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Globalizing and Organizing**

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The Ghana National Health Insurance Scheme: Barriers to Access for Informal Workers

Laura Alferts



WIEGO Working Papers

The global research-policy-action network Women in Informal Employment: Globalizing and Organizing (WIEGO) Working Papers feature research that makes either an empirical or theoretical contribution to existing knowledge about the informal economy especially the working poor, their living and work environments and/or their organizations. Particular attention is paid to policy-relevant research including research that examines policy paradigms and practice. This series includes statistical profiles of informal employment and critical analysis of data collection and classification methods. Methodological issues and innovations, as well as suggestions for future research, are considered. All WIEGO Working Papers are peer reviewed by the WIEGO Research Team and/or external experts. The WIEGO Publication Series is coordinated by the WIEGO Research Team.

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List of Acronyms

CBHI	Community Based Health Insurance (Scheme)
CHIC	Community Health Insurance Committee
CHPS	Community Based Health Planning Services
DWMHI	District Wide Mutual Health Insurance (Scheme)
GHS	Ghana Health Service
GLSS	Ghana Living Standards Survey
GTUC	Ghana Trades Union Congress
GH¢	Ghana cedi
MoH	Ghana Ministry of Health
NDC	National Democratic Congress
NHIA	National Health Insurance Authority
NHIC	National Health Insurance Council
NHIF	National Health Insurance Fund
NHIS	National Health Insurance Scheme
NMMTU	New Makola Market Traders' Union
NPP	National Patriotic Party
SGA	StreetNet Ghana Alliance
SHI	Social Health Insurance
SSNIT	Social Security National Insurance Trust
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Abstract

Ghana's National Health Insurance Scheme (NHIS) is an innovative attempt to extend social protection to informal workers, and, as such, it may hold important policy lessons for other countries where the informal economy is large and growing and where informal workers are excluded from existing social protection mechanisms. Few studies have specifically focused on the impact of the NHIS on informal workers. This WIEGO Social Protection Working Paper is an attempt to fill this gap in the literature.

The paper situates the NHIS within a theoretical framework that views institutions as both produced by, and productive of, social processes. It concentrates on the interactions between three groups of women informal workers and the scheme, focusing particularly on the barriers to accessing the scheme that they encounter and on their participation in the development and management of the scheme. The study is based on a desktop review of existing literature on the NHIS as well as three small, highly focused qualitative research studies that were conducted in Ghana during 2009 and 2010 with informal workers from three different sectors of the economy: traders, *kayayei* (headload porters), and indigenous caterers (also known as chop bar operators). Although these studies were small, they nevertheless provided detailed information and enabled deeper insights into how informal workers have so far interacted with the scheme.

The findings show while the informal workers who participated in the study have welcomed the idea of the NHIS, there are significant barriers to them accessing it. The major factor for poorer workers was the cost of the premiums, which often sit well above the mandated minimum in urban areas. For better off workers, the major barrier was the chaotic administration of the district schemes, which meant that a significant amount of time had to be spent trying to register with the NHIS. It was also discovered that there has been very little direct involvement of informal workers in either the design or the ongoing management of the scheme, with the result that it does not take into account the particular needs of informal workers.

The paper concludes that the NHIS reflects the wider inequalities of Ghanaian society and is itself reproducing them. The implication is that if the NHIS is to ever truly promote the ideal of universal access to healthcare, systemic changes in social and economic policy are necessary. Acknowledging that this is only possible in the long term, the concluding section provides shorter term recommendations for changes that would allow the scheme as it exists at present to become more responsive to the needs of informal workers.

1. Introduction

With the launch of its National Health Insurance Scheme (NHIS) in 2003, Ghana became one of several African countries to experiment with health insurance as a means with which to extend health coverage to previously neglected populations. The design of the scheme has been described as “innovative” by several commentators, largely because it has attempted to expand health insurance coverage to workers outside of the formal economy. European models of social health insurance have proved to be of limited use in the African context because of their inability to grapple with the difficulties of enforcing compulsory membership through the deduction of payroll taxes. Countries such as Ghana where over 90 per cent of the workforce works informally and where regulation is made difficult by high levels of self-employment, own account work, as well as ambiguous employer/employee relationships, require policies that reflect the realities of their labour markets. The NHIS has been Ghana’s attempt to do this, and it is therefore a social policy development worthy of attention from researchers and policy makers with an interest in the informal as well as the formal economy.

The NHIS has attracted a lot of attention from researchers, and assessments and analyses of its design and impact have been steadily increasing in number (Institute for Policy Alternatives 2006; Prah 2006; Asante and Aikins 2008; Seddoh et al. 2011; Osei-Akoto and Adamba, 2011; Abihiro and McIntyre 2013). However, although several of these studies have focused on the impact of the NHIS on the poor, few studies appear to have paid specific attention to the relationship between the NHIS and one of its main target groups – informal workers. While it is true that many informal workers are poor, “poor citizens” and “informal workers” cannot simply be aggregated. When citizens are viewed as workers – as people whose lives are shaped by the political-economy of the labour market and by the nature and context of their work – specific questions may arise not only about the particular social, political and economic forces that propel policy development, but also about their interactions with the resulting policies and social programmes. The following study is an attempt to fill the gap in the literature on the relationship between Ghana’s NHIS and informal workers. The study is conceptually rooted in an understanding of institutions (policies, laws, regulations) perhaps most eloquently expressed by Althusser (1970), who, following Marx, viewed them as products of underlying structures of power. These institutions, Althusser argues, in turn serve to reproduce those power relations in the societies in which they are rooted – an aspect of institutional political economy that he decried in 1970 as being largely ignored by scholars (Althusser 1970). Since then, numerous scholars have taken up Althusser’s call to understand institutions not only as the outcome of social processes, but also as framers of social processes. In the domain of social policy studies, Esping-Andersen’s *The Three Worlds of Welfare Capitalism* (1990) added further complexity by showing that social policies – as institutions developed within a particular political and economic context – are able to reconfigure social structures such as class and status, primarily through decisions about resource allocations that follow these policies. Social policies, which depend very much on the underlying political orientation of a society, may work to reinforce class hierarchies, or break them down, or mould social relations into “new dualisms” that may even cut across class, argued Esping-Andersen (1990). Within this framework, the goal of policy analysis is to interrogate the class formations, “dualisms and universalisms,” which crystallize around a certain set of policy interventions, including budgetary allocations.

The purpose of this paper is to interrogate the Ghanaian NHIS through the above theoretical framework with a focus on informal workers. The study concentrates particularly on the experience of women informal workers, which has further implications for the theoretical framework. Esping-Andersen’s work, which privileged class as the central analytical variable, has been roundly criticized by feminists for its lack of attention to gender (O’Connor 1993; Lewis 1992; 1997). Since then much more attention has been paid to understanding gender in relation to social policies although the response from feminist scholars has not been uniform (Strauss 2006). For some scholars, it has meant stressing the importance of gender within the framework established by Esping-Andersen – of seeing class and gender as interacting with one another to produce and reproduce particular social outcomes (O’Connor 1993). For others, the emphasis has been on

establishing an entirely new gendered conception of welfare regimes and social policy where class at best plays a very limited role in the analysis (Lewis 1997; Sainsbury 1999).

