



Ghana's Universal Health Coverage

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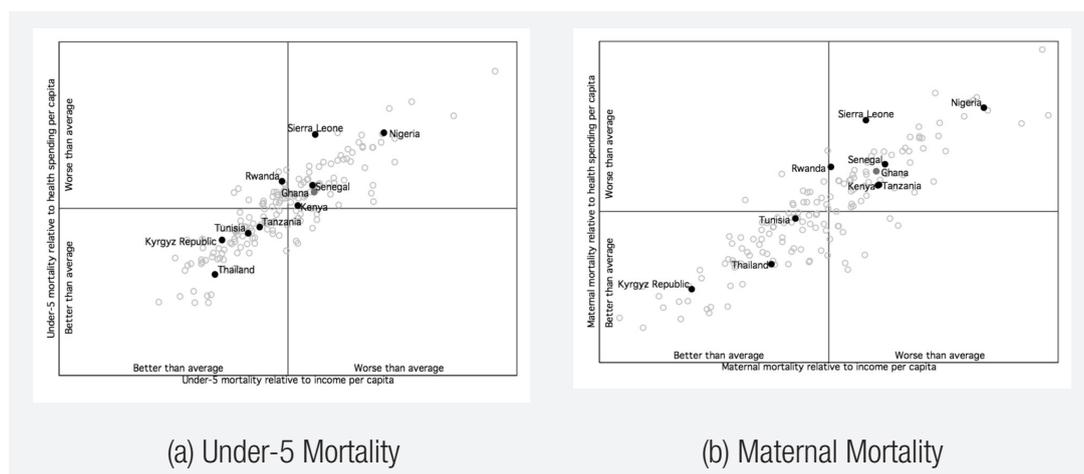
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1. Initial Conditions

Located in the western part of Africa, Ghana was one of the first nations in the region to achieve independence from the colonial rule in 1957. Categorized by the World Bank as a low-middle income country, Ghana is seen as a regional-leader in implementing plans and policies geared towards socio-economic development. However, despite ambitious large-scale programs such as Livelihood Empowerment Against Poverty (LEAP), Extended Program on Immunization and National Tuberculosis Programme, indicators of development, particularly health, continue to lag behind international targets and norms. Malaria and other vector-borne diseases remain one of the largest causes of mortalities in the country. In large part, this is because a majority of the population have no access to proper sanitation (only 13% of the Ghanaian population has access to improved sanitation). The burden of communicable diseases in the country is compounded by the large and growing share of deaths caused by non-communicable lifestyle-related illnesses such as coronary heart disease, diabetes, and hypertension. As in latest figures, non-communicable diseases account for 38% of deaths in the country, whereas communicable diseases, 53% (Saleh, 2013) (Figure 1).

Figure 1

Global Comparison of Mortality Relative to Income and Spending, 2009.



Source: Schieber and others 2012; data from the World Bank's World Development Indicators and from the WHO National Health Accounts database, http://apps.who.int/nha/database/StandardReport.aspx?ID=REP_WEB_MINI_TEMPLATE_WEB_VERSION&COUNTRYKEY=84639.

Till the mid-1980s, Ghana heavily subsidized its health sector and offered free healthcare at government operated hospitals, healthcare centers, and clinics to all citizens. However, faced with mounting debt and revenue constraints like many other African nations, the government was forced to undertake massive structural adjustments engineered by the IMF in 1983. As a part of the program, the Provisional National Defense Council (PNDC) of the government abolished free healthcare and replaced it with a user fee system, infamously known as “cash and carry”. It was hoped that the user fee would generate enough revenue to address the financial constraints and quality issues that the system was facing, and would hence promote use of, and access to, health services by the masses (Saleh, 2013). Unfortunately, a large number of households, already facing income constraints, found themselves unable to afford the user fees and had to simply withdraw from the ‘market’ for health-care. According to the GLSS-4, only 43.8% of the ill sought medical care in 1993-94, which increased to 60% in 2005-06 (GLSS-5).

