

# A Survey of Health Financing Schemes in Ghana

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*September 2001*

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# Abstract

This report looks at health care financing schemes in Ghana, in the public, private commercial, and community sectors. Government schemes examined were an abortive pilot of national insurance, a User Exemptions scheme, and a program for public sector employees. The first private sector insurance company collapsed, though more recently company set-ups have increased greatly in number. Schemes in both sectors have struggled or failed due to non-compliance and abuse by users and providers, and poor communication between different kinds of schemes, which leads to overlap and wastage. Community schemes (mutual health organizations, or MHOs) have gained in popular and donor support especially in the past two years. While they are not a panacea for resolving health care financing and delivery issues, many of their limitations – small size, limited benefits, and inability to cover all segments of the population, especially the poorest – can be overcome with appropriate design and management. The report recommends ways to encourage sustainability of MHOs, such as regulation, coordination, and reinsurance, and a national underwriting fund. These issues and recommendations are intended to inform policymakers who must decide financing and other matters regarding the schemes.

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# Acronyms

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ANC</b>	Antenatal care
<b>¢</b>	Cedi (local currency)
<b>CDL</b>	Comprehensive Drug List
<b>CSA</b>	Civil Servants Association
<b>DANIDA</b>	Danish International Development Assistance
<b>DHMT</b>	District Health Management Team
<b>GDHS</b>	Ghana Demographic and Health Survey
<b>GHS</b>	Ghana Health Service
<b>GLSS</b>	Ghana Living Standards Survey
<b>GPRTU</b>	Ghana Private Road Transport Union
<b>HIV</b>	Human Immuno-deficiency Virus
<b>ILO</b>	International Labor Organization
<b>LI</b>	Legislative Instrument
<b>MDA</b>	Ministry, Department or Agency
<b>MHO</b>	Mutual Health Organization
<b>MIS</b>	Management Information System
<b>MOH</b>	Ministry of Health
<b>NGO</b>	Non-governmental Organization
<b>NHIS</b>	National Health Insurance Scheme
<b>NIC</b>	National Insurance Commission
<b>NMMI</b>	Nationwide Mutual Medical Insurance
<b>OPD</b>	Outpatients Department
<b>PHR/PHR<sup>plus</sup></b>	Partnerships for Health Reform / Partners for Health Reform <sup>plus</sup>
<b>RHA</b>	Regional Health Administration
<b>SSNIT</b>	Social Security and National Insurance Trust
<b>USAID</b>	United States Agency for International Development



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In particular, special thanks are due to the team comprising Messrs Seth Asante, Philbert Kankye, and Patrick Apoya that collected data around the country for the MHO inventory, indispensable material for this study.

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# Executive Summary

This survey covers the panorama of formal and informal sector health care financing schemes in Ghana in recent years. Specifically, the survey found the following:

**Within the public sector,** the survey report looked critically at the abortive attempt to pilot a National Health Insurance Scheme (NHIS) in the Eastern Region, the User Fee Exemptions Scheme and the Government's health care financing arrangements for public sector employees. The abortive NHIS would appear to offer no practical lessons about the feasibility of this type of scheme in the country, as the scheme never actually got off the ground as planned. However, its abandonment in favor of community health insurance schemes modeled on the mutual health organization (MHO) approach may be instructive.

The survey found that the User Fee Exemptions Scheme, which targets the largest number of people currently covered by any health financing scheme in the country, is being unevenly implemented across regions (for instance, there is very high usage of exemptions by children under the age of five years in the three Northern Regions and very low uptake in Brong Ahafo and Ashanti Regions). Moreover, shortages of funds to pay providers for the exemptions, or delayed payments, are frequent complaints leading to some concern about the scheme's effects on the funding of health facilities, the true resource implications of full implementation of the scheme to cover all the intended target groups, and therefore the sustainability of the policy, too.

