WIEGO Social Protection Case Study

The Ghana National Health Insurance Scheme
Draft Document

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Abstract

Ghana's National Health Insurance Scheme 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. Despite this fact, few studies have specifically focused on the impact of the NHIS on informal workers. This WIEGO Social Protection case study is an attempt to fill this gap in the literature.

The case study concentrates on female informal workers in particular and has three major objectives: to describe the background, structure, implementation and context of the NHIS in Ghana, to assess the barriers faced by female informal workers in terms of accessing the Scheme, and to determine how much voice these workers have had in the development of the Scheme.

This case study is based on a desktop review of existing literature on the NHIS as well as a small, highly focused qualitative research study that was conducted in Ghana in May 2009. The in-country research was conducted using focus groups of informal workers, complemented by semi-structured interviews with key informants, as well as a number of informal interviews. The focus group participants were drawn primarily from the StreetNet Ghana Alliance and New Makola Market Traders' Union, both affiliates of WIEGO. Key informant interviews were held with the Secretary-General and the Informal Economy Desk Officer of the Ghana Trades Union Congress.

The findings of the study show that informal workers have generally welcomed the NHIS. Focus group participants who were members of the Scheme clearly felt that it had increased the quality of their lives. However, there were also a number of major problems with the scheme identified by this study.

Although awareness of the NHIS is high amongst informal workers, there is a significant amount of confusion over basic details of the Scheme, particularly the cost of premiums. This indicates a need for better dissemination of detailed information from the NHIS particularly in market areas. Haphazard changes in policy have also negatively affected the image of the Scheme, and there is a need for a more considered approach to policy making. Moreover, informal workers appear to have had very little direct say in the policy decisions of the NHIS. This is problematic considering the prominent role these workers play in Ghanaian social and economic life, and it is important that informal workers are better represented on the Scheme's decision making bodies.

There is also a need for the NHIS, which has been designed specifically to include informal workers, to better integrate a worker focus into all areas of the scheme, particularly the benefits package, exemptions policy, and premium payment options. It is also imperative that the Ghanaian public health service become more responsive to the needs of informal workers. Long delays in treatment are being reported by NHIS members, and this is negatively impacting on the image of the scheme in the eyes of informal workers, many of whom cannot afford to be away from their work for long periods of time.

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**
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**
WIEGO	**Women in Informal Employment: Globalizing and Organizing**

1. Introduction

Ghana is one of three African countries, along with Rwanda and Tanzania, which has recently implemented a National Health Insurance (NHI) scheme. NHI Schemes, based on the European Social Health Insurance (SHI) model, have been used before by African countries, but have tended to be unsuccessful (Atim *et al*., 2009). Conventional SHI models depend largely on the ability of governments to enforce compulsory membership through the deduction of payroll taxes. They are therefore most suited to contexts in which there are high levels of well-paid, well regulated formal employment (Cichon *et al*., 2003; Coheur *et al*., 2007). This stands in stark contrast to the African context, where labour markets tend to be dominated by poorly paid and unregulated informal employment.

The Ghanaian National Health Insurance Scheme (NHIS) is interesting in that it has adapted the SHI model so that informal workers can be included into the scheme. This has been done by fusing elements of SHI with elements of Community Based Health Insurance (CBHI). CBHI schemes are non-profit schemes based on voluntary membership, low premiums, and flexible payment schedules (Coheur *et al*., 2007). These schemes are well suited, in theory, to contexts in which informal employment and poverty are high. However, CBHI schemes often encounter problems of financial sustainability – high drop-out rates, small risk pools, and low premiums all contribute to this problem (Coheur *et al*., 2007). They also tend to work best in small community settings, and it has proved difficult to scale them up to facilitate national coverage (Atim *et al*., 2009). By combining a network of CBHI schemes with a centralised authority and source of funds (the SHI component) to ensure nationwide coverage and to guarantee the financial sustainability of the schemes, the NHIS has attempted to adapt the best aspects of these health financing models to fit the particular socio-economic landscape of Ghana.

The conscious inclusion of informal workers into a nation-wide health insurance scheme should perhaps come as no surprise considering that over 90% of Ghana's workforce work in the informal economy (Heintz, 2005). However, informal workers have more often than not been ignored in the design of national health and retirement insurance schemes in Africa (Atim *et al*., 2009) and Ghana has been no exception to this rule. The major Ghanaian retirement insurance

body, the Social Security and National Insurance Trust (SSNIT), was for many years accessible only to formal workers and work medicare schemes in the formal sector tended to be the only large scale health insurance available. Informal workers have therefore had to rely solely on informal social protection mechanisms such as *susu* collection (informal small scale savings schemes) and market trader association networks.

This situation has recently begun to change in Ghana. In 2003 the NHIS was introduced and, following closely on its heels, SSNIT initiated a new pension and savings scheme for informal workers in 2008. This new retirement and savings scheme has been designed to give greater flexibility to the SSNIT contributions system by using a voluntary contribution arrangement based on members "preferences and ability to pay" (Daily Graphic, 2008).

The fact that the Ghanaian government now clearly recognises informal workers as a central consideration in the design of nationwide health and retirement insurance schemes says much about the change in the way the informal economy is being viewed in this country. The change in policy direction in Ghana can, at least in part, be attributed to a wider change in the way the informal economy is understood across the globe.

Globalisation has facilitated a rapid increase in informal employment, and has been associated with "the informalization of existing employment relations, and with the generation of employment that is often flexible, precarious and insecure" (Lund and Nicholson, 2003: 13). It is estimated that informal workers in the non-agricultural workforce now comprise 60% of all workers in Latin America, 45-85% of workers in Asia (depending on the country), and 75% of workers in Africa (ILO 2002).

In the past orthodox economists viewed the informal economy as a temporary phase through which developing countries must pass on the road to development (Chen, 2004). The fact that the informal economy has become bigger rather than smaller in many developing countries has led many to question this view. Increasingly it is being accepted that the informal economy is not something that will disappear as development progresses, but is in fact an integral and probably permanent part of the greater globalised economy (Chen, 2004).

With this acceptance, the question of how to effectively extend social protection measures to informal workers has begun to attract increasing attention from both researchers and policy makers (Lund and Nicholson, 2003; Lund and Srinivas, 2000; Doane *et al*., 2002; Barrientos and Ware Barrientos, 2002). The nature of informal employment poses particular problems for the extension of social protection mechanisms such as health and retirement insurance, which are traditionally subsidised by employers. The predominance of self-employment and/or ambiguous employee-employer relationships in the informal economy means that informal workers are often unable to gain access to work related health and pension benefits. This leaves them vulnerable to catastrophic health expenditures and financial insecurity in old age.

This vulnerability is exacerbated by the fact that informal work carries with it a high level of risk. The work is often precarious, hard, and potentially perilous, the environment in which many informal workers work is unconventional and unprotected from a variety of different hazards, and the absence of labour protections means that there are few ways for informal workers to ameliorate this risk. Informal work in Ghana is no exception to this rule. Job and income insecurity are prominent features of the Ghanaian labour market (Apt and Amankrah, 2004). There is a lack of access to start up capital, loans and credit for the self-employed, particularly for women (Bendig *et al*., 2009). Physical insecurity at market places and roadsides, where many street vendors work, is another major problem. Both goods and people are at risk in these areas from traffic, criminal elements and from the weather (Davis, 2008; King and Oppong, 2003). Harassment by local authorities is rife, particularly amongst street vendors, who are apparently frequently chased from their place of work (Davis, 2008). Market traders reportedly face large increases in market rents and taxes on a regular basis (Awuah, 1997). Poor public and environmental health, in both the residential and market areas, is also a major urban problem in Ghana and jeopardizes the health of many informal workers (Apt and Amankrah, 2004; King and Oppong, 2003).

The NHIS therefore represents a much needed attempt to address the challenge of extending social health protection to Ghana's informal workers. The rapid rate of increase in coverage of the scheme bears testament to this. The scheme's reach expanded from 15% of the total

population in 2005 (3.2 million people) to 38% (8.2 million people) in June 2007 (Asante and Aikins, 2008). Figures from mid-2008 indicate that over 9 million people are now registered – representing 45% of the total population (Jones *et al*., 2008). In 2007 workers in the informal economy made up 24% of the total registered population, revealing that a significant number of informal workers are now being reached by the scheme.

The Ghana NHIS may therefore hold important policy lessons for other countries, in Africa and in other regions of the world, where the informal economy is large and growing and where informal workers are excluded from existing social protection mechanisms. As with other attempts to extend social protection to informal workers – such as Thailand's Universal Coverage scheme and the Self Employed Women's Association's VimoSEWA integrated insurance scheme – it is of interest to WIEGO, and needs to be examined closely in order to assess the ways in which it is impacting on the lives and livelihoods of informal workers.

The NHIS has attracted a lot of attention from researchers, and assessments and analyses of its design and impact are increasing in number (Asante and Aikins, 2008; Gyapong *et al*., 2007; Institute for Policy Alternatives, 2006; Adatsi, 2006; Aikins and Okang, 2006; Prah, 2006). Although several of these studies have focused on the impact of the NHIS on the poor, few studies appear to have specifically focused in-depth on the impact of the NHIS on informal workers.

It is important to recognise that although there is a higher incidence of poverty amongst informal workers than formal workers, poverty and informality are not always synonymous (Chen, 2004). Within the informal economy, there are a wide range of earnings – with some informal workers earning far more than the average formal worker, some earning similar amounts, and many earning far less. This means that studies assessing the impact of the NHIS on 'the poor' are not necessarily assessing its impact on informal workers as a whole. Furthermore, although the problems poor people may face in accessing the NHIS may be similar in many respects to the problems informal workers face, there is a difference between focusing on the problems encountered by 'poor people,' and focusing on the problems faced by 'workers,' who may encounter specific problems related to the nature and context of their work.