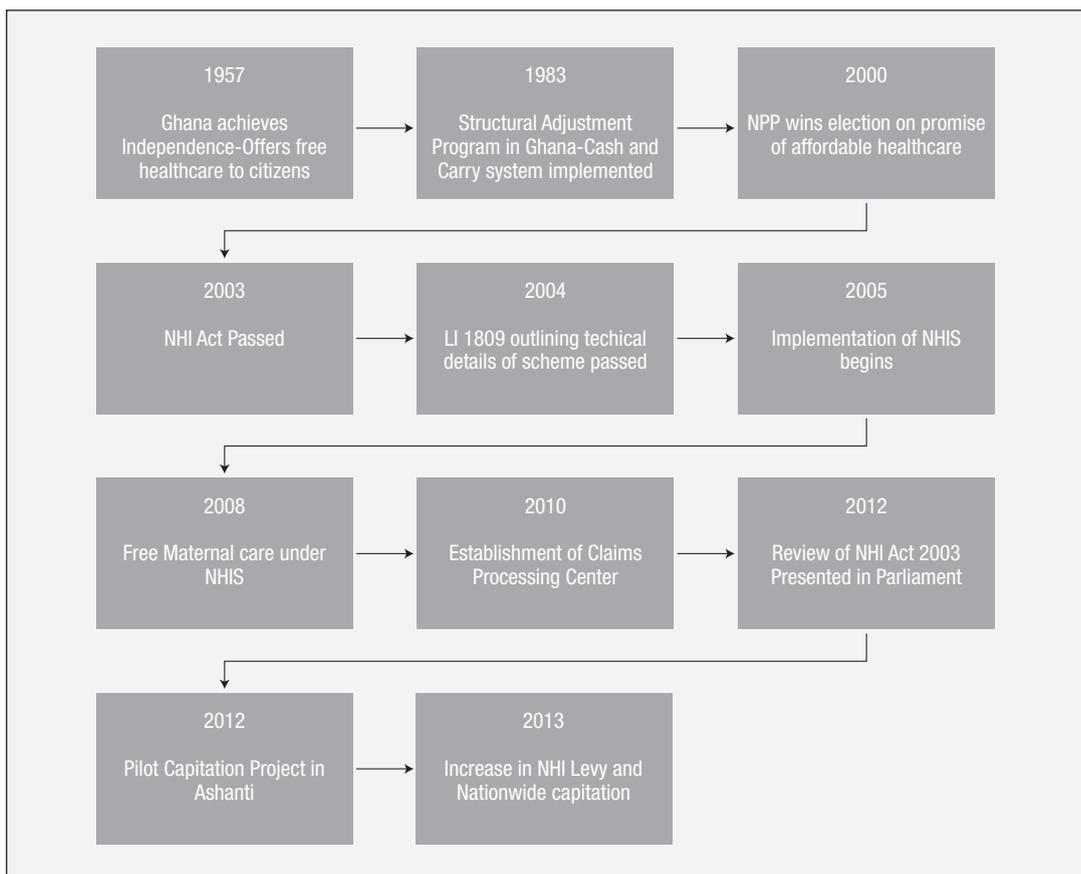
Having recognized the lack of access to healthcare by the poor, Christian mission organizations (Christian Health Association of Ghana [CHAG]) started community based health insurance schemes in poor and backward areas in the late 1980s. The CBHI schemes, however, didn't take-off as expected,

managing to enroll only 1-2 percent of the population (Blanchett et al., 2012). Nevertheless, this was only the starting point for what was to become in Ghana, a path to the universal health insurance. With strong support from bilateral organizations, all efforts were made towards scaling up CBHI schemes; however, the user fee remained as a primary means for the poor to access health services until 2000. Recognizing that mutual health insurance could be a viable means of ensuring universal healthcare access, the government institutionalized District Mutual Health Insurance Schemes (DMHIS) throughout the country in 1995, and these became the foundation of National Health Insurance Scheme (NHIS) in Ghana.

Poor health infrastructure and lack of access to healthcare became a contentious political issue in Ghana at the turn of the millennium. Rising costs and low usage of health services left the country's public health system financially unviable and gave rise to extensive political debate in the 2000 presidential and parliamentary elections. Sensing widespread discontent from the existing system, John Kufuor who led the National Patriotic Party (NPP), the main opposition party to run against the incumbent National Democratic Congress (NDC), declared implementation of an alternative to user fees as one of its main election promises. After assuming power in 2000, the NPP began to work towards setting up universal health insurance (UHI) in Ghana (Box 1).

Box 1

National Health Insurance in Ghana- A Timeline



After extensive deliberations and interaction with various stakeholders, the NHI Act (650) was passed by the Parliament in 2003. While the NHIS was to remain under the aegis of the Ministry of Health, the act reserved to set up the National Health Insurance Authority (NHIA), which was to be the main body for making and implementing rules and policies, managing the National Health Insurance Fund, and regulating the functioning of the DMHIS (Republic of Ghana, 2003). The act stipulated that three kinds of schemes must be established, namely: district mutual, private commercial, and private mutual health insurance schemes. The Act called for all Ghanaians to be enrolled in one of the three kinds of schemes but there was no mention of how, if any, this would be enforced.

