earners to register and renew their contributions to benefit from the scheme.

It is widely documented that financial consequences of ill health can be very disturbing for poor people, who often struggle to cover the basic daily needs such as shelter, food and clothing (Nguyen, Rajkotia et al. 2011). Consistent with the ideals of the UHC, the Ghana's NHIS also aims to help people deal with the unpredictability of illness and medical spending. In principle, active subscribers of the scheme virtually pay nothing when they visit accredited health facilities although anecdotoral evidence to the contrary abounds (Apoya and Marriott 2011). Generally, national OOP is recognised to have dropped by at least 4% over the past decade yet the household level OOP of 22- 37 percent of total spending is well above the 15-20 per cent WHO financial protection threshold. Additionally, clients still incur some costs in laboratory tests, diagnostic, medicines which are not available in the hospitals and informal/unofficial fees (UNICEF 2012). While some health service providers rely on OOP as a key source of finance, a number of studies have suggested that higher OOP payments can generally impoverish families, reduce the amount of services patients can receive, or even lead them to avoid seeking needed care altogether (World Health Organisation 2010). Considering that reducing financial barrier to access is one of the overarching aims of the NHIS, it is therefore important that Government continue to strengthen and implement strategies which will see through the removal of financial and other barriers to access.

The comprehensive benefit package portrays the extent of ambitiousness of the NHIS to protect the poor from large number of diseases. This is commendable in achieving universality although it comes with higher costs which threaten the sustainability of the scheme. Despite the extensive BBP covering 95% of the BOD, the weak referral serves as a great challenge as there is generally no safety net to address the resource needs when disease conditions arise beyond the package (Seddoh, Adjei et al. 2012). Furthermore, the benefit package in general is heavily biased toward curative over preventive care and a revision to include some preventive services will be beneficial to the scheme in the long run.

While the comprehensive benefits package of Ghana's scheme is commendable, they however present challenges of administrative complexity as well as financial sustainability to the scheme. In 2009, the NHIS incurred a deficit of GHC 19. 5m ($ 9. 25m) which more than doubled to GHC 47.3 m (approximately $23.6m) at the beginning of 2011 (NHIA, 2011). In 2009, subsidies and claims paid by the NHIA alone was about 88.3% the total income received (National Health Insurance Authority 2011). The annual premium which was expected to generate significant revenue to finance the scheme has performed poorly. Over the past 4 years or so, the contribution of the premium to the total revenue of the NHIA has not gone beyond 5% (National Health Insurance Authority 2011). In its 2010 Annual Report, the NHIA rightly acknowledged that, *"financial sustainability of the scheme remains a big challenge…it is projected that without any additional sources of funding to the current sources, the NHIF risks of dipping down by the close of year 2012"* (National Health Insurance Authority 2011)(p.32). In the light of these challenges associated with Ghana's comprehensive benefits package, some scholars have raised questions of long-term sustainability of the scheme (Chankova, C. et al. 2010). These challenges to the financial sustainability need to be addressed without delay as it threatens to collapse Ghana's National Health Insurance Scheme. New and additional financial resources are also required for Ghana to move forward with its progress to UHC. Contrary to the argument that Ghana should introduce cost-sharing as a means of reducing cost associated with the comprehensive BPP (Saleh 2012; Schieber, Cashin et al. 2012), this paper is of the view that such a policy may worsen the already low enrolment trends and threaten the gains toward achieving universal coverage. Rather, the country should focus on raising additional revenue, reducing administrative and operational cost 'and strategize to increase enrolment.