This WIEGO Social Protection Case Study is therefore focused on the impact of the Ghanaian National Health Insurance on informal workers specifically. Particular emphasis is given to female informal worker's access to the NHIS. A higher percentage of women than men work in the informal economy in Ghana and they tend to be concentrated in economic activities with a higher chance of low returns, such as unpaid family labour and own account work (Heintz, 2005). Furthermore, women in Ghana, as in many other developing countries, tend to face greater financial and cultural barriers to healthcare access than men (Buor, 2004). It is therefore important to assess the impact of the NHIS on this particularly vulnerable group of workers.

This case study is based on a desktop review of existing literature on the NHIS as well as a small, highly focused qualitative research study that was conducted in Ghana in May 2009. The qualitative research was conducted using three focus groups discussions with informal workers from Accra and surrounding areas. Each focus group consisted of informal workers from very different socio-economic statuses – ranging from market trader association leaders to much poorer ordinary market traders and street vendors. In addition to the focus groups, several key informant and informal interviews were held.

The study is divided into four further sections. Section 2 will lay out background information on Ghana's demographic and health indicators and the structure of its health system. Section 3 will provide a detailed description of the development, structure, financing and general performance so far of the NHIS. Section 4 will focus specifically on the NHIS and informal workers and will discuss the research conducted in-country for this case study, and Section 5 will present conclusions and recommendations.

2. Health and Health Care in Ghana

2.1 Ghana's Demographic and Health Indicators

Ghana is classed as a low income country by the World Bank, with 2007 GNI per capita standing at US$590 (WDR 2009). The incidence of poverty was estimated to be 45% at the $1 a day mark in 1998/1999 (WHO, 2007). However, the principle trend throughout the 1990s has indicated an overall improvement in poverty levels. The 2005/6 5th Round of the Ghana Living Standards

Survey (GLSS5) reported that the proportion of Ghanaians described as 'poor' had fallen from 39.5% in 1998/99 to 28.5% in 2005/6 and the proportion of people described as 'very poor' decreased from 26.8% to 18.2% between those same years. However, poverty levels are extremely unevenly distributed between urban and rural areas. While the largely urbanised Greater Accra Region reported a relatively low proportion (2.4%) of people living below the poverty line between 1995 and 2006, the equivalent figure for the predominantly rural Upper East Region was 79.6% (WDR 2009).

Ghana has a population of 23 million, and is undergoing a steady process of urbanisation (WDR 2009). The urban population increased from 31% of the total population in 1981 to 49% in 2007 (African Development Indicators, 2007). This number is predicted to rise to 55.1% by 2015 (WDR 2009). Over one-third of Ghanaians live in the two most urbanised regions of Ashanti (19.1%) and Greater Accra (15.4%) (Gyapong *et al*., 2007).

Life expectancy at birth in 2006 was 59 for males and 60 for females (WDR 2009). This reflects an increase from the 1999 figures of 54.2 for males and 55.6 for females (Global Social Trust, 2003). However, in other key indicators of health Ghana has not performed well. Malaria is still the leading the cause of death nationwide (Ministry of Health, 2008). Maternal mortality rates increased between 2005 and 2007 from 197 per 100 000 live births to 224 per 100 000 and the proportion of births attended by a trained health worker fell from 54.1% to 35.1% (Ministry of Health, 2008). In 2006 the under-5 mortality rate was unchanged from the 1990 figure of 120 per 1000 live births, which falls far short of the rate of reduction required to meet the MDG goal of reducing child mortality by two-thirds (WDR, 2009).

The GLSS5 reports that in the two weeks prior to the survey interviews, one fifth of the population reported that they had suffered an illness or injury. The most vulnerable groups were those over the age of 50 or below the age 5, with 32% of people over the age of 50 and 28.7% of children under-5 reporting ill-health or injury in the two weeks prior to the interview. On the whole, a greater number of females (22%) reported falling ill than males (19.5%). The nationwide Community Voices II survey found a high incidence of self-reported ill health amongst poor Ghanaians. Sixty-three percent of respondents reported falling ill during the three

months prior to the survey. This figure was found to be the same across gender and regions (Institute for Policy Alternatives, 2006).

A study conducted in the Volta Region by Avotri and Walters (1999: 1123) suggested that a significant number of women suffer from psycho-social health problems described by the study participants as “thinking too much” or “worrying too much.” The source of much of this worry appears to be their working roles. Heavy workloads and financial insecurity were found to contribute to the women’s anxiety, which in turn was linked to the tiredness, lack of sleep and bodily aches and pain that many of them experienced as chronic health difficulties (Avotri and Walters, 1999: 1123).

The findings of Avotri and Walters’s (1999) study are confirmed by the Women’s Health Study of Accra conducted by Hill *et al*., (2007). This study found that pain, headaches and worry were the three most frequently reported female conditions at health facilities in Accra. Sadness, fatigue, stress at work and stress at home were other frequently reported psycho-social health problems. The study found ‘pain’ to be highly prevalent amongst women. Various types of frequently reported pain included joint pain, chronic back pain, muscle pain and stiff joints. The authors attribute the high incidence of pain to heavy workloads (Hill *et al*., 2007), suggesting once again that occupational factors play a large role in women’s ill-health.

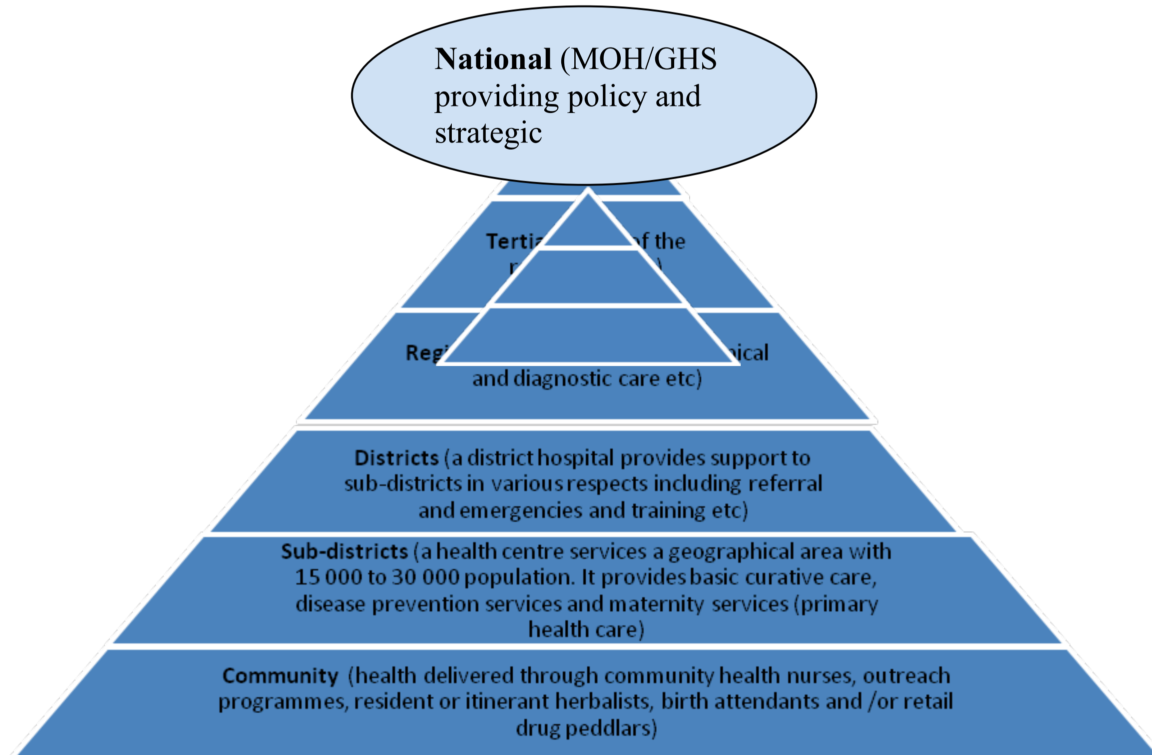
2.2 Institutional structure of public health care in Ghana

During the 1990s the Ghanaian health sector was decentralised. 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 co-ordination and resource mobilisation (Gyapong *et al*., 2007). Teaching hospitals also became autonomous bodies, overseen by their own management boards (Gyapong *et al*., 2007). 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). At the regional level regional hospitals provide curative services and public health services are provided by the public health divisions of regional hospitals and District Health Management Teams (DHMT) (Gyapong *et al*., 2007). District level curative care is provided by district hospitals and sub-district curative and preventative care is provided by primary health care centres (Gyapong *et al*., 2007: 16).

Although the institutional structure may suggest a fairly advanced level of decentralisation, the Ghanaian health system is not as decentralised as it may first appear. According to Bossert and Beauvais (2002: 24) the system can be characterised as "decentralised centralism." Although the GHS is itself a decentralised institution, it exerts relatively centralised control over the rest of the health system and has a centralised governance structure. The Director-General and the Council are appointed by the President, and they in turn appoint all the Regional and District Administrations and hospital management (Bossert and Beauvais, 2002). The District Administrations play little part in health sector governance, their role limited to an advisory one, described by Bossert and Beauvais (2002: 24) as "minimal at best."

Figure 1: Institutional structure of Ghanaian public health services



Source: Gyapong, J., Garshong, B., Akazili, J., Aikins, M., Agyepong, I. and Nyonator, F. 2007. 'Critical Analysis of Ghana's Health System with a focus on equity challenges and the National Health Insurance.' *SHIELD Workpackage 1 Report.*

2.3 Current Health Provision in Ghana

Current expenditure on health in Ghana per capita increased from $11 at the end of the 1990s to $21.66 in 2007 (Global Social Trust, 2003; Ministry of Health, 2008). However, this figure still falls far short of the $34 per capita that the Commission on Macroeconomics and Health estimated as the minimum necessary to provide a basic package of health services. At present Ghana devotes 12% of its budget to health, meaning that it has so far failed to reach the target set under the Abuja and Maputo Declarations, which committed African states to setting aside 15% of their national budget for this purpose (Jones *et al*., 2008).