WIEGO's experience in working with informal workers has shown that in order to fully appreciate the dynamics of the informal economy, class and gender have to be seen as interacting with one another. Women are overrepresented in occupations with a higher chance of lower returns (Chen 2012). At the same time, there are important class divisions between women workers in the informal economy, which means it is extremely difficult to articulate their experiences in a unitary manner. So while gender is certainly "seen" in this paper, it is the interactions that occur between gender and class that are of greater interest.

The paper will begin by situating the NHIS in its broader political and economic context and will provide information on the informal economy and the Ghanaian health system. It will then move on to a discussion of the NHIS itself – focusing on both the political and economic processes underlying it as well as on the technical operation of the scheme. The paper will then analyze data collected from several small-scale qualitative studies that explored interactions between the NHIS and informal workers. It concludes by arguing that the NHIS is a product of an unequal society and is itself reproducing those inequalities.

2. Informal Workers in Ghana: The Political and Economic Context

Ghana has recently attained lower middle income status, yet levels of formal employment remain very low – according to Heintz's (2005) calculations, formal employment stands at only 8.7 per cent of the total employment, meaning that just over 90 per cent of Ghana's workers work informally. There is an important gendered dimension to this. Formal employment makes up a higher percentage of male employment than female employment; 11.4 per cent of male employment is formal, while only 5.9 per cent of female employment is such (Heintz 2005). In the non-agricultural sector, self-employment, including own account work,¹ makes up a higher percentage of total female informal employment (37.5 per cent, of which own account workers make up 35.9 per cent) than male informal employment (15.8 per cent, of which own account workers make up 14.1 per cent) (Heintz 2005). This type of employment makes up the largest share of female employment, which is consistent with the fact that informal market trading, very prominent in urban areas, is largely considered a female profession in Ghana.

The informal economy is not an homogenous entity – it is made up of workers occupying a range of socio-economic statuses. In Ghana there are certainly informal workers who are better off than many formal workers. Overå's (2007) survey in Accra showed that wholesalers of maize and second hand clothes could earn triple the salary of a junior bank accountant. Nevertheless, as Chen (2012) argues, there is a greater likelihood of being poor as an informal worker. That likelihood is directly correlated to both status in employment² and to gender (Chen 2012). In Ghana women earn approximately 75 per cent of the earnings of men (Heintz 2005).

Despite the clear dominance of the informal economy in Ghana, the interests of informal workers have almost continuously been discounted in the development of both social and economic policies. The late colonial and post-independence governments were focused on promoting large-scale industrialization and the formation of a working-class similar to that in Britain. Market traders and

¹ Self-employed workers who do not employ others.

² In Chen's typology, self-employed workers who employ others are more likely to be better off than self-employed own account workers. Regular waged workers are likely to be better off than both own account workers and casual waged workers, while unpaid family workers usually sit at the bottom of the pyramid.

street vendors – who even then dominated urban employment – did not fit into this socio-economic framework and were largely ignored by national social and economic policies or otherwise actively discriminated against. The subsequent years of political tumult and economic stagnation did little to change that situation.

The economic collapse of the late 1970s, presided over by the Acheampong military dictatorship, spurred on a revolt that saw Flight Lt Jerry Rawlings take the presidency. From 1983, Rawlings embarked on a major overhaul of the economy, known as the “Economic Recovery Programme” (ERP). The ERP was based heavily on neo-liberal economic principles – price controls were removed, state-owned enterprises and basic services were privatized, and civil service employment was cut in dramatic fashion (Gyimah-Boadi and Jeffries 2000). The brief spurt of economic growth that followed the reforms made Ghana a poster child for the IMF and World Bank led Structural Adjustment Programmes (SAP), although the benefits were in fact short lived and the economy continued to stagnate (Gyimah-Boadi and Jeffries 2000).

Like his predecessors, Rawlings’ vision for the Ghanaian economy did not include informal workers. Under his regime, such workers were even blamed for the economic problems facing the country. Shortly after he took power in 1979, Rawlings launched an attack on the market women of Accra’s Makola Market, claiming that they were “hoarders” who were driving up the price of food. He continued this targeting of market women into the 1980s. As Claire Robertson (1983) has argued, the market women, who played a visible role in the recurring shortage of goods and foodstuffs, bore the brunt of the public displeasure that should rightly have been targeted at the less visible sources of inflation, decline in the terms of trade and general corruption that characterized the Ghanaian economy at that time.

Since the return to democracy in 1993, there has been less obvious discrimination against informal workers, although it is questionable as to whether much genuine effort has gone into promoting their interests either. The World Bank has remained one of Ghana’s largest sources of international aid (Harrigan and Younger 2000), and this has certainly played a role in the continued neo-liberal slant of economic policy, with many negative effects on informal workers. These include increased competition for livelihoods as formal sector public employment fell and failed to be replaced by formal private sector employment (Overå 2007), and the privatization of basic services that negatively affects the physical condition of many informal workplaces (Alfers 2011). However, the more recent softening of neo-liberal policy during the 2000s, combined with a growing global awareness about the economic contribution of the informal economy, has also opened up policy spaces for informal workers, as demonstrated by the NHIS and the new national retirement scheme aimed at attracting the self-employed and informal workers.

3. Health and Health Care in Ghana

The history of health policy in Ghana reflects the general trajectory of the country’s political economy as laid out in the previous section. During the immediate post-independence period, healthcare was made a right of citizenship, free to all. With the advent of the ERP, however, the focus shifted from equity to macroeconomic stability (Aryeetey and Goldstein 2000). In 1985, the Government of Ghana introduced a user fee system, popularly known as “cash and carry,” which aimed at recovering 15 per cent of the government’s total recurrent expenditure on health (Asenso-Okyere et al. 1997). At the end of the 1990s, public expenditure on health lay at an annual level of US \$11 per capita, and only 55 per cent of the total financing of care in public facilities came from government sources (Cichon et al. 2003). The cash and carry system was neither a social nor financial success. It did not result in the intended level of costs recovery, user fees resulted in a major decrease in the number of people utilizing health services, particularly amongst the poor, and population health indicators plummeted (Waddington and Enyimayew 1989).

Table 1: Ghana's Demographic and Health Indicators 2008

Indicators	
Population	24 million
GDP per capita	US \$3,100
% urban population	49% (expected to rise to 55.1% by 2015)
Life expectancy at birth	59 (male); 60 (female)
Maternal mortality rate	350/100,000 live births
Proportion of births attended by a trained health worker	35.1% in 2008
Infant mortality rate	50/1,000 live births
Under-5 mortality rate	120/1000 live births. This figure is unchanged from 1990.

Sources: World Bank 2009a; World Health Organization 2008.