For Ghana to progress towards UHC, it must therefore aim to expand its enrolment and membership to the scheme whilst also seeking additional finance to prevent the scheme from dripping down. To this end, this paper makes four broad propositions. First, in an attempt to expand enrolment, government must tackle the fundamental barriers affecting enrolment to the scheme including the perceived high premium, distance to registration centres, perceived poor quality of care for subscribers, timing of premium payments and other

behavioural and social factors (Buor, 2004; Nketiah-Amponsah, 2009). The NHIA must therefore intensify its outreach programmes to bring more people under the scheme while also facilitation the address of the supply side issues such as quality of care. It is further proposed that NHIS staff should move to communities to convince them to register rather than expecting them (i.e. communities) to come to the registration centres. Additionally, rather than paying NHIS staff, the government should also consider paying NHIS registration staff on commission based on how many new subscriber each worker registers on the scheme every month. This could encourage workers intensify efforts at registering people unto the scheme. It is also recommended that the annual conditional premium payments have to be carefully assessed to achieve a balance between increasing enrolment and raising revenues to support the scheme. Indeed, Ghana needs to implement other indirect and pre-payment options to cover the population in the non-formal sector that are required to directly pay the premium. So long as the section of the population in the informal sector are required to pay for and annually renew their premiums/contributions, attaining the ambitious goal of every resident belonging to the national insurance could be a mirage.

Closely linked to the challenge of enrolment relates to the financial sustainability of the scheme. Considering that the vast majority of current NHIS revenues come directly from the NHIS VAT levy, which is entirely unconnected to the NHIS membership rate, one possible option of ensuring that those in the informal sector, especially rural residents get enrolled is possibly to fund their contributions entirely from indirect taxes and budgetary allocation to the health sector. In this instance, this paper recommends the introduction of sinful taxes especially on alcoholic products, sugary drinks, the booming fast-food markets and other foods high in transfats as well as mobile telecommunication tax to generate some funds to support the NHIS. A WHO report (World Health Organisation 2010) shows that by raising tobacco taxes and other 'harmful products' by 50%, low-income countries like Ghana could together generate new funds for health to the tune of about $1.4 billion each year. The good thing about "sin taxes" is that they raise money while also protecting health. On telecommunication tax, Ghana was estimated to be having almost 17 million telecommunication subscribers and if each subscriber is deducted at least GHC 3 ($1.50) a year to finance the scheme, is it not GHC 51 million which is being generated—an amount twice as those generated from the annual premium? The current economic growth and the general macroeconomic environment further serve as a potential toward this direction—but implementation will of course not be easy and needs to be assessed carefully. There are other range of barriers that impede enrolment which all needs to be addressed including, distance to health facilities, place of residence, poor quality of care, timing of premium payments and other behavioural and social factors (Buor 2004; Nketiah-Amponsah 2009).

The NHIA had a very good financial base from its start until about 2009 when it expenditure began to exceed the income sources (Mensah 2012). Consequently, the second proposition is that the government would also need to expedite actions on diversifying and increasing sources of funds for the scheme as the NHIS is almost solvent at the moment. Currently there are calls to increase the NHI levy and this paper joins these calls for government to consider increasing the NHIL by about 0.5-1.5% from its current 2.5% to a maximum of about 4%. This increment is important to enable the NHIA meet it's ever increasing cost on claims, operations and administration. As a word of caution, adequate public education and sensitisation have to be made to explain the rationale and the benefits to avoid public upheaval. While such an increment may not be able to bring in all the revenues that the NHIA needs, it will nevertheless serve as an important contributor into the coffers of the Authority. As highlighted earlier on, the 2.5% NHI levy has consistently been accounting for around 75% of the total income for the scheme while the premium from the informal sector has not exceeded 5% of the total income of the NHIA. A focus on the NHI levy rather than the premiums will therefore go a long way to help solve the threatening financial sustainability of the scheme.