Private providers contribute 35% of total health services in Ghana. Private health facilities include hospitals, clinics, company clinics and maternity homes. The Government target is to raise private healthcare provision to 65% over the next 10 years (Gyapong *et al*., 2007). Access to private care is one of the features of the new NHIS system, although only Greater Accra,

Ashanti and Brong Ahafo Regions have fully private hospital beds available (Ministry of Health, 2007).

There is a general lack of professional medical personnel in Ghana. Between 2000 and 2006 there were 3240 registered physicians in the country – a density of 2 doctors per 10 000 people. This is low even compared to the average density for low income countries (LICs), which lies at 5 doctors per 10 000 people (World Health Statistics, 2008). During the same period there were 19707 registered nurses and midwives – a density of 9 per 10 000, lower again than the LIC average of 11 per 10 000 (World Health Statistics, 2008). The problem is particularly acute in the rural northern areas where the doctor to population ratio lies at 1: 63 614 in some parts (Government of Ghana, 2007).

These depleted health staff numbers are attributed to the fact that training institutions have failed to keep up with demand, as well as to high rates of emigration. It is estimated that Ghana has lost 50% of its nurses over a 20 year period to countries such as the US and UK, and 68% of medical officers trained between 1993 and 2000 (Gyapong *et al*., 2007). To stem this tide the Ghanaian government has recently instituted increases in salaries, overtime pay and benefits for public health workers.

Physical access to basic health facilities appears to be easily manageable in the more urbanised regions. A study conducted by the ILO in two urbanised districts found that 97% of respondents had access to a health facility in their own town or village (ILO, 2005). However, there are large regional disparities in the provision of health infrastructure, particularly hospitals. Greater Accra has a total of 4 427 hospital beds, compared to only 1129 hospital beds in the rural Northern Region (Ministry of Health, 2007). These infrastructural inequalities mean that a large number of Ghanaians (40%), mainly those living outside of urbanised areas, live more than fifteen kilometres away from basic health care facilities (Dovlo, 1998).

The quality of care provided at public hospitals appears to vary. Gyapong *et al*., (2007) suggest that the large and relatively well equipped teaching hospitals are likely to provide better quality care than some of the lower level district hospitals and primary healthcare facilities. The

Community Voices II survey found that most poor Ghanaians use drug stores and herbalists as their first line of care rather than official health facilities (Institute for Policy Alternatives, 2006). However, in line with the hypothesis of Gyapong *et al*., (2007) that people would rather bypass lower level health facilities in favour of higher level hospitals, the survey found that a large number of people travel long distances, at significant cost, to access distant hospitals as their second line of care instead of utilising local clinics. The Ghana Health Service Annual Report (2007) claims that inadequate numbers of qualified staff and a lack of appropriate equipment at the primary levels of the health service have made people unwilling to use these services. The Ministry of Health Independent Review (2008) similarly states that a lack of basic obstetric care is one reason why many women feel there is little difference between giving birth at home and giving birth in a local health facility.

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% 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 2.20 GH¢ ($1.60) and 2.90 GH¢ ($2.07). This is high considering that the average Ghanaian earns less than 1.10 GH¢ a day (GLSS5). Moreover, higher level care appears to be much more expensive. According to De Graft-Aikins (2007), controlling one case of diabetes cost between $106 and $638 per month in 2007. The monthly average salary of civil servants, who are high risk for diabetes, lay at $213 in the same year (De Graft-Aikins, 2007).

3. The National Health Insurance Scheme

3.1 The Development of the NHIS

As with many other African countries, the post-independence Ghanaian public health service was founded on the principle of equity. General taxes and external donor funds were used to construct hospitals and health centres in previously neglected areas, and access to health services was free (McIntyre *et al*., 2008). By the mid-1980s, however, a struggling economy, and the neo-liberal reforms which accompanied the economic downturn, meant that equity was replaced by cost recovery as a guiding principle (McIntyre *et al*., 2008).

In 1985, the Government of Ghana introduced a user fee system, popularly known as 'cash and carry,' which aimed at recovering 15% 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 $11 per capita, and only 55% 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. The system did not result in the intended level of cost recovery. The Ministry of Health failed to meet its 15% cost recovery target only managing, on average, to recoup 10% or less of its annual costs through user fees (Asenso-Okyere *et al*., 1997). More importantly, user fees resulted in a major deterioration in the number of people utilizing health services (Waddington and Enyimayew, 1989). Long delays in reporting ill-health for those who did finally consult health services (resulting in more serious illnesses and expensive treatment), incomplete prescription purchases, and the sharing of prescription drugs were some of the other adverse effects reported (Asenso-Okyere *et al*., 1997). Although exemptions from user fees for pregnant women and those classed as 'indigent' did officially exist, in practice these exemptions did not work well and many of those who should have been exempted were not (Aikins *et al*., 2001).

The inherent and largely predictable problems of a user fee health system did not go unrecognized by the Ghanaian Government. At various intervals since the early 1980s, proposals to institute a National Health Insurance Scheme (NHIS) have been considered at national level (Aikins *et al*., 2001). The ILO, WHO, EU and London School of Hygiene and Tropical Medicine

have all been requested by the Ministry of Health to provide technical advice on such a scheme and in 1997 an NHIS pilot project was launched in the Eastern Region. Due to a lack of consensus on health financing policy in general however, the pilot project broke down (Aikins *et al*., 2001).

The NHIS concept was revitalised in Ghana in 2000 when the New Patriotic Party (NPP) came into power after narrowly defeating the incumbent National Democratic Congress (NDC). One of NPP's key policy platforms was the abolishment of the deeply unpopular cash and carry system, and the introduction of a new system of national health insurance. The stated goal of the new government was to have 50-60% of the population covered by health insurance within 10 years of the implementation of the new scheme, with a final goal of universal health insurance coverage (Cichon *et al*., 2003).

As the vast majority of Ghanaians work in the informal economy, it was recognised early on that a state sponsored statutory social health insurance (SHI) scheme would most likely be untenable in Ghana (Cichon *et al*., 2003; Coheur *et al*., 2007). Consequently, the NPP appointed two task teams to design a system that allowed for the inclusion of informal workers (Rajoktia, 2007). The outcome was the 'hub-satellite' model of a national fund and authority (the hub) regulating and subsidising a national network of CBHIs (the satellites).

In line with its election promises the NPP hastened to implement the NHIS, despite the fact that the design of the scheme faced major opposition from key stakeholders. The labour unions, in particular, were unhappy about the recommendation that a portion (2.5%) of formal workers' Social Security National Insurance Trust (SSNIT) contributions go towards the financing of a centralised National Health Insurance Fund (Asamoah, interview). Existing Community Based Health Insurance Schemes (CBHIS) were unhappy about the threat to their autonomy, and donors and civil servants in the MoH were also concerned about the technical soundness of the scheme (Rajkotia, 2007). Notwithstanding these concerns, the NPP passed Act 650 in August 2003, after a concession to the labour unions of free NHIS membership for all SSNIT contributors.

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 healthcare 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)).

Both the Ghana Health Service and the Ministry of Health have an oversight function with respect to the National Health Insurance Authority. The GHS NHIS co-ordination office is located within the office of the Director-General. Its role includes the support of health care providers, monitoring of NHIS implementation, acting as a liaison with other stakeholders, and the education of health staff on implementation issues (GHS, 2007). The NHIC is required to submit an annual report, including the report of the Auditor-General, a report on the effect of implementation of the NHI policy on the nation, and a report on the NHI Fund, to the Minister of Health.

Box 1
Act 650, Section 3 (1) establishes a National Health Insurance Council, consisting of:

- the chairperson
- one representative of
    - the Ministry of Health not below the rank of a Director
    - the Ghana Health Service not below the rank of a Director
    - the Society of Private Medical and Dental Practitioners nominated by the Ghana Medical Association
    - the Pharmaceutical Society of Ghana
- one representative each of licensed
    - mutual health insurance, and
    - private health insurance schemes
- one representative of the Minister responsible for Finance not below rank of Director
- one legal practitioner with experience in health insurance nominated by the Ghana Bar Associations,
- one representative of the National Insurance Commission
- one person representing organised labour
- two persons representing consumers one of whom is a woman
- one representative each from
    - the Ministry of Local Government, and
    - Social Security and National Insurance Trust, and
- the executive secretary appointed under Section 92.

The purpose of the NHIS is to "assure equitable universal access to a quality basic package of health services for all residents in Ghana" (Asante and Aikins, 2008: 1). In order to provide this basic package of services, the NHIS covers both public and private health care providers at all levels of the health system, subject to their accreditation by the NHIA. At present all public facilities have been given a provisional accreditation and 800 private providers (many of them pharmacies and 'chemical shops') have been accredited by the NHIA (Ghana Health Service, 2007). In 2004 a memorandum of understanding regarding services to be provided and prices to be charged was agreed on by the NHIC and service provider representatives. This memorandum now forms the basis of all contracts between the health schemes and providers (Grub, 2007). A drugs list – detailing the drugs that can be supplied under the NHIS – has also been agreed upon.

According to the National Health Insurance Regulations (LI 1809, Regulation 19 (1)) the first point of attendance for accessing health care under the NHIS should be a primary healthcare facility. This includes CHPS, health centres, district hospitals, polyclinics, quasi public hospitals, private hospitals, clinics and maternity homes. Where the only facility is a Regional Hospital, it will also be considered a primary healthcare facility. In emergencies, any accredited healthcare facility may be utilised.