Neo-liberal structural adjustment led also to a major process of reform during the 1990s when the Ghanaian health sector was decentralized. The 1996 Ghana Health Service and Teaching Hospital Act removed administrative and service delivery responsibilities from the Ministry of Health (MoH) and delegated them to an autonomous body known as the Ghana Health Service (GHS). The activities of GHS are overseen by the Ghana Health Service Council and a Director-General. The MoH has retained responsibility for policy formulation, planning, donor coordination and resource mobilization (Gyapong et al. 2007). Teaching hospitals also became autonomous bodies, overseen by their own management boards (Ibid). The basic institutional structure of the public health system is pyramidal, with tertiary level teaching hospitals representing the apex of the referral system and Community-based Health Planning and Services (CHPS) and other community level services representing the base (Gyapong et al. 2007). In between these levels are 10 Regional Health Administrations and 110 District Health Administrations, which manage and supervise the levels located beneath them (Bossert and Beauvais 2002).

The softening of neo-liberal policy during the 2000s has allowed for some improvements in the rather dire situation the Ghanaian health system was in by the end of the 1990s. Expenditure on health in Ghana per capita increased from US \$11 at the end of the 1990s to US \$21.66 in 2007 (Global Social Trust 2003; Ministry of Health 2008). However, this figure still falls far short of the US \$34 per capita that the Commission on Macroeconomics and Health (2003) estimated as the minimum necessary to provide a basic package of health services. Health expenditure as a percentage of total government expenditure is difficult to determine, as there is a lack of comprehensive data on this (Jones et al. 2009). The 2006-2009 Medium Term Expenditure Framework places the figure between 14.6 and 16.2 per cent, including contributions to the National Health Insurance Fund (Jones et al. 2009). Gyapong et al. (2007) estimate the 2006 figure at 19 per cent based on government budget projections for that year. On the other hand, a health financing survey conducted in 52 African countries (2010), using data from the WHOSIS database, shows Ghana's general expenditure on health care as a percentage of total government expenditure to have steadily decreased from 11.6 to 5.5 per cent between 1999 and 2007.

The cuts to the civil service that occurred under the ERP had a significant impact on the health sector, and there is still a general lack of professional medical personnel in Ghana. Between 2000 and 2006 there were 3,240 registered physicians in the country – a density of two doctors per 10,000 people. This is low even compared to the average density for low income countries (LICs), which sits at five doctors per 10,000 people (World Health Organization 2008). During the same period there were 19,707 registered nurses and midwives – a density of 9 per 10,000, lower again than the LIC average of 11 per 10,000 (World Health Organization 2008). The problem is particularly acute in the rural northern areas where the doctor to population ratio lies at 1: 92,046 in some parts (Government of Ghana 2007). These depleted health staff numbers have been exacerbated by high rates of emigration. It is estimated that Ghana has lost 50 per cent of its nurses over a 20 year period to countries such as the USA and UK, and 68 per cent of medical officers trained between 1993 and 2000 (Gyapong et al. 2007). To stem this tide, the Ghanaian government recently instituted increases in salaries, overtime pay and benefits for public health workers.

There are large regional disparities in the provision of health infrastructure, with the rural/urban divide being particularly noticeable (Ministry of Health 2007). A large number of Ghanaians (40 per cent), made up mainly of those living outside of urbanized areas, live more than 15 kilometres away from basic health care facilities (Dovlo 1998). The quality of care provided at public hospitals varies. Gyapong et al. (2007) suggest that the large and relatively well-equipped teaching hospitals are more likely to provide better quality care than some of the lower-level district hospitals and primary health care facilities. The Community Voices II survey found that most poor Ghanaians use drug stores and herbalists rather than official health facilities as their first line of care (Institute for Policy Alternatives 2006). The survey also found that a large number of people travel long distances, at significant cost, to access distant hospitals as their second line of care, rather than utilizing local clinics, which are considered vastly inferior.

Unpleasant staff attitudes towards patients, and particularly towards poorer patients, are another reported reason for a general reluctance to use health facilities (ILO 2005). The Community Voices II survey found that an “appalling” medical staff attitude towards poorer patients was a common complaint from the survey respondents (Institute for Policy Alternatives 2006). The problem of staff attitudes is exacerbated by the heavy workloads and poor working environments in which many health staff have to operate (Clarke 2003).

The cost of medical care is high compared to average earnings in Ghana. A study conducted in the Eastern Region found that 80 per cent of surveyed households had experienced difficulties in paying their medical bills at some stage in the past (Asenso-Okyere et al. 1997). Sulzbach et al. (2005) found the cost of basic outpatient care (including informal care and transportation) generally ranged between GH¢2.20 (US \$1.40) and GH¢2.90 (US \$1.90). This is high considering that the average Ghanaian earns less than GH¢1.10 a day (Ghana Statistical Service 2008). Moreover, higher level care appears to be much more expensive (De Graft-Aikins 2007).

4. The National Health Insurance Scheme

4.1 The Development of the NHIS

The development, direction and design of the NHIS has been influenced by a number of factors both internal to Ghana and arising from international trends and pressures. In Ghana itself, the cash and carry system had become deeply unpopular, and this had not gone unnoticed by politicians. In the 2000 general elections, the National Patriotic Party (NPP), which was subsequently elected to power, promised to abolish the system and develop a more equitable solution to the country’s pressing health problems. The stated goal of the new government was to have 50 to 60 per cent of the population covered by a national health insurance scheme within 10 years of the implementation of the new scheme, with a final goal of universal health insurance coverage (Cichon et al. 2003). In order to reach this goal, the scheme’s designers had to grapple with the difficulties of instituting a state insurance scheme that could also cover the informal economy.

However, while health equity may certainly have played an important part in the scheme’s development, it was certainly not the only motivation behind it. Despite the facts and figures presented in the previous section the NHIS, which has been the flagship health programme of successive governments since 2003, is in fact delinked from concerns about health service provision. The NHIS and the GHS operate as very distinct entities, with the NHIS being seen solely as a financing mechanism according to Seddoh et al. (2011). So although the NHIS may make health care more affordable, it does nothing to actually improve the quality of care that is available. The paradox of this situation is captured by Seddoh et al. (2011) when they state “the uptake of skilled birth attendants has dropped since insurance was introduced. A number of other public health indicators are also dipping. These could be more symptoms of health service delivery weakness than the financing end effect.”

This raises suspicions that the NHIS is perhaps less driven by concerns about health equity than by other motives. Seddoh et al. (2011) highlight one of these motives when they state that the NHIS has “brought

on board private sector participation and allowed it access to government funding.” Indeed the Ghanaian government has made it known that it would like the share of private healthcare provision in total provision to increase from 35 per cent to 65 per cent by 2017 (Gyapong et al. 2007). While private health providers may be better equipped and resourced than state institutions, there is a wide literature to show that private health service provision often fails to work in the interests of the poor and marginalized (Baum et al. 2009; McIntyre 2010; Doherty 2011). Nevertheless, this is still a strategy that is pursued by powerful actors on the international health scene, including the World Bank.

Of course, the turn towards insurance in Ghana may have much to do with the country’s own history. Nkrumah’s free health system never did deliver the results it intended to. His gaze too quickly shifted from the provision of countrywide basic primary healthcare centres to the building of large and expensive hospitals in the main centres. The succession of economic disasters that occurred during and after Nkrumah’s rule took their toll on an already vulnerable health system (Addae 1996). This in all likelihood has engendered a lack of trust of the free universal healthcare model amongst modern policy makers in Ghana. Yet the influence of international actors like the World Bank in promoting an enlarged private health sector cannot be discounted, particularly considering its history in Ghana.