Starting from a completely tax funded system, the NHIS was to be funded by a 2.5% VAT known as the NHI Levy, 2.5% Social Security and National Insurance Trust (SSNIT) contributions (from

formal sector workers), interest earned on investments, and premium from informal sector workers (NHIA, 2003). Persons under the age of 18 and over 69 were automatically included under the scheme without the payment of premium. A loosely defined category of 'indigents' was also included under those who were exempt along with pregnant women (since 2008). While there were some debates about what diseases were to be included under the scheme, an estimated 95% of diseases were included except cosmetic surgeries, prosthetics, organ implants, HIV antiretroviral drugs, and cardiac surgeries not caused by accidents.

2. Policy Framework and Institutional Structure

It is important to examine why Ghana chose to take the path of UHI and not take tax funded free-healthcare, which was in existence before the cash-and-carry system and continued to operate in countries such as UK, Sweden, Norway, and New Zealand. Perhaps the most important reason for taking UHI was the political dynamics that urgently needed policies that would immediately ensure access to affordable healthcare for a majority of the population. The NHIS was the NPP's main election promise and it was necessary for the party to propose a scheme that could come to fruition before the next election to maintain political legitimacy since elections in Ghana are held every four years. The NHIS, in its nascent form, exploited the existing DMHIS and upgraded to a national level program fairly quickly. The scheme could hence be rolled out at a relatively small administrative cost and little political resistance owing to NPP's majority in the parliament. That the NHIS was motivated largely by political consideration has been widely documented (Rajkotia, 2007; Agyepong & Adjei, 2008) (Table 1).

Table 1**Stakeholder Analysis of NHIS**

Stakeholder	Role in NHIS	Degree of Influence
Central Government	Ghana Health Services (GHS) under MOH responsible for conceptualizing and implementing NHIS. Mobilization of NHI Levy and other funds primarily under central govt. Primary actor in policy and decision making.	Very High
Local Government	Responsible for assisting GHS District Health Administration in grassroots implementation of health services. Primarily facilitative role, limited autonomy in management of health facilities.	Low
Pharmaceutical Companies	Strong lobby of private sector drug companies. Tariffs and drug prices were negotiated regularly and kept artificially high.	High
Labor Unions	Members are automatically included under NHIS without paying a regular premium. Automatic deduction from SSNIT contributions. Exercised strong influence on initial design of scheme.	Medium
Missions/Faith-based Organization	CHAG and other mission operated and managed health facilities, obtained large amount of funding from central government resources. Although their influence on NHIS is limited, they own 50% of health facilities in Ghana, particularly in rural areas.	Low
Community Based Organizations/ NGOs	CBO's in favor of expanding government spending on the scheme rather than raising revenues through premiums. Criticized scheme for not being inclusive. OXFAM amongst strongest critic of NHIS.	Low

Source: Health Systems 20/20 Project and the Research and Development Division of the Ghana Health Service, (2009), Rajkotia (2007), OXFAM (2011), Ghana Health Service (2006), Oxford Business Group (2012), Author's analysis.

The NHIS had been hotly debated in the international circles as well with OXFAM being one of the most vociferous opponents of the scheme in its earlier forms. A report released in 2011 branded the NHIS “unfair and inefficient”, and accused the government of misreporting enrollment figures (OXFAM, 2011). Clearly drawn from UK’s National Health Service model, the report urged the government to remove regular premium payments and make healthcare free for all citizens by 2015. One of the election promises of the NDC, which came to power in 2009, was to bring free healthcare to the forefront of policy debate in the country by introducing a system of one-time premium payment. However, no steps have been taken towards the introduction of such a fee. Researchers have pointed out regular premiums as NHIS’s major design flaw because universal coverage cannot be ensured until issues of health infrastructure, access, and human resources are adequately addressed even though various quarters have supported the single lifetime premium (Agyepong et al., 2011). Moreover, in a

low middle-income country like Ghana, it is worth rethinking if general taxes could cover the poor and the vulnerable without compromising the financial viability of the scheme.

The NHI Bill was introduced in the parliament in July 2003 with one week given for review and voting. However, this met huge resistance, particularly by labor unions, who demanded more time to examine the bill and put forth their concerns. One of the major oppositions of the labor unions towards the bill was the unwarranted compulsory deduction of 2.5% from their social security payments (Wahab, 2008). Protests by labor unions stalled the bill temporarily and their members were offered premium exemption in exchange for their support. In August 2003, the parliament was recalled and the bill was discussed and put to vote. The opposition party felt that it was a financially unstable scheme and didn't vote but the bill was passed due to NPP's majority in the parliament.

Over the next two years, various committees were formed to oversee the development of the NHIA and the subsequent operationalization of the scheme. By 2005, the NHIS came into existence. What started as a pilot in 46 districts soon spread to all 145 districts and it was reported that roughly less than 40% of the population had enrolled in the scheme by 2008 (NHIA, 2010). Revised figures released by the NHIA indicate that as of 2011, 8.2 million people (33% of the total population) were active members registered under the scheme, which was much lower than the figures reported in previous years (NHIA, 2011).