3.2 Structure, Operation and Financing of the NHIS

As mentioned earlier 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-satellite" model (see Figure 2). The "hub" of the system, which is essentially based on the 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 "satellites" are a country wide network of CBHI schemes known as District Wide Mutual Health Insurance (DWMHI) schemes which are monitored, subsidised and re-insured by the "hub."

The NHIF is financed from several different sources. These include:

- Donor funds (few details on these donor funds are available)
- Funds allocated to the scheme by the Government of Ghana via Parliament

- 2.5% of the 17.5% Social Security and National Trust (SSNIT) contribution made by formal sector employees (the 17.5% contribution is made up of a 12.5% contribution from employers and 5% contribution from employees)
- A 2.5% 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'
- Member premiums
- Money that accrues to the fund from investments made by the NHIC

The vast majority of the money coming into the NHIF in 2006 was from the NHIS VAT levy. This made up 76% of the total available funds, followed by the SSNIT contributions which made up 24% of the funds. The premiums paid by scheme members made up only an estimated 0.01% of the NHIF in 2006 (Ghana Health Sector Review, 2007 cited in Atim *et al*., 2009).

At present employers are not held to anything in terms of contributions, other than ensuring the necessary SSNIT deductions are made from the payrolls of formal sector employees. However, the NHIC has apparently made it known that it would prefer employers to contribute a sum equal to that of the employee's contribution (Gyapong *et al*., 2007).

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, although there are plans to eventually introduce compulsory membership (Gyapong *et al*., 2008). 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.

Each DWMHI scheme is managed by a Board, which is elected by a General Assembly comprised of Community Health Insurance Committee (CHIC) representatives. CHIC representatives represent geographically determined 'Health Insurance Communities' within each district (Grub, 2007). The CHIC exists 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 DWMHIS (www.nhis.gov.gh).

The NHIA has set the DWMHI annual premium levels at a minimum of 7.20 GH¢ and a maximum of $48 GH¢ (approx. $5-$34 in 2009) 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). Contributors to SSNIT are automatic members of their respective DWMHI schemes because of the health insurance deductions made from their SSNIT contributions, and are only required to pay an initial registration fee. The premium structure therefore applies only to those who work in the informal economy or who are not SSNIT contributors. These members pay their premiums to the DWMHI schemes directly. The schemes employ collectors who move between houses and market stalls to receive premium payments. Alternatively, premiums can be paid to banks, or to designated pharmacies or 'chemical shops' (www.nhis.gov.gh). 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 a number of recent review articles written on the NHIS, which themselves appear to contradict one another. 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 7.20 GH¢ per member, rather than using the graded premium system. However, Jones *et al*., (2008) state that schemes now charge a flat rate of 9GH¢ as a premium. To clarify this issue an interview with a district scheme manager was held, and he indicated that graded premiums are still being charged by some schemes at least. In this particular manager's scheme, a minimum of 7.20GH¢ was charged as a premium for those classed as 'very poor and poor,' a minimum of 18GH¢ charged for those classed as 'middle income,' and a minimum of 48GH¢ charged for those classed as 'rich or very rich.' According to the scheme manager, 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.

The recent return to power of the NDC in the 2008/2009 elections may signal a significant change in the premium structure, however. The new 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 life time premium may be in the range of 150GH¢ (just over $100), although the figure of $10-12 is also heard.

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 (District Scheme Manager, interview).

Exemptions are also granted for children under the age of 18. For all others classed as member dependants, including children over the age of 18, members have to contribute a full adult rate per dependent (www.nhis.gov.gh). 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. In May 2008 the President of Ghana ordered a change to this policy. Currently all children under the age of 18 are exempted from NHIS premium payments irrespective of the NHIS membership status of their parents (Jones *et al*., 2009).

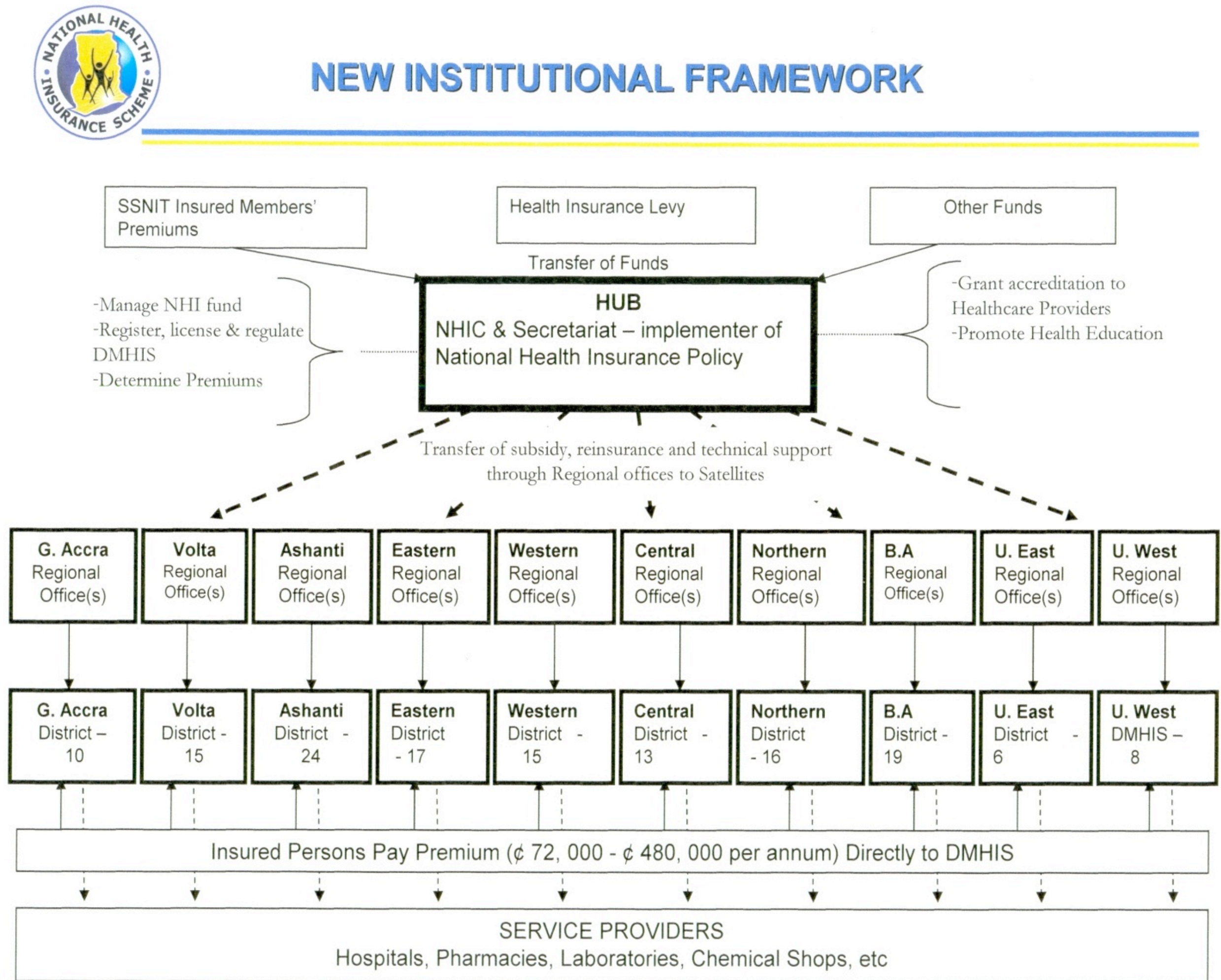
During the course of the in-country research for this case study, it became clear that although children's membership is now delinked from parent's membership and is in theory free, NHIS membership is still not totally free for children. Participants in the focus groups were adamant that extra charges to add children still existed and a conversation with a district scheme official to clarify this issue confirmed that extra fees are still being charged for children. 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 1 and 2GH¢, 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 6GH¢ ($4) extra to register

all her minor children. The district scheme official did not appear to see any contradiction between the collection of these registration fees and the edict allowing for free health insurance to be given to children under the age of 18, stating that it was an important way for schemes to mobilise resources.

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 subsidises 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 DMHI schemes via the regional offices of the NHIA. These regional offices are also the interface between the district schemes and the NHIA in terms of reinsurance and technical support.

Figure 2: Structure of the NHIS



Source: Boateng, R. 2007. National Health Insurance Scheme Presentation, Health Summit, Accra.

Box 2
Act 650, Schedule [Section 87] Part One: Exemptions from the National Health Insurance VAT Levy