A final important factor in the development of the NHIS was the resistance to the scheme that arose amongst formal workers. The labour unions protested the recommendation that a portion (2.5 per cent) of formal workers’ Social Security National Insurance Trust (SSNIT) contributions go towards the financing of a centralized National Health Insurance Fund (Interviewee 2009). Formal workers were also worried that their medical benefits might be downgraded if employers opted to pay for NHIS coverage rather than private medical insurance. Compromise was reached when it was agreed that formal workers would be able to access the scheme for “free,” and that employers would only move to the NHIS once it was established that the benefits were at least equal to the existing benefits under private medical schemes.

4.2 Structure, Operation and Financing of the NHIS

The NHIS is a hybrid of the social and community based health insurance models. The basic structure of the NHIS is described as a “hub-spokes” or “hub-satellite” model. The “hub” of the system, which is essentially based on the Social Health Insurance (SHI) model of pooled public tax resources, is the National Health Insurance Fund (NHIF), which is administered by the National Health Insurance Authority (NHIA). The “spokes” are a country-wide network of CBHI schemes known as District Wide Mutual Health Insurance (DWMHI) schemes, which are monitored, subsidized and re-insured by the “hub.”

The NHIF is financed from several different sources, which include the following:

- donor funds (few details on these donor funds are available)
- funds allocated to the scheme by the Government of Ghana via Parliament
- 2.5 per cent of the 17.5 per cent Social Security and National Insurance Trust (SSNIT) contribution made by formal sector employees (the 17.5 per cent contribution is made up of a 12.5 per cent contribution from employers and 5 per cent contribution from employees)
- a 2.5 per cent health insurance levy added to VAT (for exemptions from this levy, see box 2)
- the central exemptions fund, formerly used to provide exemptions from user fees for those classed as “indigent”
- money that accrues to the fund from investments made by the NHIC

www.nhis.gov.gh

The vast majority of the money coming into the NHIF in 2009 was from the NHIS VAT levy. This made up 72.2 per cent of the total available funds, followed by the SSNIT contributions, which made up 22.1 per cent. Allocations from parliament made up a further 4.9 per cent of the funds, and investments made up 1.8 per cent. Membership premiums are collected at scheme level and are not officially part of the NHIF. In 2009 these contributed 3.7 per cent of total NHIS resources (Seddoh et al. 2011). At present, employers

are not held to additional contributions over and above their contributions to the SSNIT. However, the NHIC has apparently made it known that it would prefer employers to contribute an additional sum to the NHIF equal to that of the employee's contribution (Gyapong et al. 2007).

The National Health Insurance Act 650 establishes an independent national governing body for the scheme, the National Health Insurance Authority, whose mandate is “to secure the implementation of a national health insurance policy that ensures basic health care services to all residents” (Act 650, Section 2 (1)). Section 3 of the Act establishes the governing body of the Authority, known as the National Health Insurance Council (NHIC), which administers the National Health Insurance Fund. The President of Ghana is given sole power to appoint the chairperson and members of the Council (Act 650, Section 3 (2)). The Secretary-General of the Ghana Trades Union Congress (GTUC) sits on the Council as the representative of both formal and informal labour.

Each district in Ghana has a District Wide Mutual Health Insurance scheme, and some larger metropolitan districts have several (McIntyre et al. 2008). As with the other CBHI schemes, membership is voluntary (Gyapong et al. 2007). The DWMHI schemes have their own management structures and have a certain level of autonomy in the setting of premiums and the charging of other costs, although these have to be kept within the limits established by the NHIA. The original plan for each DWMHI was that it would be managed by a Board, elected by a General Assembly comprised of Community Health Insurance Committee (CHIC) representatives. CHIC representatives were to represent geographically determined “Health Insurance Communities” within each district (Grub 2007). The role of the CHIC was officially to oversee the collection of contributions within its designated Health Insurance Community, to supervise the deposit of these into the District Health Insurance Fund, and to represent community interests in the management structures of the DWMHI scheme (www.nhis.gov.gh). However, as Seddoh et al. (2011) point out, this structure has not been in operation. When the National Democratic Congress (NDC) took power in 2009, it dissolved the DWMHI boards in a heavily contested attempt to centralize the scheme, and they have never been replaced. The CHICs have also remained a theoretical idea more than anything else, as little has been done to formally lay out a role for them in the current setup (Seddoh et al. 2011).

The NHIA has set the DWMHI annual premium levels at a minimum of GH¢7.20 and a maximum of GH¢48 (approx. US \$4.70-\$31) per adult member, to be determined by income status. The NHIA website states that this can be paid as a lump sum, or in 12 monthly instalments (www.nhis.gov.gh). Members pay their premiums to the DWMHI schemes directly. Premiums can be paid at any time during the year – there is no set registration period.

The information on premiums available on the NHIS website has been contradicted by recent review articles. For example, according to McIntyre et al. (2008), the difficulty of accurately assessing earnings in the informal economy has meant that DWMHI schemes now generally charge a flat rate of GH¢7.20 per member rather than using the graded premium system. Jones et al. (2009) state that some urban schemes now charge between GH¢15-20, while others charge the flat minimum rate of GH¢ 7.20, and still others maintain the graded premium systems. Where graded premiums are still used, judgements on the socio-economic status of potential scheme members are made on the basis of questions asked at the time of registration as well as on the recommendations of CHIC representatives.

New developments in the scheme may signal a significant change in the premium structure, however. The government is considering the possibility of instituting a one-time premium that would guarantee access to the NHIS for life. Although no definite figures have been given as yet, rumour has it that the lifetime premium may be in the range of GH¢150, although the figures as low as GH¢15 are also heard. A paper by Abihiro and McIntyre (2012) reveals that four years after the idea was first presented, there is still a lack of consensus about whether this will go ahead and a lack of clarity as to what is meant by a one-time premium. This general state of confusion was exacerbated by a statement from the CEO of the NHIA that proposed a dual system of one time payments and annual premiums (Abihiro and McIntyre 2012).

Exemptions from premium payments exist for SSNIT contributors, SSNIT pensioners, those over the age of 70, and for those classed as indigent. Indigents are classified as those people who:

- have no visible source of income
- have no fixed abode
- are not living with an employed person with a fixed abode
- have no consistent source of support from another person

www.nhis.gov.gh

The granting of indigent status is determined in consultation with CHIC representatives (Interviewee 2009). Since 2008, pregnant women have been exempted from having to pay for any pre- and post-natal health services, including NHIS registration and premiums. In the same year, exemptions were also extended to all children under the age of 18. Initially, this exemption for children was only granted to those whose parents were members of the NHIS, with children's names being added to a "folder" attached to the membership card of the mother. This system drew much criticism for effectively denying health insurance to children whose parents were not NHIS members.