Public servants enjoy limited free health care paid for by the Government but the method of reimbursement (involving lengthy bureaucracy and delays to get refunded after presenting receipts), low ceilings per employee (and their families), lack of defined benefits package, and apparent incentives for public servants to abuse the system have led to some dissatisfaction and to current attempts to replace this practice with some form of MHO-type insurance scheme (pioneered by two regions – Upper West and Ashanti).

**In the private commercial sector,** the survey found that despite the collapse of the first health insurance company, the private commercial sector has grown very rapidly in terms of numbers of such company set-ups in the country: The first private health insurance company in the country collapsed after only a few years due to an unanticipated large number of claims, non-compliant behavior by users and providers alike, and attendant cost escalation. Since then, however, other companies have entered the field and there is continuing dynamic growth in this sector, though these are limited to Accra and a few urban areas. More recently also, some of the companies have refined their control and management systems with more robust techniques to enhance their profitability and sustainability.

**In the community sector,** the survey relied on the results of a parallel inventory of mutual health organizations in the country conducted by USAID-supported Partnerships for Health Reform (PHR) earlier in the year. This inventory identified 47 schemes, including proposed ones (an increase from just four schemes only two years ago). Eastern, Northern, and Brong Ahafo Regions lead the

country in numbers of emergent schemes and scheme memberships. The mean size of MHOs nationally is rather high, at over 6,000 members per MHO.<sup>i</sup> Only eight (20 percent) of MHOs are more than two years old; the rest are younger, reflecting the emergent nature of this phenomenon. In terms of design, there is a discernible trend towards more participatory models and away from the predominantly facility-based and controlled scheme, as the Nkoranza scheme was at the start. With dissemination of lessons learnt from elsewhere and tools developed by development partners such as USAID/PHR and Danish International Development Assistance, the MHO schemes now tend to include fairly robust risk management features in their design, which improves their viability.

The following salient points also stand out from this report:

- ▲ User and provider non-compliance with certain regulations designed to avoid abuses of financing schemes appear to bedevil both the public sector and private commercial sector initiatives alike.<sup>ii</sup>
- ▲ Such non-compliant attitudes are also a tendency in community-based schemes, but the evidence seems to show that, when they are designed according to widely accepted norms, the opportunities for this are more reduced as the capacity to draw on community social capital is one of the features that distinguishes this type of scheme from others; while their usually smaller size – often seen as a disadvantage in other terms – is itself an advantage in managing some insurance risks including user abuse and moral hazard.
- ▲ Additionally, MHOs currently enjoy a lot of goodwill from the donor community, which has translated, *inter alia*, into the availability of a broad range of management and organizational tools that have been developed exclusively for such organizations in the country.
- ▲ It appears that much could be gained by having clear coordination between the various efforts to establish different health insurance schemes. For example, the Ghana Healthcare Company set up by the Social Security and National Insurance Trust (SSNIT) counts on enrolling nearly all public sector employees (180,000 in total). At the same time, associations of civil servants and teachers are actively studying proposals and plans to promote or set up professional-based insurance schemes for their members. This gives the impression that, at the very least, those behind these different initiatives do not know what the others are doing although the efforts could be mutually incompatible and could result in unnecessary duplication and waste.
- ▲ The USAID/PHR<sup>plus</sup> survey report presents the various kinds and basic characteristics of health financing systems in the country (excluding the user fee or “cash and carry” system), including their current constraints and problems. It might therefore be relevant to ask other related questions, such as: what is the relative contribution of each of these systems to the financing of health care in Ghana compared to direct, out-of-pocket, household spending on health care? And what is the potential available from each of those sources if various bottlenecks identified in this report are addressed?

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<sup>i</sup> This number is fairly high as MHOs are generally of smaller size elsewhere in the sub-region. But this average figure conceals the fact that there are smaller-sized as well as considerable large MHOs.

<sup>ii</sup> This observation is strikingly similar to the experience of the private commercial insurance sector in neighboring countries including Cote d'Ivoire – where commercial schemes have been running chronic deficits, usually financed by earnings from other products in the companies' portfolios; and Nigeria – where health insurance company collapse similar to the nationwide experience pre-dates Ghana's entry into the private commercial health insurance market.