(a) Medical services.
(b) Pharmaceuticals. Essential drug list under Chapter 30 of the Harmonised Systems Commodities Classification Code, 1999 produced or supplied by retail in Ghana, and the active ingredients for essential drugs specified by law. Imported special drugs determined by the Minister of Health and approved by Parliament.
2. Mosquito net. Mosquito nets of man-made textile material whether or not impregnated with chemicals.
3. Goods for the disabled. Articles designed exclusively for use by persons with disability.
4. Water. Expenditure on water, excluding bottled and distilled water.
5. Education. Expenditure on educational services at any level by an educational establishment approved by the Minister for education,
fully assembled computers imported or produced locally by educational establishments that are approved by the Minister of Education, Laboratory equipment for educational purposes and library equipment.
6. Live Animals. Cattle, sheep, goat, swine and poultry but excluding horses, asses, mules and hinnies, and similar exotic animals.
7. Animals, livestock and poultry imported for breeding purposes. Live asses, mules and hinnies; live bovine animals; live swine; live sheep and goats; live marine mammals, live fish and aquatic invertebrates.
8. Animal product in its raw state. Edible meat and offal of the animals listed in item 6 provided any processing is restricted to salting, smoking or similar process, but excluding pate, fatty livers of geese and ducks and similar products.
9. Agricultural and aquatic food products in its raw state produced in Ghana. Fish, crustaceans, and molluscs (but excluding ornamental fish); vegetables and fruits, nuts, coffee, cocoa, shea butter, maize,sorghum, millet, tubers, guinea corn and rice.
10. Seeds, bulbs rootings, and other forms of propagation. Of edible fruits, nuts, cereals tubers and vegetables.
11. Agricultural inputs. Chemicals including all forms of fertilizers, acaricides, fungicides, nematicides, growth regulation, pesticides, veterinary drugs and vaccines, feed and feed ingredient.
12. Fishing equipment. Boats, nets, floats, twines, hooks and fishing gear.
13. Salt. Denatured salt, compressed salt used in animal feeding and salt for human consumption including table salt.
14. Land, buildings and construction. (a) Land and buildings: the granting of assignment or surrender of an interest in land or building; the right to occupy land or buildings excluding hotel accommodation, warehousing, storage and similar occupancy incidental to the provision of the relevant services;
(b) Civil engineering work;
(c) Services supplied in the course of construction, demolition, alteration, maintenance, to buildings or other works under (a) and (b) above, including the provision of labour, but excluding professional services such as architectural or surveying.
15. Electricity. Domestic use of electricity up to minimum consumption level prescribed in Regulations by the Minister, and Compact Fluorescent Lamps.
16. Transportation. Includes transportation by bus and similar vehicles, train, boat, and air.
17. Postal services. Purchase of postage stamps.
18. Machinery. Machinery, apparatus appliances and parts thereof, designed for use in
a) agriculture, veterinary, fishing and horticulture;
(b) industry;
(c) mining as specified in the mining list and dredging; and
(d) railway and tramway.
19. Crude oil and hydrocarbon products. Petrol, diesel, liquefied petroleum gas, kerosene and residual fuel oil.
20. Financial services. Provision of insurance; issue, transfer, receipt of, or dealing with money (including foreign exchange) or any note or order of payment of money; provision of credit; operation of any bank(or similar institution) account; but excluding professional advice
such as accountancy, investment and legal.
21. Printed matter. Books and newspapers fully printed or produced by any duplicating process, including atlases, books, charts, maps, music, but excluding imported newspapers, plans and drawings, scientific and technical works, periodicals, magazines, trade catalogue, price lists, greeting cards, almanacs, calendars and stationery.
22. Transfer of going concern. The supply of goods as part of the transfer of a business as a going concern by one taxable person to another taxable person.

3.3 Benefits Package

The health services covered by the NHIS are laid out in the minimum basic benefits package. The list is fairly extensive and purports to cover 95% of all health problems reported in Ghanaian healthcare facilities (see Box 3). A prescribed medicines list is also delineated. Expensive, highly specialised care such as dialysis for chronic renal failure, and organ transplants are not covered by the NHIS. Neither are ARVs for the treatment of HIV/AIDS, 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 healthcare payments, there are no deductibles, and no co-payments have to be made by NHIS members when accessing healthcare (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).

There is a notable emphasis on female reproductive health in the benefits package. Benefits for maternity care include antenatal care, caesarean sections, and postnatal care for up to six months after birth. Treatment for breast and cervical cancer are included in the package, although treatment for other cancers is not.

Private CBHI schemes and Private Commercial Health Insurance Schemes are also available under the NHIS. However, Act 650 requires private health insurance providers to pay a security deposit of approximately $600 000 (Rajkotia, 2007: 5). Private schemes must also be registered with the NHIA and licensed by them, and must provide the minimum benefits package prescribed by the Authority. Neither the private CBHI schemes nor the commercial schemes are entitled to receive a subsidy from the NHIF (Act 650, Section 53). Private schemes are able to charge their own premiums and compete by providing 'luxury' extras such as VIP ward care or overseas treatment options.

Box 3

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

- Antenatal care
- Deliveries (normal and assisted)
- Caesarean session
- Postnatal care

Emergencies

There refer to crises in health situations that demand urgent attention such as:

- 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 Retroviral drugs
- Assisted Reproduction (eg 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

3.4 General Performance of the NHIS to date

As mentioned earlier, there has been a rapid increase in the numbers of people registered with the NHIS since its inception in 2003. However, it is important to recognise that registration statistics do not give a wholly accurate picture of the scheme's reach. Only those with valid ID cards are able to actually access NHIS benefits. The percentage of the population holding ID cards is much lower than the percentage registered, although this number has also increased rapidly. ID cards were held by 6.8% of the population in 2005, but this figure increased to 19.3% in 2006 (Government of Ghana, 2007). Member satisfaction with the scheme appears to be high – Asante and Aikins (2008) found that 97.2% of card carrying members surveyed were happy enough with the scheme to continue with their membership.

The introduction of the NHIS also appears to have increased utilisation of formal health facilities – one of the major goals of the scheme. Use of outpatient and inpatient department services almost doubled between 2005 and September 2007, according to the Ministry of Health (2008). However, the Ministry of Health 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.

Nevertheless, this data appears to demonstrate that the introduction of the NHIS has been welcomed by a significant proportion of the Ghanaian population. Although the NHIS faced some stiff opposition in the early stages of planning and implementation it is now generally viewed as an essential component of the Ghanaian health system and has gained widespread political and public acceptance. This political acceptance has been particularly important for the continued existence of the scheme in the light of the recent 2008/2009 NDC election victory. Despite the fact that the scheme was an NPP driven project, the new NDC government has repeatedly affirmed its support for the NHIS, giving the scheme a national credibility that extends beyond its origins as the election promise of a single political party.

Despite this generally encouraging news, the NHIS still has some major hurdles to overcome. Financial woes have dogged the scheme and its financial sustainability has repeatedly come into

question. According to Rajkotia (2007) there have already been unofficial reports of insolvency from over 20 schemes and five were bailed out to the tune of $2.8 million between 2005 and 2006. These problems are particularly worrying in light of the current global recession, which may mean a decrease in the VAT revenues which fund a large portion of the NHIF.

The roots of the scheme's financial problems are multiple, but one of the major factors is the low cost of the premiums, which have been set at levels deemed affordable rather than on a 'technically sound' actuarial basis (Gyapong *et al*., 2007; Rajkotia, 2007). Another major factor is the high number of exempt enrolees – 64% of the scheme's total membership do not pay for the services they use (Asante and Aikins, 2008). The high level of exempt enrolees is partially a consequence of the fact that there are major incentives for schemes and premium collectors to enrol exempt individuals. The district schemes receive a subsidy of 8 GH¢ per exempt member, which is higher than the standard minimum rate. Anecdotal evidence also points to the fact that premium collectors (who apparently receive a 10% commission on the number of enrolled members) are soliciting bribes in order to register people as exempted (Gyapong *et al*., 2007).

On the other hand, questions about the purported 'pro-poor' nature of the NHIS have also been asked. Although the scheme premiums were kept low in order to encourage membership from across the socio-economic spectrum, it appears that membership is still differentiated in this respect, with those in higher income brackets more likely to be card carrying members (Asante and Aikins, 2008).

A major barrier to extending registration to poorer sections of society is the cost of the premiums. Of the non-registered respondents interviewed by Asante and Aikins (2008), 91.7% claimed that the premiums were too expensive. The problem of premium affordability illustrates one of the key dilemmas of the NHIS – that of determining who is in fact poor enough to qualify for exemptions (Ministry of Health, 2007). Approximately 18% of the population are classed as 'very poor' and a further 28% are classed as 'poor,' yet the exemption system only covers those classed as 'indigent,' and the 2008 budget allows for only 10% of the population to be registered as such under the NHIS (Ministry of Health, 2007). There are a significant number of people,

therefore, who do not fall under the indigent exemption, yet are unlikely to be able to afford the minimum premium.
In addition to doubts over the financial sustainability and pro poor orientation of the scheme, questions relating to the quality of care provided by Ghanaian health system under the NHIS have been raised. The increased utilisation of health services has starkly revealed the capacity problems facing the Ghanaian health system. Overcrowding of higher level health facilities has occurred, as insured patients have started to bypass the cheaper, but ill-equipped and understaffed, lower levels of the health service. This has resulted in long delays for treatment and an increased workload for already struggling doctors and nurses (Ghana Health Service, 2007).

Administrative problems have also plagued the NHIS. Long delays in the issuing of new or renewed ID cards appear to be a big problem, leaving many members disgruntled (Rajkotia, 2007). Furthermore, the re-imbursement of claims from health service providers is running late. Late reimbursement is very problematic for health facilities, whose access to supplies depends on prompt payment, and it appears to be leading to bad feeling developing between the NHIS and some important health service providers. One of the hugely negative consequences of the late payments is that health service providers are now reportedly giving preferential treatment to cash paying patients over card carrying NHIS patients. This trend has apparently also been aggravated by the overcrowding occurring at health facilities.

4. Informal Workers and the NHIS

4.1 In-country research: Objectives, Methods, Participants

Despite the fact that the NHIS has been designed with informal workers specifically in mind, few studies have focused directly on the effect the NHIS on informal workers. The objective of this research was to determine the general impact of the NHIS on informal workers and to identify the specific barriers that these workers face in accessing its services.

A secondary objective was to determine whether the NHIS has created any sense of solidarity between formal and informal workers in Ghana. One of the interesting features of the NHIS is the way in which it has established a system where formal workers, through the 2.5% SSNIT deductions, subsidise health insurance for informal workers. Examining the feelings that formal

workers have about this subsidisation is important because it might provide some insight into a changing dynamic in the relationship between formal and informal workers – one which may have the potential to strengthen so-called 'cross-class alliances' and thereby reinforce the workers movement as a whole.

Three focus groups sessions with informal workers were held, complemented by semi-structured interviews with key informants, as well as a number of informal interviews. Prior to the focus group sessions, a short questionnaire was filled out by all participants. The purpose of this questionnaire was to gather a basic profile of the participants and to determine NHIS membership status. A Twi speaking translator was used during the focus group sessions to enable all participants to speak freely.