During the course of this research, it became clear that although children's membership is now delinked from parent's membership and is in theory free, NHIS membership is still not totally free for children. As will be seen, participants in this study were adamant that extra charges to include children still existed, and a conversation with a district scheme manager to clarify this issue confirmed that extra fees were still being charged for children at the time this study was done (Interviewee 2009). These are classed as registration fees, which schemes are empowered to collect by the legislative instrument governing the implementation of the NHI Act. The registration fees for children vary between GH¢1-2, depending on the scheme, and are multiplied by the number of children registered. So a woman with three children could have to pay up to GH¢6 extra to register all her minor children.

Once registration has taken place and premiums have been paid or exemptions granted, new members have to wait three to six months for an ID card to be issued (this waiting period appears to vary between individual schemes). Only once the card has been issued are members actually able to access health services. These cards have to be renewed on an annual basis, although this too would change with a one-time payment premium system.

The NHIF subsidizes the district schemes by refunding them for the exemptions they grant according to the number of exempted members registered by each scheme. These funds reach the DWMHI schemes via the regional offices of the NHIA. These regional offices are the interface between the district schemes and the NHIA in terms of reinsurance and technical support.

4.3 Benefits Package

The health services covered by the NHIS are laid out in the minimum basic benefits package. The list purports to cover 95 per cent of all health problems reported in Ghanaian health care facilities (**see box 1**). There is also a prescribed medicines list. Expensive, highly specialized care such as dialysis and organ transplants is not covered by the NHIS. Neither are antiretrovirals (ARVs) for the treatment of HIV/AIDS covered as these drugs are supplied by a separate government programme (www.nhis.gov.gh). As one of the reasons for the NHIS's existence is to stop out-of-pocket health care payments, no additional payment of any kind is supposed to be made by NHIS members when accessing health care (Asante and Aikins 2008). Claims are made by the health services, and the district schemes pay providers on a fee-for-service basis (McIntyre et al. 2008). As mentioned earlier, since 2008, all pre- and post-natal care is free for pregnant women irrespective of NHIS membership status.

Box 1: NHIS Benefits Package

Outpatient Services

- general and specialist consultation reviews
- general and specialist diagnostic testing, including laboratory investigation, X-rays, ultrasound scanning
- medicines on the NHIS medicines list
- surgical operations such as a hernia repair
- physiotherapy

Inpatient Services

- general and specialist inpatient care
- diagnostic tests
- medication – prescribed medicines on the NHIS medicines list, blood and blood products
- surgical operations
- inpatient physiotherapy
- accommodation in the general ward
- feeding (where available)

Oral Health

- pain relief (tooth extraction, temporary incision and drainage)
- dental restoration (simple amalgam filling, temporary dressing)

Maternity Care

- ante-natal care
- deliveries (normal and assisted)
- caesarean section
- post-natal care

Emergencies

- medical emergencies
- surgical emergencies
- paediatric emergencies
- obstetric and gynaecological emergencies
- road traffic accident

Exclusions List

- appliance and prostheses including optical aids, heart aids, orthopaedic aids, dentures, etc.
- cosmetic surgeries and aesthetic treatment
- HIV antiretroviral drugs
- assisted reproduction (e.g. artificial insemination) and gynaecological hormone replacement therapy
- echocardiography
- photography and angiography
- dialysis for chronic renal failure
- organ transplantation
- all drugs not listed on the NHIS list
- heart and brain surgery other than those resulting from accidents
- cancer treatment other than breast and cervical
- mortuary services
- diagnosis and treatment abroad
- medical examinations for purposes other than treatment in accredited health facilities (eg visa application, educational, institutional, driving licence, etc.)
- VIP ward (accommodation)

Source: www.nhis.gov.gh

4.4 General Performance of the NHIS to Date

Official data supplied by the NHIA suggests a rapid increase in the number of Ghanaians registered with the NHIS since 2003. As of June 2010, the NHIA claimed to have registered 66 per cent of the population with 59.5 per cent being holders of ID cards and therefore able to access benefits. Member satisfaction was high according to a study by Asante and Aikins in 2008, which found that 97.2 per cent of the card carrying members surveyed were happy enough with the scheme to continue with their membership. Osei-Akoto and Adamba (2011) also report that NHIS membership has protected households from high health expenditures.

The NHIS has increased utilization of formal health facilities – one of the main goals of the scheme. Use of outpatient and inpatient department services almost doubled between 2005 and September 2007 according to a report by the Ministry of Health (2008). However, the report does not make it clear whether this was a reflection of an increase in the number of people using health services or whether it was the number of visits to health services that increased.

Moreover, problems with the NHIA's data on coverage have been pointed out in a recent report by Apoya and Marriott (2011: 24), who argue that ID card holders probably represent no more than 18 per cent of the Ghanaian population. The report claims that the NHIA has manipulated the data to achieve inflated figures in two ways: firstly, by measuring coverage against 2004 population figures, thereby failing to account for population increase; secondly, ID card figures have allegedly been inflated by using an accumulated figure of the number of people who have ever held an ID card rather than measuring the number of people with a valid ID card at any one given time. This means that those people who once held ID cards, but no longer do, are still counted as ID card holders.

Apoya and Marriott (2011) have also been particularly critical of the NHIS's exclusion of the poor, arguing that although all Ghanaians contribute towards the NHIF through the extra VAT payments, only a small proportion – the wealthier ones – actually benefit from it. In this way, the poor help to subsidize health care for those who are wealthier while remaining excluded themselves. The report describes the NHIS as a “tax-funded national health care system, but one that excludes 80% of the population” (Apoya and Marriott 2011).

Financial woes have dogged the scheme since its inception and its sustainability has repeatedly come into question. According to Rajkotia (2007), there have been unofficial reports of insolvency from over 20 schemes, and five were actually bailed out by government with US \$2.8 million between 2005 and 2006. District schemes rely on membership premiums for a substantial part of their revenue. The fact that 64 per cent of those registered with the NHIS have done so under exempt status clearly has financial implications for these schemes (Seddoh et al. 2011)

5. Informal Workers and the NHIS

5.1 In-country Research: Objectives, Methods, Participants

Having detailed the underlying political and economic context of the NHIS, this paper now moves on to an analysis of informal workers' interactions with the scheme. The empirical research that informs the following section sought to understand the perceived benefits of the scheme to informal workers, the barriers workers (particularly women workers) have faced in accessing it, and their representation on the scheme's governing committees and boards. Contact with most of the workers interviewed in this study was established through the GTUC, to which a number of informal worker organizations are affiliated.

Forty workers, 39 of them women, participated in three separate research studies that took place over a two year period (2009-2010) in Accra. Although the studies were small, they nevertheless enabled important insights into the nature of the interactions informal workers have had with the scheme. Participants in each of the studies were drawn from three different occupational groups: market traders, indigenous caterers (otherwise known as chop bar operators, women who run informal eating houses serving local food) and *kayayei* (headload porters, usually young women and girls who have migrated from the rural northern regions). The study with traders purposefully focused on their relationship with the NHIS, and participants were aware that the NHIS would be the main topic of discussion. The traders were split into three groups, and separate focus group discussions were held with each of the groups. The research conducted with the indigenous caterers and the *kayayei* were more exploratory in nature and focused on working conditions more generally. Questions about NHIS membership were inserted into semi-structured individual interviews, and participants did not know beforehand that the NHIS would be a topic for discussion.