Third, the Government must make effort to address challenges faced by subscribers in enjoying quality care once they join the scheme. A number of anecdotal examples that impede quality care that have been widely documented by the Ministry of Health (Ministry of Health 2009) include but not limited to provider discrimination against NHIS-insured patients, low likelihood of being seen by a qualified doctor, long queues and waiting time, less likelihood of receiving all drugs prescribed, unofficial fees where users are asked to pay for supplies and commodities that are out of stock at the public health facility from which they seek care as well as informal fees (additional fees charged at the point of service provision by frontline health staff usually with the aim of supplementing their income). Other general barriers to access including inadequate availability of staff and equipment (Witter, Arhinful et al. 2007; UNICEF 2012) in primary health care facilities and the poor staff attitudes towards clients perceived to be poor (UN Millennium Project Task Force on Child and Maternal Health 2005; Gilson and Schneider 2007) also demand adequate attention on the fast road to UHC.

Fourth, the MOH and the NHIA together with the service providers and other stakeholder have to collaboratively

work to reduce the escalating cost and the fraudulent practices characterising the NHIS while also working towards strengthening the overall health systems and reduce fragmentation. Some research estimate that at least savings worth about 36% of total government health expenditure in 2008 (an equivalence of US$10 per capita) could be made on the inefficiencies and cost escalation in the health system if government pays attention to pursuing (Apoya and Marriott 2011). Some of the strategies of achieving these cost-savings include strengthening the referral system and putting in place an effective gate keeper system, regular clinical audit to reduce fraud and leakages; better negotiations with suppliers and reducing unnecessary cost escalation along the medicine supply chain and investing more in preventive rather than curative health.

6. Conclusion

This paper sought to synthesis available literature on the progress of Ghana towards universal health coverage, where the whole population including the rich and poor, men and women, ethnic or religious majorities and minorities will obtain full and equal access to the key health services at an affordable cost (Gwatkin and Ergo 2011). This paper has shown that in terms of the depth of coverage (i.e. which services are covered), it is seen that the NHIS covers a broad range of diseases which are free to subscribers in principle, although not all of them are still free in practice. In terms of the height of coverage, which is proportion of cost is covered, it has been highlighted that although national averages of out-of-pocket payments seem dropping, household out-of-pocket spending is still in excess of WHOs recommended threshold. However, in terms of the breadth of coverage- the population covered--, there is quite a long way to go for Ghana as over 60% of the population still remain uninsured after decade of implementation of the NHIS.

The question as to whether the NHIS had a promising start but bleak future or the converse is not one which is easy to answer. In view of the debilitating effect of the 'cash and carry' system, the introduction of the NHIS in 2003 was greeted with great prospects: to equal access to reasonable health care, ensuring financial protection, mobilizing additional funds for health care, promoting, pool health risks, prevent impoverishment and improve the efficiency and quality of health care. Over the past decade, the NHIS can be credited for recognising broad diseases to be covered by the scheme and for providing windows for financial protection of healthcare. Generally, the situation of healthcare and several health indicators seem better today compared to the cash and carry era (Ministry of Health 2010). Paradoxically, even at a relatively low premium rate and large windows for exemption groups, coverage of the scheme could best be described as low after nearly a decade of implementation of the NHIS. The question that emerges frequently is: if only about 40% of the population can access care as active card holders, what then are the implications for the remaining 60% of the population? Have they reverted to the devilish out of pocket payment at the point of service delivery? How have these proportion been obtaining healthcare? Have they resorted to alternate practices or they have refrained from attending health facilities at all? If it has taken nearly a decade to for the NHIS to cover about a third of the population, how long will it take Ghana to cover all the population, which is the ideal situation espoused by the Universal Health Coverage agenda? These questions are important in thinking about the future prospects of the NHIS.

Moving forward, this paper proposes that considering that many of the population that are not enrolled are in the informal sector, Ghana needs to, beside increasing enrolment and renewal driving strategies, implement other indirect and pre-payment options to cover these population which are required to directly pay the premium and possibly fund their contributions entirely from indirect taxes, increased budgetary allocation to the health sector and other innovative sources such as introduction of ‘sinful’ and mobile technology taxes. Also, this paper calls for mechanisms to strengthen the general health systems as well as measures to address barriers faced by subscribers in enjoying quality care once they join the scheme including providing adequate supplies, equipments, staff and primary health care services which are closer to communities.

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