The focus group participants were drawn from primarily from the StreetNet Ghana Alliance (SGA) and New Makola Market Traders' Union (NMMTU), both affiliates of WIEGO. The first two groups consisted of five participants each, and the last group consisted of three participants. The first focus group (FG1) was made up of female market traders from Accra's Makola Market. These women all occupy various leadership positions within the SGA and NMMTU. The second focus group (FG2) was made up of female market traders from the Makola Market. These women were all ordinary members of the NMMTU. The third focus group (FG3) was made up of market traders from different markets in and around Accra. This group included one male and two female traders. The male market trader was from the Madina Market, and the female traders were from the Kaneshie market.

The average age of the FG1 participants was 50.4 years. Three had been traders for over 25 years, and two had been traders for 10 years or less. The highest earner in the group earned 200GH¢ ($142) a week, and the lowest earned 60GH¢ ($43) a week. Two of the other participants had weekly earnings of 100GH¢ ($71), and one earned 70GH¢ ($50) a week. These women therefore earn well above the Ghanaian average daily income of less than 1.10GH¢ a day (GLSS5). Of all the groups, this group had the highest proportion of card carrying NHIS members – three out of five were fully paid up NHIS members, one had paid her premiums and

was waiting to receive her ID card, and one was registered with NHIS, but was not a card carrying member.

The average age of the FG2 participants was 50 years. Three had been traders for 25 years or more, and two had been traders for 15 years or less. The highest earner in the group earned 70GH¢ ($50) a week, and the lowest earned 15GH¢ ($11) a week. Two of the other participants earned 20GH¢ ($14.2) a week, and one earned 30GH¢ ($21.4) a week. Although significantly poorer than the women in FG1, these women still earn above the Ghanaian average of 1.10GH¢ a day. This group had only one card carrying NHIS member. Three were registered with the NHIS but had failed to pay their premiums, and one was not registered at all.

The average age of the FG3 participants was 39 years. One participant had been a trader for 30 years, and the other two had been traders for 10 years or less. The highest earner in the group earned 200GH¢ ($142), and the lowest earned 45GH¢ ($32). The other participant earned 50GH¢ ($36) a week. This group was, on average, poorer than the first group but better off than the second group, and the average earnings are well above the Ghanaian average. Again, this group had only one card carrying NHIS member. The other two participants were not registered with the NHIS.

The focus group questions focused on four main areas. Firstly, there were questions relating to whether the NHIS had improved the participant's access to quality healthcare. The second group of questions focused on the barriers to informal worker's access to the NHIS. These questions were not asked in a direct fashion. Instead, each focus group was given an assortment of cards, each detailing a specific potential barrier identified through the literature review. The participants were asked to put the cards in order of importance, from those which they considered to be the most significant barriers to those which they considered to be the least significant. Thirdly, to give emphasis to the specific worker focus of this study, participants were asked about whether the NHIS had improved their productivity or made their working lives easier in any way. Finally, the participants were asked their opinions on what they would like to see change about the NHIS to make it more accessible to informal workers.

As the first focus group was made up of informal worker association leaders, additional questions on the issue of voice and representation were inserted into this session. In particular, the questions focused on whether these women represented informal workers on any NHIS committees and whether they felt that they had any policy influence with regard to the NHIS.

Key informant interviews were held with the Secretary-General and the Informal Economy Desk Officer of the Ghana Trades Union Congress (GTUC). The Secretary-General of the GTUC also sits on the NHIC as the labour representative. Both the StreetNet Ghana Alliance and New Makola Market Traders Union are affiliated to the GTUC, which is the largest representative of organised labour in Ghana, and which has made a concerted effort to include informal workers into its ranks. Informal interviews were also conducted with a district scheme manager, as well as some formal workers in order to gauge opinion on the issue of the SSNIT deductions and the subsidisation of informal workers.

4.2 Focus Group Research Findings

The focus group sessions revealed that there was a generally positive feeling about the NHIS from the participants. Importantly, it was those who were actually card carrying members (making up 5 of the 13 participants) who felt the most positive about the scheme. This would seem to corroborate Asante and Aikins' (1998) finding that over 90% of card carrying members were satisfied enough with the NHIS to continue their membership.

Card carrying participants stated that the NHIS has 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 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 women felt she had benefitted enormously from being able to access a private mission hospital accredited by the NHIS, where she felt that 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. The NHIS has also allowed some of the women to take better preventive care of their health by going for regular blood pressure checks. This is a significant finding, considering the high and rising levels of hypertension amongst Ghanaian women in Accra (De Graft Aikins, 2007).

The focus on reproductive and gynaecological health also seemed to be welcomed by most of the participants, whether they were members or not. The free care given to pregnant women pre and post 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 had to have a caesarean section and who *was well catered for and did not have to pay even ten pesewas* for the operation or her 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 carrying members was that, unconstrained by financial considerations when in need of healthcare, they experienced a greater sense of freedom in their lives as a whole. In the words of one participant:

> *Before the NHIS came healthcare 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 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 wellbeing amongst its members.

The problem is, of course, that the majority of the participants in this study (8 out of 13) were not card carrying members of the scheme. Those who were not card carrying members were unsurprisingly far less positive about the NHIS. Although agreeing that the scheme was a very good idea in theory, and that it was much better than the cash and carry system, these participants tended to be heavily critical of certain aspects of the scheme. Interestingly, each focus group identified different problem areas as 'most significant' in terms of preventing their access to the NHIS.

Participants in FG1, which was made up of SGA and NMMTU leaders, considered the greatest barrier to NHIS access amongst informal workers to be a lack of education about the scheme and

its benefits. Although the SGA and NMMTU had themselves been very active in educating their members, they felt that other informal workers did not really understand the benefits that they would derive from joining the scheme. According to this group, there is a particular problem with the fact that 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. Another problem is that rumours apparently circulate in the market about the poor quality of care available under the NHIS. This means a lot of informal workers have a more negative perception of the NHIS than is perhaps warranted. To combat these issues, those in FG1 felt that better education services in the market places should be a top priority of the NHIA. According to them many of the education campaigns have bypassed informal workers because of their inability to leave work and attend the mass education rallies that have been held. Instead of these 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.

For the participants in FG2, however, education was not a problem at all. This group felt that they had been well informed about the scheme and that there was *enough on the radio* to educate most people. Of course, these women were also members of the NMMTU, an association which has made a concerted effort to educate its members about the NHIS, so these views should be seen in a cautious light.

Those in FG2 were adamant that the major barrier to NHIS access was the cost of the premiums – which according to their generally agreed upon consensus, were set at a minimum of 24 GH¢ ($17). This was considered to be too great a price to pay by four out of five of the members of this group, whose earnings were the lowest of all the groups interviewed. Considering that most of the participants earned 20GH¢ or less a week, the feeling that premiums of 24GH¢ were too expensive to pay all at once does seem justifiable. The single participant who was willing to pay this amount was also the highest earner in the group by a significant margin. None of the women seemed to be aware that, according to official NHIA policy at least, premiums can be paid in 12 monthly instalments. When asked what they would consider to be an affordable premium, the

rest of the group agreed that they would be willing to pay 5GH¢. This is lower than even the minimum official premium of 7.2GH¢.
There seemed to be a lot of confusion amongst the various focus groups as to what the price of the minimum NHIS premium was. As mentioned above, those in FG2 were convinced that the minimum premium available cost 24GH¢. However, the participants in FG1 were adamant that the minimum premium cost 15GH¢, and the participant in FG3 thought that it cost between 20 and 22 GH¢, depending on whether or not children were added as dependents.

An interview with a district scheme manager to check up on these figures revealed that the minimum official premium is still the 7.2GH¢ originally set by the NHIA. None of the focus group participants were aware of this. District schemes do have a certain degree of autonomy in deciding on their premium levels (as long as they are within 7.2 – 48GH¢ range), so it is perhaps not surprising that the participants had varying ideas of what these premium levels were. Furthermore, it appeared in the focus group discussions that much of the evidence used to ascertain the cost of premiums comes from word of mouth and hearsay circulated in the markets.

The problem with this is that people who would possibly qualify for a lower premium level, such as the women of FG2, are not aware that the premiums they would have to pay might be significantly lower than 24GH¢ paid by a market neighbour who earns more than they do. Without the knowledge that there are variations in the premiums according to income status, the women feel that the scheme is unaffordable, when this may in fact 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 both FG2 and FG3 were also concerned about the extra charges to register minor children. To them, 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. This was aggravated by the fact that the poorer women tended to have more children. The feeling seemed to be that if all couldn’t be covered by the scheme, then it was better that 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 them to register as their dependents.

Another important issue regarding premiums was brought up by those in FG1. These women spoke of the need to include the 'Kayayei' (or porter women) of the markets under the indigent exemption. The Kayayei are migrants from the poorer, northern regions of Ghana, who migrate to the cities of the south in order to earn money to send home or to set themselves up in business when they return home. They work for the market women by porting huge loads on their heads. For doing this, the Kayayei earn very little money, and are often unable to afford even to pay the 1-1.5GH¢ per week necessary to rent a small space to sleep in a room in Ghana's urban slums (COHRE, 2008). Most of the money that they do earn is saved or sent home to families in the north. There is nothing left over to pay for healthcare, which they are often in need of due to the frequent physical and sexual assaults they suffer when sleeping outdoors (COHRE, 2008).

The FG1 participants said that it was impossible for the Kayayei to afford the NHIS premiums, due to the meagre amount of money they earn and their need to save and send home remittances. As a result the market women often find themselves having to pay for healthcare for the Kayayei, which, depending on the level of care required, can become a real drain on the market women's resources. This story reveals a major problem with NHIS indigence exemption policy. This is that the exemption system 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 even afford the most basic premium available.