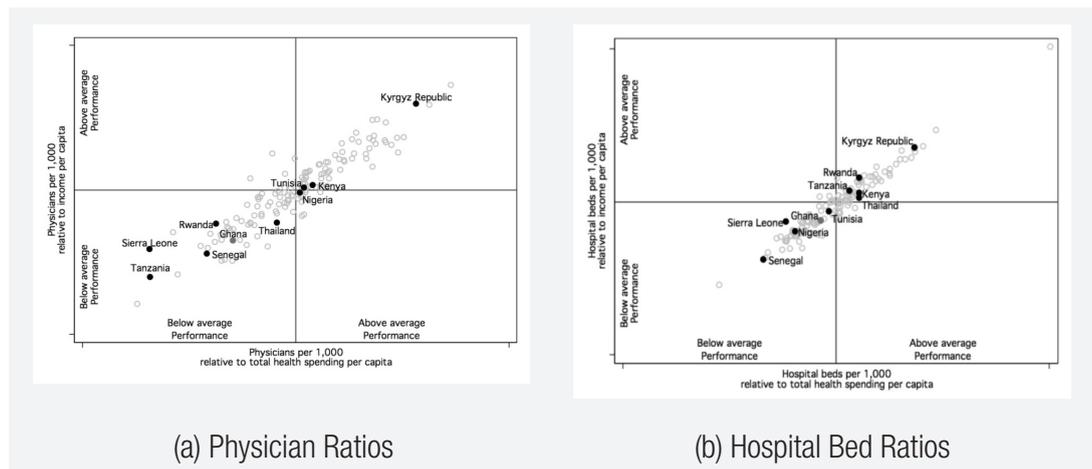
3. Implementation Issues and Overcoming Bottlenecks

While there was an agreement in the board about the need to address the failure of the cash-and-carry system, the NHIS went through considerable debates within the political system as well as within the civil society. As noted before, the NHIS in its present form was a product of NPP's electoral promise and an attempt to appease growing dissatisfaction with the old system. Changes to the NHI Act 2003, proposed by the NDC after its 2009 victory, also seemed to address the mounting frustration of the public towards a bureaucratic health insurance system plagued by financial instability, access inequality, and administrative inefficiency. The NHIS was, and continued to face challenges that stemmed from executive decisions that favored political mileage at the cost of technical soundness.

Health Infrastructure: One of the biggest bottlenecks that the scheme faces is the inability of the existing health infrastructure to meet the rising demand for health care in the country. In the decade before the NHIS came into effect, indicators of health had begun to worsen steadily. In addition, infrastructure was also flailing, plagued by low usage and limited revenue. Even now, the ratio of doctors to persons in Ghana is lower than that of many other comparable African countries. Only 0.81 hospital beds exist in the country per 1000 persons (Saleh, 2013), lower than the level in 1990. A large number of them (27%) are concentrated in certain regions and urban areas (ibid.) (Figure 2).

Figure 2

Global Comparison of Physician and Hospitals Bed Ratios Relative to Income and Health Spending, 2009



Source: Schieber and others 2012; data from the World Bank's World Development Indicators database and the WHO National Health Accounts database, http://apps.who.int/nha/database/StandardReport.aspx?ID=REP_WEB_MINI_TEMPLATE_WEB_VERSION&COUNTRYKEY=84639.

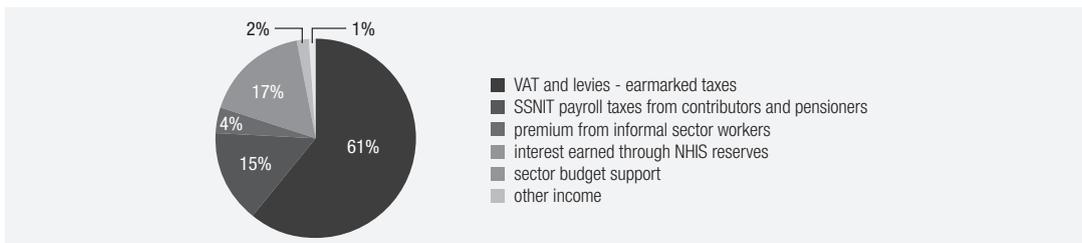
Note: Beds and gross domestic product per capita data are for the latest available year.

Regional Disparities: Widespread regional disparities exist in the distribution of both healthcare workers and infrastructure, leaving the relatively impoverished northern region and rural areas to be serviced by mission run hospitals and healthcare centers. While a large number of health services are run by missions with many concentrated in backward areas, their number is not enough to fill the gap

left by the absence of government health services.¹ The hospital bed ratio in the northern region is worryingly low (0.51) compared to that of the national average (0.81) and significantly lower than that in Volta (1.14), one of the most prosperous regions in Ghana (Saleh, 2013). Health workers also tend to be concentrated in affluent urban regions such as Greater Accra and Volta, whereas health services in the northern and western regions remain critically understaffed (GHS, 2010).