The socio-economic characteristics of each of the three occupational groups were very different. The chop bar owners on the whole were the best off of the three groups. Many of the women interviewed had moved up through trading and hawking of foodstuffs to eventually owning, or inheriting, a chop bar. The *kayayei* women, all of whom were migrants from the rural north of Ghana, were the poorest group overall, with average daily earnings of only GH¢3 (US \$1.94). The market traders were a mixed group – Focus Group 1 (FG1) (weekly average earnings of GH¢106/US \$68.83) and Focus Group 3 (FG3) (weekly average earnings GH¢98/US \$63.64) having significantly higher earnings than Focus Group 2 (FG2) (weekly average earnings GH¢31/US \$20.13).

As can be seen from table 2, the majority of participants interviewed – 31 out of 40 – were not NHIS members.

Table 2: NHIS Membership Among Participants

	Current NHIS members	Lapsed NHIS members	Never registered with NHIS	Total Interviewed
Chop Bar Operators	3	5	12	20
Market Traders	6	4	3	13
<i>kayayei</i>	0	0	7	7
TOTAL	9	9	22	40

5.2 Research Findings

The participants who were card holders of the NHIS felt that it had allowed them to better care for their and their families' health by removing the financial barrier of out-of-pocket payments at the point of service. Two women in the focus groups spoke of the way in which the NHIS had allowed them to care for their sick children at a time when they were short of readily available cash. One of these woman felt she had benefitted enormously from being able to access a private mission hospital accredited by the NHIS, where she felt the quality of care was superior to the public facilities. Accessing this facility was not something she had been able to afford under the old cash and carry system.

There are high and rising levels of hypertension amongst Ghanaian women in Accra (De Graft Aikins 2007). According to some of the participants in this study, the NHIS has made it easier for them to have regular blood pressure checks, which are free under the scheme. By increasing access to such preventive health facilities such as these, the NHIS has the potential to make important inroads into reducing the load on the health system in the longer term.

The focus on reproductive and gynaecological health was also welcomed by most of the participants, whether they were members or not. The free care given to pregnant women before and after birth was seen in a very positive light, although most of the women were themselves past childbearing age. One woman talked about her sister-in-law who had to have a caesarean section and who "was well catered for and did not even have to pay ten pesewas" for the operation or post-operative care. Another participant spoke of the importance of the free fibroid removal operations available under the NHIS. She felt that these operations had saved the lives of a lot of women who in the past would not have sought treatment because of the prohibitive cost of the operation.

The overall impression given by the card holders was that unconstrained by financial considerations when in need of health care, they experienced a greater sense of freedom in their lives. In the words of one participant:

"Before the NHIS came health care was so expensive, you had to pay a lot of money. Now we feel fine, we feel free, because if you didn't have money and you were sick it was very terrible – how could you go to hospital? But now that the health is free, you can go whenever you feel that you are not fine. You just pick [up] your card and go and see the doctor. We feel free now, it is good for us."

In this way, the NHIS has most certainly contributed to a greater sense of well-being among its members. The problem is, of course, that the majority of participants in this study were not card carrying members of the scheme. When asked about why they were not members of the scheme, there were a number of different responses with a noticeable division along class lines. These responses can roughly be divided into two categories – those to do with the premiums, and those to do with the more general structure and functioning of the scheme.

5.2.1 Premium Related Barriers to Access

For the poorer workers, such as the traders of FG2 and the *kayayei*, the most important barrier to access was the cost of the premiums. This was not considered a problem by the other trader groups, and only one chop bar owner (classified as "poor" by her interviewer based on a visual assessment of her workplace) said she considered this to be a problem. This gives an indication, suggested earlier by Apoya and Marriott's (2011) criticism of the scheme, that the NHIS is in fact reinforcing rather than challenging class divisions amongst informal workers.

For the *kayayei*, who earn on average GH¢3 a day and in many cases have a child to care for, even the lowest annual premium of GH¢7.20 seemed out of reach. All of the women in this group interviewed

were migrants from the north with no family connections in Accra. On their GH¢3 a day, they paid for accommodation and electricity supply in a small wooden structure, shared with eight others, located in Komkomba Market in Accra. They also had to pay daily for fresh water and the use of the toilet in the market, in addition to food, clothing, and other subsistence items. In addition, they sent remittances to families back home. Moreover, there is no security available in the market, and the women are left vulnerable to theft and assault.

The living and working conditions of the *kayayei* are such that the women are prone to ill health; common issues include body pain, malaria, and sexual assault. They cannot afford the NHIS premiums, and neither can they afford the fees charged by health facilities. They complained that their employers (market traders and chop bar owners) “neglect” them when they are ill. As a result, they self medicate, except in really serious cases when they will pool money to send a co-worker to hospital. The failings of the exemption system are clear in this case – it ignores the large numbers of “working poor” in Ghana who, because they work, cannot be classified as indigent, yet do not earn nearly enough to afford the most basic premium available.

The traders of FG2 were somewhat better off than the *kayayei* although they also felt that the premiums were too expensive. The only NHIS member in this group was also the highest earner by a large margin. However, one particularly striking aspect of the focus group discussions about the premiums was the extent of confusion about the minimum premium rate. The women of FG2 insisted that the minimum annual premium was GH¢24, which they considered to be too high to pay at one time. However, the participants in FG1 were equally adamant that the minimum premium cost GH¢15, and the participants in FG3 thought that it cost between GH¢20 and GH¢22 depending on whether children were added as dependants.

An interview with a District Scheme Manager to review these figures revealed that the official minimum premium is still the GH¢7.20 originally set up by the NHIA. None of the focus group participants was aware of this. District schemes do have a certain degree of autonomy in deciding on their premium levels (as long as they are within the broad GH¢7.20-48 range), so it is perhaps not surprising that participants had varying ideas of what the premium levels were. Furthermore, it appears from the focus group discussions that much of the evidence used to ascertain the cost of premiums comes from hearsay circulated in the markets.

Unfortunately, this can mean poorer workers who might qualify for a lower premium level, such as the women of FG2, are not aware that the premium for them might be much lower than the GH ¢24 paid by a market neighbour who earns more than they do. Because they lack the knowledge that there are variations in the premiums according to income status, the women feel that the scheme is unaffordable, when this may not always be the case. Moreover, this lack of knowledge means that they do not have the power to negotiate a more affordable premium level for themselves.

Participants in FG2 were also concerned about the extra charges to register minor children. These charges made the premium seem even further out of reach financially. Several focus group participants were unwilling to join the scheme because they could not afford to pay for themselves and their children; also, the poorer women had more children. The feeling seemed to be that if all family members couldn't be covered by the scheme, then it was better if no one was. This was also true for women who had children over the age of 18, and who would have to pay a full premium for these children to register as their dependants.

Although this group did not consider premiums to be the main barrier to NHIS access, other significant discussions around the NHIS premiums occurred during FG3. The possible introduction of a one-time premium was one focus of this session. Although no official statements about the introduction of the premium had been made by the government, rumours about it were rife. The figure of GH¢150 came up in conversation, although no one was sure about what the actual figure would be. Interviews with key informants suggested that the premium might also be kept low – around GH¢15. Participants in FG3 wanted more information on this premium.