The first question is clearly a subject for a national health accounts study. The second can be addressed with the aid of this report, the proposed national accounts study, and further data easily available from the statistical department. This would not be an academic exercise but one designed to inform policymakers about the relative weight (and therefore resources) to be devoted to each type of health financing available, especially the measures that could be put in place to tap the full potential of each of those types.

- ▲ The exercise suggested above will provide a good evidence base for the Government to effectively play its expected role of setting the policy environment and direction for the development of different types of schemes identified as having useful potential. It would also facilitate coordination of the various efforts including interventions by donors and promoters in the area of health financing in the country.
- ▲ It is also important to acknowledge that MHOs are not a panacea to the health financing problems of the country. They are not necessarily appropriate in every circumstance and, moreover, their often small size, limited benefits package, and inability to cover all sectors and groups of the population (for example, the very poorest) may sometimes limit their efficacy as instruments for the sustainable financing of health care. However, experience has also shown that these problems are not necessarily inherent but are often related to design and management flaws for which adequate and feasible solutions exist, though their application may require an active role for the Government and other partners so as to enable MHOs to realize their true potential. Specific recommendations for reinforcing the long-term sustainability of MHOs as health financing mechanisms are offered below.
- ▲ To address some problems related to the relatively small size of MHOs, the precariousness of the financial situation of many of their members, and to assure their long-term sustainability, it is suggested that:
  - △ MHOs be encouraged and assisted to come together in democratic district and regional federations or coordination bodies so that, while retaining the participatory and risk management advantages of their small size, they could also benefit from the economies of scale and insurance advantages of a larger size. The regional federations would negotiate collectively with providers on behalf of individual MHOs and provide other services that individual MHOs would not be able to provide, or would not be able to provide as cheaply.
  - △ In addition, each region should be encouraged to put in place a regional social reinsurance fund (with the regional health administration, and regional MHO federations, if they exist, playing a leading part). The principal objective of this fund would be to contribute to the viability and long-term sustainability of the individual MHOs being set up spontaneously all over the country; and it would combine the functions of financial reinsurance for high cost care, promotion of scheme set-ups, support for schemes in temporary difficulty, promotion of health education, risk equalization between low risk and high risk groups, and equity between different districts and social groups.

The funding for these social reinsurance schemes could come from:

- ▲ Contributions from all the existing schemes (a small percentage of their total income)
- ▲ Contributions from well-to-do individuals, companies, organizations, citizens living abroad, etc.

- ▲ Specific fundraising activities
- ▲ Government contributions
  - △ A national health fund set up by Government (with possible donor contributions) could underwrite the regional health funds, and transfer funds to regions to ensure equity and coverage of vulnerable groups, etc. The director of the Policy, Planning and Monitoring and Evaluation division of the MOH has also suggested that such a fund could help ensure that all MHOs cover a defined basic package of health services for their members, an important objective of national health policy. As described, such a fund would therefore have reinsurance, risk equalization, and equity functions.

# 1. Introduction

The Government of Ghana wishes to make strategic decisions concerning the future direction of financing of health care in that country. This paper assembles and analyzes information concerning existing and prospective health financing innovations in the public, private, and community sectors.

The information was gleaned from a survey that began as an effort to capture the scale, significance, and potential of the growing mutual health organization (MHO, or community health insurance) phenomenon in Ghana in recent years, as part of an evaluation exercise at the end of the Partnerships for Health Reform (PHR) project, funded by the United States Agency for International Development (USAID), in March 2001. It was also thought to be cost-effective because an inventory of MHOs could be easily done using a common format during the program of regional dissemination workshops for MHOs, which USAID was funding as part of the PHR end-of-project activities.

Subsequently, USAID extended the coverage of this inventory exercise to include a survey of other alternative forms of health care financing in the country, with a view to developing the evidence base for better targeting and programming of USAID's technical assistance to the Government of Ghana in what was becoming an increasingly important area.