Financial Sustainability: No aspect of the NHIS has attracted as much debate as financial viability, both within the country as well as internationally. As early as 2006, the ILO predicted that the scheme would have a net deficit of 810 billion cedis by 2010 (ILO, 2006), making it financially unviable in the long run. As of 2011, the scheme was financed primarily through progressive VAT which formed 73% of NHIA funding, followed by SSNIT contributions (17.5%), interest on investments (5.2%), and premium payment (4.5%) (NHIA, 2011). The NDC’s main criticism on NHIS was that the scheme could not be sustained with tax alone when it was brought for voting. Indeed, the levy was intended to cover high initial costs and was to be financed by a sustainable and balanced mix of resources in the long run. However, even after ten years, SSNIT and premiums together did not even make up a quarter of NHIA revenue. While the fiscal status of the scheme remained precarious, there had been a sharp increase in healthcare utilization across the board. Coupled with issues of moral hazard, ineffective gate keeping, overuse of health facilities, and high domestic drug prices, this posed an exponential cost burden on the program. Although steps have been taken to generate revenue and cut costs recently, NHIS hangs precariously on the brink of insolvency (Figure 3).

Figure 3
Sources of Financing for the NHIS in 2009 (in percent)



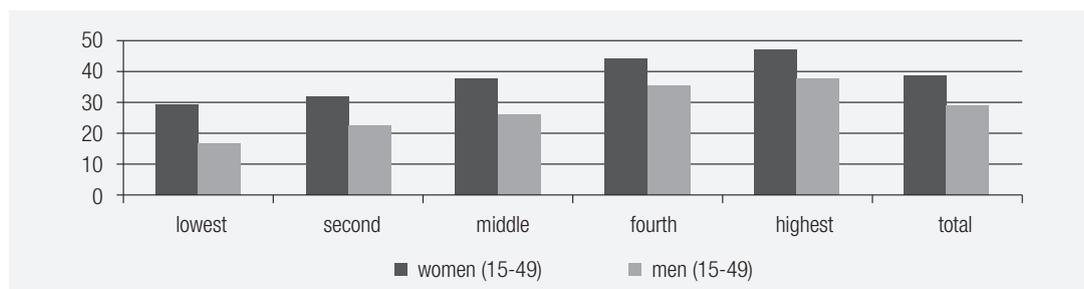
Source: National Health Insurance Authority, Annual Report, 2010.

¹ CHAG estimates that its member institutions provide 42% of total health services in the country, second only to the Ministry of Health (CHAG, 2012).

Despite the fact that nearly 28.5% of Ghana’s population is poor (2006 figures), only a quarter is covered under the NHIS. On the other hand, nearly 55% of the beneficiaries are in the age-based exemption category (NHIA, 2011), which did not take economic deprivation into consideration. Consultation with key players and stakeholders has revealed that the premium amount was calculated as double the per-capita cost to cover the exempt young and the old. However, this calculation was not based on any formal actuarial analysis (Rajkotia, 2007). As a result, NHIS continues to be financed primarily through VAT on goods and services, which is passed on to consumers including the poor in the form of higher prices (Figure 4).

Figure 4

NHIS Enrollment by Income and Gender Differentials, 2008



Source: Ghana Statistical Service 2009.

Exclusion of the Poor: The NHIS has also been heavily criticized for failing to reach the poor and the marginalized, a majority of whom were informal sector workers and suffered the most under the user-fee system. The NHI Act 2003, very broadly defined the category of indigent as “a person who does not have a visible or adequate means of income or who does not have a person to support him or her and by the means test qualifies as an indigent”. The act however did not elaborate any further on how these people were to be identified. Thus, it was left to the individual DMHIS to identify and establish exemption status based on the income level. Not surprisingly, the lack of methodology for identification of the poor and the absence of any grievance redressal mechanism meant that a majority of the needy were left out of the scheme who were unable to pay the regular premium (SEND-Ghana, 2010; Saleh, 2013b; Blanchett, 2012). Moreover, this led to wide disparity across regions in the definition of indigents since the DMHIS were free to set the standards for identification of the extremely poor. As a result, various studies found that the rich and the affluent formed a majority of those

registered under the scheme, whereas enrollment in the low income quartiles remained much lower than expected (Asante & Aikens, 2008).