Other significant discussions relating to the NHIS premiums occurred during FG3. In particular, the issue of the possible introduction of a one-time premium was focused on during this session. Although no official statements about the introduction of this premium have been made by the government, rumours about it are rife. The figure of 150GH¢ seems to come up in conversation, although no one is sure about what the actual figure will be. Interviews with key informants suggested that the premium might also be kept low – around $10-12. Participants in FG3 wanted more information on this premium, going so far as to ask the interviewers whether we had any information for them regarding this issue.

When asked what they felt about the possible 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 40GH¢ premium would be affordable, while another considered 100GH¢ 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 would have considered 100GH¢ to be an acceptable amount to pay. However, even FG3 felt that 150GH¢ far too much to pay in one go. 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 150GH¢!*

A second issue with regard to premiums that was brought up by FG3 was the current confusion over the timing of premium payments. According to some members of this group, the premium of 20GH¢ (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 very brief period under the old NPP government, and has since been revoked by the new NDC government, who are 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 changes in policy have significantly increased the more general confusion that exists around the premiums.

Although the discussion in FG3 focused a lot of attention on the issue of premiums, these were not considered to be the most significant barrier to NHIS access by this group. Rather, those in FG3 considered difficulties with registration and the issuing of ID cards, and perceived corruption within the district schemes as the most problematic areas. This was mainly due to the negative experiences of the two members of the group who were not registered with the NHIS. According to one participant he had attempted to register with the NHIS when the scheme first came into existence. He and six of his friends had paid an amount of 8GH¢ each as an initial premium. However, none of them received ID cards after the agreed upon waiting period of 6 months. When they returned to the district scheme to find out what had happened, they were told that the 8GH¢ premium had been "abolished," and that therefore they did not have NHIS

membership. They were then told that the premium had changed to 20GH¢, and that they would have to pay this amount in full to join the scheme. As a consequence of this negative experience, neither the FG3 participant nor any of his friends had tried to join the scheme again.
A similar story was told by another of the FG3 participants, who had on two occasions paid her premiums, but had yet to receive an ID card. Whether or not the problems that these two participants encountered were the result of administrative concerns, or of corruption within the district schemes is not clear. However, these incidents had very obviously left both participants with a feeling that district schemes were not to be trusted with their money.

These feelings were apparently further compounded by the fact that there is a three to six month initial waiting period before ID cards are issued after registration. The purpose of this waiting period, as in many commercial insurance schemes, is to create a financial buffer for the scheme by exempting it from having to pay out for a certain period of time. However, this principle has clearly not been explained well to the general public, because many of the participants in this study felt that the waiting period was just another way for the schemes to treat them unfairly by preventing them from getting their money's worth during the three to six months. *What is your money doing during that time?* asked one participant.

Aside from the barriers to access considered as most significant by each group – education, premiums and difficulties with registration/corruption/issuing of ID cards – there were two other barriers agreed to be significant by all the groups. The first of these was the fact that NHIS card holders are reportedly being made to wait for treatment in favour of cash paying patients at health facilities. As mentioned earlier, this appears to be a consequence of overcrowding of health facilities and the late payment for health services by the NHIS.

Most of the focus group participants seemed convinced that the delay in treatment for NHIS card holders was happening – although interestingly it was those who were not NHIS card holders who complained about it the most. However, even those who were card holders, and who were in general more positive about the scheme, admitted that the waiting period at health facilities was longer for those with NHIS cards. One card holder did add that this was a recent phenomenon which had not happened in the early days of the scheme. Participants from both FG2 and FG3

stated that they would like to see this situation revert back to *how it was in the old days* of the scheme, where people with NHIS cards were given priority and where those without cards were even turned away from health facilities.

The long waiting times are especially problematic for informal workers, for whom time is very literally money. While these workers are trying to get treatment for their health problems, their shops have to remain closed and they may lose a significant amount of income depending on the length of time they are made to wait. When one of the groups was asked if they felt that 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 other major barrier identified by the focus groups 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 study, 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* and another participant complained about the treatment of women in labour, saying *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 the nurses in public facilities.

Other quality issues that were identified involved the drugs that are available under the NHIS. According to a number of participants the only drugs NHIS card holders are given are paracetamol, quinine and multi-vitamins, and not drugs that are appropriate to the condition. One participant also mentioned that the facilities available in public health facilities are poor, complaining that *the beds are bad, the environment is unpleasant, and there is no furniture to sit on.* These quality concerns have left many of the focus group participants with a very negative

feeling towards the healthcare system, and this has certainly contributed to an unwillingness to join the NHIS.

It must be added, however, that those who were most vocal about the failings of the public healthcare system were also those who were not NHIS members. Those who were NHIS members tended to be less critical of the quality of care provided by the health services. Furthermore, there was a general feeling that the quality of care was far better in the private and faith-based facilities, some of which are accredited by the NHIS, and which the NHIS had allowed at least two of the card holders to access.

The distance to and from healthcare facilities was not seen as problem by any of the groups. This is consistent with the fact that the provision of these facilities is relatively good in the urban areas. The Makola Market has its own clinic located within the market area, so none of the workers from this market had any trouble in terms of physically accessing healthcare. The participants from FG3, who were not from the Makola Market, also felt that they had good physical access to healthcare facilities.

The major recommendations put forward by the focus group participants were:

- that education on the NHIS should be increased and brought to the market areas
- that the premium levels should be set at a more affordable rate (considered to be 5GH¢ by the group with the lowest socio-economic status)
- that workers who earn particularly meagre salaries (such as the Kayayei) should be given indigent status
- that the government should insist on health staff giving priority to NHIS card holders over cash paying patients so that the long waiting times are reduced
- the attitudes of health staff should improve
- the NHIS drugs list should be expanded
- the administrative problems in the district schemes should be addressed, so that people are not left without ID cards even after paying their premiums
- that there should be no waiting periods for ID cards – they should be given as soon as the premiums are paid.

4.3 Representation and Voice of Informal Workers

In addition to the questions which focused on NHIS access, questions relating to the representation and voice of informal workers in the NHIS decision making process were asked of the participants in FG1. The ensuing discussion revealed that representatives from informal worker associations have had very little representation or voice in the decision making processes or in the governance structures of the NHIS. None of the participants in FG1 sat on any of the governing bodies of the district schemes, or were even 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, on the ground* in terms of issues to do with the scheme's functioning and reach.

The issue of representation and voice was also discussed at a more general level during this focus group session. It was discovered that representatives of informal worker associations have been involved in the design and implementation of the new SSNIT scheme for informal workers, and have in the past been engaged by the NDC government on a number of other issues. However, the FG1 participants felt that the new NPP government was sidelining them. According to the participants, since the new government had come into power neither the SGA nor the NMMTU had been called in to any meetings with the government. Although they felt that it was still probably too soon to make any judgements on the new government, the lack of consultation that had so far exhibited was viewed as a worrying sign by the women, who seemed to feel that political alignments had changed and that their worker associations were going to suffer as a result.

4.4 The NHIS and formal/informal worker solidarity

A secondary aim of the in-country research was to determine whether the NHIS – through its unique financing system whereby formal workers partially subsidise health insurance for informal workers – has led to a greater sense of solidarity between informal and formal workers

in Ghana. Traditionally, informal workers have been seen as a threat to the hard won labour rights of organised formal labour. In Ghana, however, trade unions have started to make a concerted effort to include informal workers into their ranks, with many unions, including the Ghana Trades Union Congress (GTUC), having a desk devoted to the informal economy. According to Kofi Asamoah, the GTUC Secretary-General, the GTUC does not distinguish between formal and informal workers, but prefers rather to emphasise commonality and to view both formal and informal workers simply as workers (Asamoah, interview).

This is the official line of the GTUC, however, and it does not mean that in reality commonality of interest exists. The NHIS is an interesting lens through which to view the relationship between formal and informal workers, because in some respects it sets up a huge conflict of interest between these two groups. This is because formal workers are forced to subsidise the NHIF through the 2.5% SSNIT deductions that are taken from their salaries. In return, and as a concession to the labour unions, SSNIT contributors have been granted free membership of the scheme. However, in reality many formal workers have chosen not to register with the NHIS because their health insurance is already provided for by private work medicare schemes (Asamoah, interview). In this case, formal workers are in fact subsidising a scheme from which they do not benefit.

Furthermore, the NHIS is itself becoming a threat to the medicare benefits enjoyed by formal workers. It seems that a significant number of employers now want to do away with work medicare, and instead register their employees with the NHIS (Asamoah, interview). This has been viewed with alarm by formal workers who feel that the NHIS benefits may not be of the same quality as the work medicare benefits. In response the GTUC has urged further negotiation between business and labour, saying that it supports the NHIS, but that formal workers should not have to compromise on the quality of health insurance available to them. The bottom line, according to the GTUC, is that no worker should have to transfer to the NHIS if an arrangement is not made so that the benefits are at least equal those previously enjoyed under the work medicare scheme (Asamoah, interview).

In light of the above, an interesting point to consider is the feelings formal workers have about the NHIS and their subsidisation of the scheme. During the research trip to Ghana an opportunity arose to talk to a public sector teacher about his feelings regarding this issue. He said that there is a quite a high level of resentment amongst formal workers regarding the SSNIT subsidisation:

> *Your SSNIT contribution is your security for your retirement, so if you are told a portion is being taken out without your approval or consultation, you will be unhappy about it. Me and my colleagues were very unhappy about it. We are now made to cross-subsidise all other people in the country. We formal workers only make up 10-20% of the economy, yet we have to subsidise everyone! And it is not even ALL formal workers – only SSNIT contributors. Sure, we don't feel it now because it comes off SSNIT not off your salary, but you still think about it – it means my pension is going to reduce! That makes me feel bad.*

Although this is simply a response from one affected person, his view is logical. Despite the official GTUC stance of acceptance of the SSNIT deductions, it appears, from this point of view at least, that the NHIS had certainly not contributed to any sense of solidarity with informal workers.