When asked what they felt about the introduction of such a premium, those in FG3 agreed that it would be a good idea so long as the cost was kept within affordable limits. One participant felt that a GH¢40 premium would be affordable, while another considered GH¢100 to be acceptable. It must be remembered that this group, on average, earned significantly more than those in FG2. It is very unlikely that the FG2 participants or the *kayayei* would have considered GH¢100 to be an acceptable amount to pay. However, even FG3 felt that GH¢150 was far too much to pay in a single instalment. As one woman put it, “we have to pay rent, we have to pay for utilities, we have to buy goods and we have to buy food. With all of that who can afford to pay GH¢150?!”

A second issue regarding the premiums was the timing of premium payments. According to some members of FG2, the premium of GH¢20 (which they thought was the minimum) covers an individual for five years, not one. However, further discussion revealed that this five year policy was introduced for a brief period under the old NPP government and has since been revoked by the new NDC government, which is considering replacing it with the one-time premium. According to the male participant in this group, if one had to register with the NHIS now, one would only receive coverage for one year, although not everyone seems to be aware of this. What is clear, however, is that these seemingly haphazard or poorly-communicated changes in policy have significantly increased the general confusion around the premiums.

5.2.2 Administrative Systems as Barriers to Access

The problems informal workers have in accessing the NHIS sometimes work across class divisions. One of the most important barriers to access cited by all participants, regardless of their socio-economic status, was the chaotic administration of the district schemes. This was considered to be the major barrier to access by FG3 as well as by four of the chop bar owners who were not NHIS members. Though the sample size was small, the participants conveyed a convincing sense that the problems faced by many informal workers in accessing the scheme are very basic, practical ones.

One participant in FG3 related how he had attempted to register with the NHIS when the scheme first started. He and six friends had paid an amount of GH¢8 each as an initial premium. However, none of them received ID cards after the agreed upon waiting period of six months. When they returned to the district scheme to find out what had happened, they were told that the GH¢8 premium had been “abolished,” and that they therefore did not have NHIS membership. They were told that the premium had changed to GH¢20 and that they would have to pay this amount in full to join the scheme. As a consequence of this negative experience, neither the participant nor any of his friends had tried to join the scheme again.

A similar story was told by another market trader, who had on two occasions paid her premiums, but had yet to receive an ID card. One of the chop bar owners had tried to renew her membership, paid her premiums, not received an ID card, and said that she had not had the time to follow up and so had given up on the NHIS. Three other chop bar owners had experienced the same problem when trying to register for the scheme. One woman had followed up, only to find that the district scheme offices had moved to an unknown location: “I have done this [tried to register for the scheme] three times, yet I have not been able to get it. The last time I did it and paid I had no response. I used to visit the place, but now they are no longer in the place they used to be. I went there to do it, yet I have had no response from them.”

Two other problems were identified as significant barriers to access. First, NHIS card holders are reportedly being made to wait for treatment behind cash paying patients at health facilities. As mentioned earlier, this appears to be a consequence of overcrowding at health facilities and the late payment for health services by the NHIS.

Most of the focus group participants were convinced that there was a delay in treatment for NHIS card holders – although interestingly, it was those who were not NHIS card holders who complained about it the most. However, one of the three chop bar owners who was a card holder complained about this, saying that

hospitals pay “no attention” to NHIS members. Participants in FG2 and FG3 stated that they would like to see the situation revert back to “how it was in the old days” of the scheme, where people with NHIS cards were given priority and those without cards were even turned away from health facilities.

The long waiting times are especially problematic for informal workers, for whom time is, quite literally, money. While these workers are trying to get treatment for their health problems, they are unable to operate their businesses and they may lose a significant amount of income depending on the length of time they are made to wait. When one of the focus groups was asked if they felt that the NHIS had improved their productivity in any way, one of the card holders said that it had most certainly not because “going to get care with your NHIS card means you won’t be able to open your shop at all, you’ll be there so long.” This problem is apparently aggravated by the late opening times of many health facilities, which prevent workers from being able to access treatment before going to work.

The second major barrier identified was the quality of care available under the NHIS. The poor attitudes of health staff towards patients at public health facilities was singled out in particular. As indicated earlier in this report, this is a commonly identified problem in Ghana and around the developing world. One woman in FG2 claimed that “the doctors and nurses are worse than the disease. Another participant complained about the treatment of women in labour, saying that the pain is bad enough – you don’t need to be spoken to rudely as well.” One of the FG3 participants even went so far as to blame the poor Ghanaian maternal mortality statistics on the attitudes of nurses in public facilities.

Other quality issues that were identified involved the drugs available under the NHIS. Two of the chop bar owners complained that their NHIS membership did not cover them for expensive drugs. One cited it as her reason for not renewing her membership. These claims were supported by a number of focus group participants who said that NHIS card holders are only given paracetamol, quinine and multi-vitamins and not drugs appropriate to their condition. There were also complaints about the physical environment of public health facilities. One focus group participant complained that “the beds are bad, the environment is unpleasant, and there is no furniture to sit on.” These concerns about quality left many of the street and market traders, as well as the chop bar owners, with a very negative feeling towards the health care system, and these feelings have certainly contributed to an unwillingness to join the NHIS. This points again to the paradox inherent in setting up a health insurance scheme without simultaneously strengthening the health system on which its efficacy relies.

One final barrier to access was discussed by the association leaders in FG1 who felt that the greatest barrier to NHIS access among informal workers was a lack of education about the scheme and its benefits. Although the New Makola Market Traders’ Union – NMMTU – has been active in educating its members, the leaders felt that other informal workers did not really understand the benefits they would derive from joining the scheme. According to this group, many informal workers are uneducated about the basic principle of insurance and are therefore hesitant to join because they do not want to pay for a service they may not use. Certainly this was a theme that emerged during the chop bar interviews. Two chop bar owners had allowed their NHIS membership to lapse because they hadn’t needed to use it, and so considered it to be a waste of money, and another had not joined at all because she was “never sick” and so saw little point in it. It seems the scheme’s three to six month waiting period has also not been well explained to the public. The purpose of the waiting period, as in many commercial insurance schemes, is to create a financial buffer by exempting it from having to pay out for a certain period of time. A number of participants in this study felt, however, that the waiting period was just another way for the scheme to treat them unfairly by preventing them from getting their money’s worth. “What is your money doing during that time?” asked one participant.

The association leaders in FG1 felt that better education services in the market places and other centres of informal work should be a top priority of the NHIA to combat these problems. They said many of the education campaigns have bypassed informal workers because of the workers’ inability to leave work and attend the mass rallies that have been held. Instead of such rallies, the FG1 participants thought it would

be a good idea to have a health information booth installed in the markets where people would be able to get information about the NHIS. “We market workers cannot always go to them, they must also come to us,” said one participant.