The NHIA has recently updated its definition to include all those who “do not have any visible source of income, do not have a fixed place of residence, do not live with a person who is employed and has a fixed place of residence, do not have a consistent source of support from another person” (NHIS, 2013). While this definition is more explicit, it still does not specify a structured method to identify the poor. Opaque classification means that targeting remains ineffective and ill-defined exemption categories pose significant financial burdens on the scheme. The Act itself defines indigents as those identified by the Minister responsible for social welfare (Republic of Ghana, 2012) effectively attempting to link the NHIS with the Livelihood Empowerment Against Poverty program, a conditional cash-transfer scheme of the Ministry of Employment and Social Welfare (MESW). This is a part of an overall attempt by the NDC government to make the NHIS more centralized and uniform across districts, limiting superfluous bureaucracy at the lower levels of government.

As per latest figures, informal sector workers form only 36.4 percent of active NHIS enrollees (NHIA, 2011). Informal sector employment in Ghana, which forms about 80-85% of all employment, is characterized by lack of formal contracts, limited or no social security, and lax enforcement of labor laws and regulations. This leaves the workers vulnerable to even the slightest income shocks, which can push them into severe poverty. The NHIS, which automatically guarantees to include formal sector workers by virtue of their contribution to the SSNIT, makes no such provision for workers in the informal sector when in fact it is these workers who face uncertainties in case of illness. Serious illnesses leave the poor unemployed and burdened with high medical bills. This can wipe out household savings and assets and push the entire household into crippling debt, trapping them in a vicious cycle of poverty (Table 2).

Table 2**Challenges to NHIS and Policy Initiatives**

Implementation Challenge	Policy Response	Status
Health Infrastructure	Nearly half of health facilities and a third of hospital beds belong to missions and private providers. Enhancement in health infrastructure but not geographically equitable. Improvement in community-based health initiatives to reach poor and backward areas.	Partially resolved
Regional Disparity	Wide regional differences in enrollment and infrastructure continue to exist. Medical staff and hospitals concentrated in urban areas and the south.	Unresolved
Financial Sustainability	No steps have been taken to ensure the financial viability of NHIS. Premiums form small part of the total revenue. Reliance on taxation. High drug prices exert pressure on financial resources of scheme. Pharmaceutical lobby keeps drug prices artificially high.	Unresolved
Exclusion of the Poor	The definition of indigents has been broadened and the process to identify the poor is underway. No provision to encourage informal sector workers' enrollment	Partially resolved

Source: Author's analysis.

4. Early Outcomes/ Results

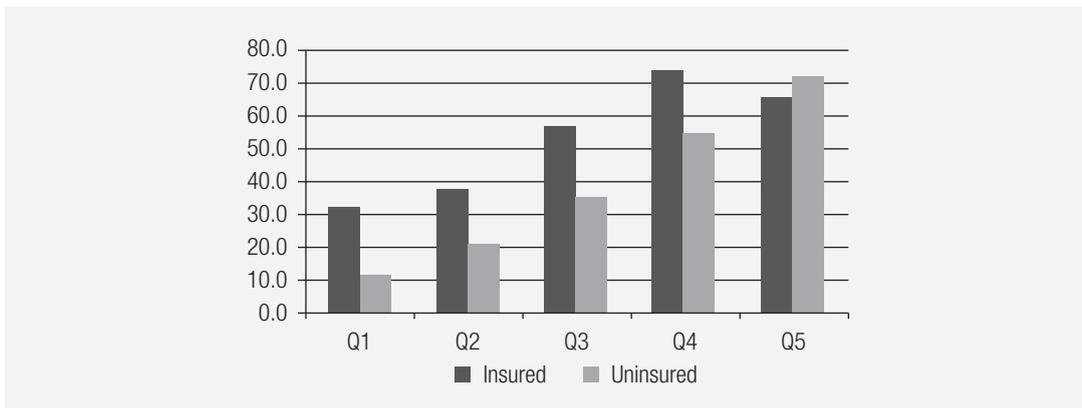
Despite the roadblocks and technical shortcomings, there is no denying that the NHIS is an ambitious program with the potential, which would make affordable healthcare a reality for the people of Ghana in the very near future. Enrollment in the scheme, though far from universal, has been steadily increasing. In principle, considering the high cost of healthcare for the uninsured, there is a significant financial incentive for people to enroll in the scheme. Despite this, it has been found that wealth and education have had a strong positive correlation with enrollment. This indicates that richer and more educated people were more likely to enroll in the program compared to the poor (Blanchet, 2012). The study also found that limited and inequitable coverage meant that people at higher risk of illness were more likely to enroll in the scheme leading to problems of adverse selection, and subsequently higher program costs.