Interestingly, an informal worker, in a different interview, said that informal workers do not necessarily view themselves as being 'subsidised' by the formal workers. This worker argued that informal workers pay just as much towards the NHIF because everyone is made to pay the 2.5% VAT levy, and it is the VAT levy which contributes most towards the fund. This means that informal workers contribute significantly to the NHIF through everything they have to purchase – from basic subsistence goods through to the stock they buy to sell. From the informal workers perspective, then, there also appeared to be little feeling of solidarity with or sense of appreciation for the contribution made by formal workers. These interviews seem to indicate that the NHIS has therefore done little so far to foster any sense of alliance between informal and formal workers.

5. Conclusions and Recommendations

The recently announced collaboration between the World Bank and the Government of Ghana, the 'National Health Insurance Project' (NHIP), is an attempt to deal with both policy and operational issues negatively impacting on the NHIS (Ghana News Agency, 2009). The NHIP will focus on improving the performance of the NHIS in three component areas: Policy

Development, Information and Communication Technology (ICT) and Management Training (Ghana News Agency, 2009). The specific details of each NHIP component programme, particularly in terms of Policy Development and Management Training, is not yet known. However, improvements in the scheme's information technology systems have long been on the cards. A computerised database of registration information has been discussed previously, as well as the introduction of 'smart cards' to make the ID card registration and renewal process more efficient (Boateng, 2007).

This research points to a number of issues that could be addressed by a project such as the NHIP. Projects and programmes such as this should be about improving the NHIS with the ultimate goal of making it a better social service for Ghanaians. Considering that the vast majority of Ghanaians are informal workers, and that the NHIS has been specifically designed to be inclusive of informal workers, it is vital that any such programme be fully aware of the specific needs and barriers to access that this sector of the population face. What follows is a series of recommendations for further consideration and research based on the major issues identified and discussed in this case study.

5.1 Availability of Accurate Information

Awareness of the NHIS amongst Ghanaians appears to be high – no one interviewed during the course of the in-country 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 the details of the scheme. This was demonstrated most clearly in the focus group's confusion over premiums. The confusion suggests that there needs to be much better dissemination of information on the ground to combat the rumour and possible misinformation that appear to dominate discussions on the NHIS. The market areas are particularly important places to provide detailed and accurate information. As one of the market women said:

> *Everyone hears things in the market, and then they go and tell others. So you need the right information in the markets.*

As recommended by the market women themselves, an important way to get this information into the markets would be to install health booths in these areas 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.

Another important way in which to address the lack of accurate information would be to appeal for donor funding to pay for an upgraded media management and dissemination of information department in the NHIA. It is quite clear that little attention has been given to creating and controlling a coherent "public image" for the scheme, and this needs to be rectified as a matter of urgency.

5.2 Representation and Voice of Informal Workers

The NHI Act does make provision for a representative of organised labour to sit on the National Health Insurance Council (see Box 1). This position has been filled, since the inception of the scheme, by the Secretary-General of the GTUC. As the GTUC represents both formal and informal workers and both the SGA and NMMTU are affiliated to it, informal workers are technically represented on the governing body of the scheme.

However, as mentioned in the earlier section on the NHIS and formal/informal worker solidarity, there is a significant clash of interests between formal and informal workers with regards to the NHIS. This means that, whatever good intentions are present, 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 a representative of informal organised labour to sit on the NHIC. Considering that there are two consumer representatives, and that Government has several representatives on the Council, it should not be unimaginable for another representative of labour to be included on the NHIC. Moreover, leaders of both the SGA and NMMTU, as representatives of informal labour specifically, sit on the bodies tasked with guiding the development of the new SSNIT scheme for informal workers. The NHIS could well follow this example.

In addition to a national representative on the NHIC, it is also important that representatives of informal workers be included in the governing bodies, and particularly the CHICs, 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.

A further recommendation is that an employer representative be included on the NHIC. Considering the issues that are arising around work medicare benefits and the NHIS, it would seem important to have the participation and input of such a representative on the Council.

5.3 Policy

Changes to the NHIS policy appear to have been made in a rather haphazard manner at times, and this has added greatly to the confusion about specific details of the scheme, and has done little to bolster the scheme's image in the public eye. The change from an annual membership renewal system to a five year membership renewal system, then back to a one year membership renewal system, and now possibly to a one-time premium system is a case in point.

Another example of haphazard policy making that has seemingly not been well thought through is the delinking of parent and child NHIS membership. Although this sounds like a progressive policy in theory, its beneficial effects are likely to be severely constrained by the fact that a registration fee of 2GH¢ per child still exists. This is a considerable extra amount to have to pay per child for many poorer parents. The implications and practicalities of policies such as these need to be given much greater thought in future.

5.4 Informal Worker Focus

The NHIS is a scheme that is meant to be inclusive of informal workers, it was designed specifically for this purpose. In some ways it has succeeded – the informal workers interviewed during this research study, and who were NHIS members, were generally happy with the scheme. However, several major barriers to access for informal workers still exist, and these need to be addressed if the NHIS is ever to really be inclusive of these workers.

Firstly, there is little point in having a health insurance scheme that is meant to cater for informal workers, when it is near impossible for them to access healthcare at the point of service. Time is money for informal workers, and many of them simply cannot afford to have to wait very long

hours to access treatment, or to wait for health facilities to open later in the morning. Of course, the fact that there are long waiting times is a problem that lies with the Ghanaian health system in general, and not specifically with the NHIS. However, there is little point in instituting an NHIS if the health system itself is not functioning in accordance with the principles on which the scheme is based.

Both the previous and present Ghanaian Governments have put in place measures to reinvigorate public health services. The new Minister of Health has recently promised the establishment of a network of "well equipped health facilities" in every district (Ghana News Agency, 2 March 2009). The previous government also instituted significant pay increases for public health professionals in the hope that this would make the understaffed public health service more attractive to them. Along with these types of quality improving initiatives, it is important that a concerted effort is made by the Government to ensure that health facility staff comply with health policy and do not bypass card carrying NHIS members in favour of cash paying ones. The fact that this is happening severely compromises the NHIS's public image, and if it continues will mitigate against the NHIS ever being viewed as a quality social service.

Secondly, there is the issue of premiums. Few people in Ghana do not work – the male labour force participation rate stands at 89.6% and the female labour force participation rate at 87% (Heintz, 2005). Moreover, there are a significant number of workers – particularly informal workers – who do not earn enough to be able to afford to pay an NHIS premium. This includes women such as the Kayayei, as well as many of the 21.2% of the female labour force who work as unpaid family labour (Heintz, 2005). Premium exemption status needs to be extended from only covering those who are 'indigent' (defined as those with no visible source of income), to covering those who could be classified as the 'working poor.' Extreme poverty is not limited to those with 'no visible source of income,' but is also a fact of life for many workers and this should be acknowledged by the premium exemption system if the NHIS is ever to truly cater to the needs of informal workers.

Another point to consider in terms of premiums is a payment system based on instalments. As stated earlier, the NHIA website claims that paying premiums in 12 monthly instalments is

possible. However, it does not seem to be common knowledge that this system exists and certainly none of the card carrying members interviewed in this study knew about an instalment system. If the instalment system is in fact operating, then the case for improved dissemination of information is strengthened even further. If the instalment system is not operating, then the NHIA could consider promoting and enforcing this payment option amongst the district schemes.

Low cost health insurance schemes around the world and in Ghana (notably the VimoSEWA scheme in India and the Nkoranza Scheme in Ghana) have attempted to implement such instalment systems in the past, and have failed because many members did not complete the necessary annual payments. However a willingness to pay study conducted by Asenso-Okyere *et al*., (1997) found that urban informal workers in Ghana (Nkoranza was a rural scheme) favoured the idea of an instalment payment option in a national health insurance scheme. Furthermore, a culture of making small daily savings and deposits already exists in Ghana's markets, through the *susu* system. Although it is still debatable as to whether an instalment system would actually work, both of these points indicate that such a system may be welcomed by urban informal workers. District schemes should therefore be offering this payment option at least on a trial basis. This would be particularly important if the one-time premium comes into force. While 150GH¢ may be too much to afford at once for many workers, 150GH¢ paid over a period of time may be a far more affordable alternative.

Lastly, the benefits package available under the NHIS should be mentioned. The focus group participants were positive about the reproductive health focus of the benefits package, and it is certainly to be commended for the way in which it focuses on women's health in particular. This has clearly been welcomed by many Ghanaian women. However, it should be noted that too often women's health services in the developing world are dominated by the focus on reproductive health (Avotri and Walters, 1999). Yet women are also workers, and focusing health services on their working roles and the health problems that these cause are also important.

The NHIS does not cover any kind of mental health service. With the pervasiveness of psycho-social health problems amongst women in Ghana, and these being clearly linked to their working roles (Hill *et al*., 2007), it is important that ways in which to incorporate mental health services into the NHIS are considered. This is, of course, not simple and it is important not to be too critical of this omission from the benefits package. As in many other developing countries, there is a shortage of mental health practitioners in Ghana. However, this is an issue which should certainly be kept in mind by health policy planners in Ghana.

5.5 Further Research

Ghana's National Health Insurance Scheme is an innovative attempt to extend social protection to informal workers. As such it is important that it is constantly monitored and evaluated in order to determine whether it is having the desired impact on this sector of Ghana's population. Research in this area is lacking, and there is a need for more large scale qualitative and quantitative research in addition to qualitative studies such as this.

An important area for further research would be to explore the issue of middle-class 'buy-in' and the NHIS. Without the support of the politically and economically strong middle-classes, who are likely to demand a certain standard of service, the NHIS will become a social service for the poor – with all the quality concerns that this implies. It is therefore important to explore the extent to which the middle classes support the NHIS, both in terms of membership numbers, and in terms of their support for the principles and mechanisms on which the NHIS is founded.

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