Aside from the fact that they relate to difficulties with the scheme’s administrative functioning and systemic design, there is another common thread that runs through the above stories: time and its relationship to money. As mentioned above, most informal workers work on their own time, and when they lose that time, they also lose a proportion of their productivity and their income. Considering that 90 per cent of workers in Ghana are informal, social programmes that serve to take informal workers away from their workplaces for long periods of time must also have an impact on the overall national productivity. Yet nothing in the design of the NHIS, in its administrative set-up or its communication strategy, or in the Ghanaian health system more widely, gives any indication that time has been properly considered by policymakers. It points to another possible dualism being created by the NHIS – those with the time to wait for the NHIS (or the resources to bypass cumbersome systems) and those without it.

5.2.3 Representation and Voice of Informal Workers

In addition to the questions that focused on NHIS access, participants in FG1 were asked questions relating to the representation and voice of informal workers in the NHIS decision-making process. It was clear that representatives from informal worker associations have had very little direct representation or voice in these processes or in the governance structures of the NHIS. The Secretary-General of the GTUC does formally represent informal workers on the NHIC. However, none of the existing informal economy leaders sat on any of the governing bodies of the district schemes or were represented on the CHICs. Neither had they been consulted, as representatives of informal labour specifically, on any policy decisions related to the NHIS. As a consequence, they felt that neither the district schemes nor the central body had any real idea about what is actually going on in the markets or on the ground in terms of issues to do with the scheme’s functioning and reach.

6. Conclusions and Recommendations

Ghana is a country on the rise; newly discovered oil reserves and political peace and stability saw it move from low income country status to middle income country status in 2011. Yet this newfound wealth has not translated into benefits for all the country’s citizens equally – although income poverty has been reduced, income inequality is on the rise (Kanbur 2013). Rising inequality in Ghana has been and remains a consequence of its integration in the global economy, where liberal trade and growth-based economic models set the terms of engagement and which have led to rising inequality across the globe. As Althusser pointed out, if the underlying structures of power promote inequality, the policies and institutions that derive from those structures are likely to reproduce it. “How can one have equity in health matters in fundamentally unequal societies?” ask Coburn and Coburn (2012: 18).

While the NHIS has in some ways represented an attempt to create “equity in health matters” in an unequal society, it itself is a product of this society. The focus on increasing private sector involvement in healthcare, to the point where equity seems to have been somewhat side-lined as a major policy goal, reflects this. The fact that informal workers were not included in the deliberations around the scheme, had no say in its final design, and are still not properly represented in the scheme reflects their marginal economic and social status. From this small study, it is not possible to make generalizations about the scheme’s impact across Ghanaian society as a whole. Much more would need to be known about the private sector’s role in health provision and whether the failings of the NHIS had caused a greater shift towards private health provision. However, the results from this study do suggest that the scheme may be reinforcing rather breaking down class divisions, including those that exist between informal workers and perhaps even between women workers.

The NHIS has also created a dualism between those with the time to deal with the cumbersome administrative procedures and to access the necessary information on the scheme and those without the time. The time issue may of course be seen as a nuance on the general class division that the NHIS has reinforced. Those with more resources can pay others to do the work for them, and it has been reported that district schemes tend to make registration easier and more accessible in the wealthier parts of town. Yet it does not adhere completely to the lines of socio-economic status. The chop bar operators interviewed in this study are fairly well off – perhaps better off than many formal workers, yet their time was still too valuable to them to lose. In contrast, a formal worker with a lower socio-economic status may well have been able to take a day's paid leave to sort out his or her NHIS registration. Rather than serving to break down the dualism between the formal and the informal, the NHIS may only have served to reinforce it.

Apoya and Marriott's (2011) report on the NHIS, which was supported by three Ghanaian NGOs and Oxfam, is titled *Achieving a Shared Goal: Free Universal Healthcare in Ghana*. This gives an indication of the report's main recommendation: to replace the NHIS with a non-insurance based universal health care system. Apoya and Marriott's report cites many of the problems that have also emerged during this present research – the expense of premiums for the poor, bad administration of overly complicated structures, confusion, and corruption – to argue their case. They argue that the money spent to maintain the NHIS could be better spent on developing a more equitable system that all Ghanaians can access. The report has caused a stir in Ghana and in international health policy circles.³ Going into the details of the debate is not within the scope of this paper, but it should be pointed out that Thailand is one country where a health scheme that required very low contributions from users was later converted into a free universal health care system.

Whatever health financing route the Ghanaian government ultimately decides to take, it is important, for now, that the scheme begin to address some of the specific barriers to access that informal workers face. Some of these barriers are related to the wider functioning of the health care system and of the scheme itself and may not be simple to solve. This study has identified some areas, however, where focused action could be taken in a relatively straightforward manner:

1. Regulation of urban premium levels: Anecdotal evidence suggests that the minimum premiums in urban areas are set well above GH¢7.20 because urban areas are considered to be wealthier than rural areas. It is not always easy to draw a clear geographical line between the rural and the urban in Ghana – there are significant populations of very poor, rural migrant workers, such as the *kayayei*, living and working in cities like Accra. Ideally for workers as poor as the *kayayei*, there should be some form of premium exemption. Failing this, there should be regulations which force urban district schemes to at least offer the lowest premium (GH¢7.20) to such workers.
2. Better dissemination of information in informal workplaces: Awareness of the NHIS amongst Ghanaians is high – no one interviewed in the research was unaware of the scheme's existence. However, there is a difference between a general awareness about the scheme's existence and the wide availability of accurate information on how it works. The market areas could be strategic places to provide this kind of information. The market women themselves suggested that health booths could be installed in the markets to act as information points. They could also be used as a central space in which to conduct targeted, detailed education campaigns for market workers and customers alike. Using worker organizations to spread accurate information about the scheme may also be a good idea.
3. Better representation of informal workers at all levels of the NHIS: The NHIA makes provision for a representative of organized labour to sit on the National Health Insurance Council (NHIC). This position has

³ The report was heavily criticised by the NHIA who argued that Oxfam and its Ghanaian partners had used a "flawed methodology." Oxfam and partners refuted this and provided a strong defence of both their methodology and the report as a whole.

been filled since the inception of the scheme by the Secretary-General of the Ghana Trades Union Congress (GTUC). As the GTUC represents both formal and informal workers, informal workers are technically represented on the governing body of the scheme. However, the interests of formal and informal labour are not always the same, and it is likely to be very difficult for one individual to truly represent the interests of both groups. In this case, it is important that provision is made for an additional representative of informal organized labour to sit on the NHIC.

It is also important that representatives of informal workers be included in the governing bodies of the district schemes. All levels of the NHIS need to keep in touch with what is happening on the ground, and including representatives of informal labour in these bodies is a necessary part of doing that, especially considering the central role these workers play in Ghanaian social and economic life.

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About WIEGO: Women in Informal Employment: Globalizing and Organizing is a global research-policy-action network that seeks to improve the status of the working poor, especially women, in the informal economy. WIEGO builds alliances with, and draws its membership from, three constituencies: membership-based organizations of informal workers, researchers and statisticians working on the informal economy, and professionals from development agencies interested in the informal economy. WIEGO pursues its objectives by helping to build and strengthen networks of informal worker organizations; undertaking policy analysis, statistical research and data analysis on the informal economy; providing policy advice and convening policy dialogues on the informal economy; and documenting and disseminating good practice in support of the informal workforce. For more information see www.wiego.org.



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