Healthcare Utilization: In less than eight years of its existence, NHIS has made huge strides in improving healthcare utilization among the poor and non-poor. According to the Women's Health

Survey of Accra,² more than three fourths of women enrolled under the scheme visited a health clinic or hospital in the year preceding the survey, whereas only half the women without insurance did (Blanchett et al., 2012). Controlling for individual characteristics, it was found that enrollees were 83% more likely to have made over-night hospital stays and had 57% more prescriptions. Researchers have highlighted that outpatient visits have been increasing dramatically since 2005 compared to the previous stagnant level of usage (Witter & Garshong, 2009). With the use of household and patient exit surveys, another study found that the insured were twice more likely to seek formal healthcare in case of illness and were less likely to report self-medication compared to the uninsured. Similarly, insured pregnant women were more likely to have institutional deliveries than the uninsured (Health Systems 20/20 Project and the Research and Development Division of the Ghana Health Service, 2009) (Figure 5).

Figure 5

Institutional Delivery at Facilities among Insured Compared to Uninsured, 2008



Source: Ghana Statistical Service 2009.

Out-of-Pocket Expenditure: Since the inception of NHIS, out-of-pocket expenditure as a share of total health expenditure has also dramatically reduced in Ghana. It is estimated that out-of-pocket expenditure fell from 47% to 37% of the total healthcare expenditure between 2000 and 2009. This was accompanied by an increase in government expenditure on health from per capita \$19 in 2000 to \$29 in 2009 (Saleh, 2013). Other studies showed that out-of-pocket expenses have almost halved in

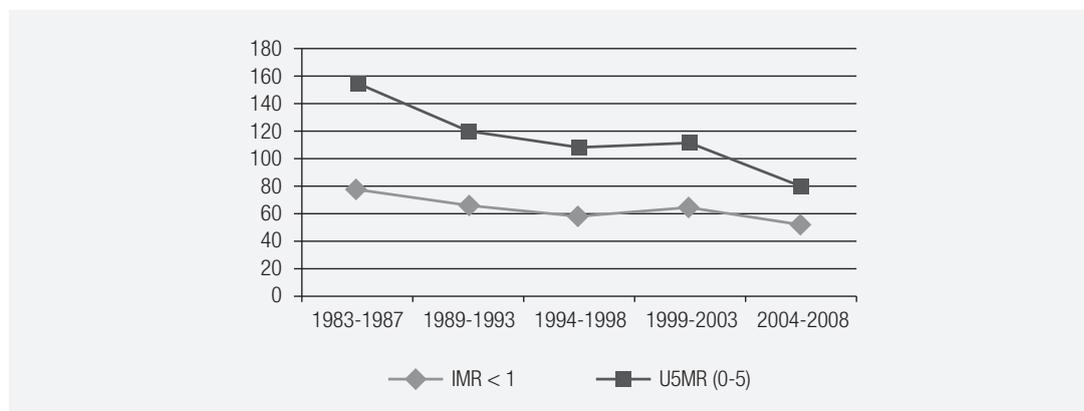
² Regionally representative sample of 3200 women in Wave I and 2800 women in Wave II (age 18 years and above). Wave I was conducted in 2003 and Wave II was conducted between September 2008 and June 2009.

the years following the implementation of the scheme, reducing (on average) from 43,604 to 19,898 (old) cedis in outpatient care and from 311,105 to 149,112 (old) cedis for hospitalization between 2004 and 2007 (Health Systems 20/20 Project and the Research and Development Division of the Ghana Health Service, 2009- figures are per visit).

Health Indicators: The Ghana Demographic and Health Survey (GDHS, 2009) of 2008 is the only available resource that allows us to examine the effect of NHIS through the use of a large, nationally representative dataset. The GDHS showed that between 2003 and 2008, IMR in Ghana reduced from 65 to 50 and under-5 mortality reduced from 111 to 80, a marked improvement. Institutional deliveries went up from 45% to 58% and may have increased even more in recent years since pregnant women were included in the exempt category of NHIS from 2008. Similarly, the proportion of children under the age of 2 who are fully immunized increased to 80% from 69% in 2003 and 62% in 1998. It is worth noting that these improvements in health indicators are the fastest among other indicators that Ghana has experienced in over 20 years. A substantial part of this may be on account of improved access to affordable healthcare under NHIS (Figure 6).

Figure 6

Under-five Mortality and Infant Mortality in Ghana, 1983 to 2008



Source: Ghana Statistical Service 2004, 2009. Data are from the Ghana Demographic Health Survey.

Identifying the Poor: Perhaps one of the most significant achievements of the NHIS is that it has necessitated and put in motion a formal mechanism to identify the poor. Ineffective targeting and arbitrary exemption categories had meant that benefits of health insurance were not reaching the

people who needed it the most. It is only recent that policymakers in Ghana have acknowledged that there is a need to institutionalize a uniform method to identify the poor and “indigent” rather than to rely on the subjective assessment of individual DMHIS. This may have important spillover effects for other existing (and future) schemes and programs since it allows the government to monitor benefit incidence so that services reach the poor and there is no unnecessary duplication of benefits under different schemes.

5. Lessons Learned

It is the vision of NHIS “To be a model of a sustainable, progressive and equitable social health insurance scheme in Africa”, and it is not wrong to say that Ghana has made great strides towards the fruition of this vision. Over the past few years, NHIA has attempted to use technology to streamline the scheme’s value chain: from enrollment to claims processing. Electronic claims management was introduced in 2012 and a call center was established to ensure prompt redressal of issues and queries (Dsane-Selby, 2012). The government also introduced a pilot capitation project in Ashanti and plans to expand this nationwide in the years to come. Discussion is also underway to increase the NHIL to 3.5%. However, with contributions already significant, a move of this kind may face resistance from the opposition and the civil society.

Coverage and Access: Revised estimates released by the NHIA show that the number of active insured members is not as high as before. This means that a large number of poor and vulnerable persons continue to depend on the expensive cash-and-carry system for their health needs. Informal sector workers are also under-represented among the active members and need to be incentivized to enroll in the scheme. This is critical so that the poor can benefit from the program and the premium paying non-poor can enroll and bring in much needed revenue. The fact that poorer regions report lower enrollment shows that, among others things, enrollment is hindered by both demand and supply constraints. There may be lessons learned from international experiences on UHI (Table 3).

Table 3**Universal Health Insurance around the World**

Thailand	Pioneer in achieving universal health coverage despite low government expenditure on health. Phased, but swift, extension of compulsory health insurance from formal sector workers to the entire population-funded entirely by tax revenue.
Costa Rica	Implemented compulsory health insurance for entire population through social security fund. Premiums for poor paid by government revenue. High government expenditure on healthcare.
India	Among the lowest government expenditure on healthcare. Government funded health insurance for the poor, premium paid by government- mix of public and private insurance schemes. Low levels of health insurance coverage.
Malawi	Low GDP country with poor health indicators. The majority of government expenditure on health is funded by donor. Initiation of steps towards free healthcare for the most vulnerable through partnership between MOH and Christian mission organizations.
Nigeria	Compulsory health insurance for all central government employees through National Health Insurance Scheme, funded by employee and employer contribution. Proposal to extend NHIS to state employees- adopted by 3 out of 36 states.

Source: McIntyre et al. (2013).

Financial Sustainability: In order to prevent its financial woes from escalating, it is imperative for the government to re-evaluate its health financing strategy without delay, particularly in relation to the NHIS. The first step towards this would be to review the exemption policy of the scheme and ensure that premium is waived off only for those who truly cannot afford to pay it. Alternatively, a graduated premium payment system can be devised which would link the premium amount to income or other indicators of economic wellbeing. Identification of the poor should be the first step towards ensuring progressive benefit incidence and should be operationalized and executed on an urgent basis (Schieber et al., 2012). Drug prices in Ghana are several times higher than the international reference price and are regularly negotiated by the lobby of service providers. Not only does this pose a burden for the uninsured poor but also for the program which reimburses providers at this unreasonable high price. A review of the medicine list, and drugs and services tariff rate is therefore needed.

Efficiency: The NHIS has been plagued with complaints of fraudulent claims, inefficient gatekeeping, moral hazard, and ineffective risk pooling. Mechanisms, that ensure efficient use of services along with checks and balances that dis-incentivize over-use, need to be put in place. Increased use of technology in claims processing and monitoring can help in reducing, to a large extent, inefficiencies that arise from having multiple levels of bureaucracy. Regular audit, random inspections,

and penalties for fraud may reduce corruption in the scheme. Moreover, the scheme should not provide curative care in isolation but should run parallel to activities that promote disease prevention.

Infrastructure: Ensuring universal enrollment in NHIS will be futile if it is not met with a parallel increase in the provision of hospitals, clinics, and healthcare centers. There is an urgent need to improve the quality of healthcare services and infrastructure in backward and rural areas. Health services and institutions run by missions should complement public provision and not serve as a substitute for them. In addition, human resources and staffing issues in backward regions also need to be addressed. There have been reports of increased workload of nurses and health staff (without a corresponding increase in remuneration) that may create dissatisfaction. This can be transferred to patients in the form of poor service (Alfers, 2009; SEND-Ghana, 2010). Ghana has lost a large number of its doctors due to international migration and the remaining few are concentrated in urban areas. Requiring compulsory rural posting of doctors and nurses graduating from medical and nursing colleges may ensure the availability of trained medical staff in all regions.

The successes and failures of the NHIS in Ghana have important lessons for countries embarking on the path of universal healthcare. However, nothing is as important as sustainable development and healthcare policies which should consider technical efficiency and equity, not political leverage.

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