This exercise acquired a renewed importance when the new Minister of Health requested technical assistance from the USAID-funded PHR project with the new Government's policy on health care financing. It was judged important to assemble information on recent and current forms of alternative health care financing schemes (i.e., alternatives to user fees or "cash and carry"), with a view to understanding the trends, strengths, constraints, and potential of each of those alternative forms of financing in preparation for the policy-oriented technical assistance. The "cash and carry" system itself was not covered. "Cash and Carry" has been widely denounced for bringing untold hardships on the poor, who cannot afford the often high fees charged at health institutions as a result of its implementation.<sup>1</sup>

As part of this study, four local consultants were contracted to undertake the survey, and in the process, to gather data with particular reference to the following:

Public sector schemes:

- ▲ The pilot National Health Insurance Scheme (NHIS) attempted in the Eastern Region in recent years
- ▲ The user fee exemptions scheme
- ▲ Other public sector schemes for covering health care

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<sup>1</sup> The intentions behind the user fee or cash and carry system originally were to encourage greater responsibility in the use of scarce resources, mobilize additional funds for improving quality, and extend primary health care facilities to where they are needed.

Private companies providing health insurance cover:

- ▲ Private commercial health insurance schemes
- ▲ Various health endowment funds, etc.

Mutual health organizations:

- ▲ Community health insurance schemes
- ▲ Social financing schemes based on health insurance (e.g., ethnic solidarity networks)<sup>2</sup>
- ▲ Health insurance schemes set up and run by non-governmental organizations (NGOs), professional associations, etc. for their members

USAID intends to share the fruits of this research with the Ministry of Health (MOH) and the Ghana Health Service (GHS), as well as with other donors and stakeholders involved in this area of health care financing in Ghana.

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<sup>2</sup> In actual fact, an attempt was made to capture such networks only in one region, Brong Ahafo, and even in that case this was strictly limited to a couple of solidarity networks that have made the conscious leap to systematic health insurance cover for their members in line with well-known MHO principles.

## 2. Methodology

The data on MHOs in this report came from an inventory carried out between March and April 2001 at the request of the PHR Regional Advisor for West and Central Africa and based on a common form designed by PHR to facilitate the data collection process and its later analysis.<sup>3</sup> That inventory exercise was also timed for cost reasons to coincide with the holding of regional MHO tools' dissemination workshops which afforded the consultants the opportunity to meet all the MHO representatives in one place. (A separate MHO inventory report is forthcoming.)

As far as the other forms of health financing were concerned, a different format based on the terms of reference was used. No convenient regional seminars bringing these organizations together were available, and their heterogeneity did not lend itself equally easily to utilization of a common data collection format. The main sources used were: relevant available documents, legislations, reports, records and proposals (Annex B). Formal and informal interviews and discussions were also held with program officers and staff of the institutions concerned (Annex C).

For some of the schemes covered more information is available than for others. Hence, the study provides more details and analysis in these areas. In all cases the study team sought to assemble the maximum amount of information that is available.

Quantitative data were analysed using descriptive statistics and narrative or qualitative data were summarized in point form.

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<sup>3</sup> The PHR consultants who carried out the inventory exercise were Messrs Patrick Apoya, Seth Asante, and Philbert Kankye. Their contributions are gratefully acknowledged.



## 3. Government and Other Public Sector Initiatives

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### 3.1 Introduction

This section presents the abortive pilot National Health Insurance Scheme, the user fee exemptions scheme and the civil servants medical cover arrangements, including recent innovations where civil servants in two regions have voted with their pockets to set up MHO-type health insurance schemes for their families.

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### 3.2 Pilot National Health Insurance Schemes (Eastern Region)

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#### 3.2.1 Background

The widespread unpopularity of the “cash and carry” system, especially its negative consequences on the poor, led the Government to commission various studies into alternatives, principally insurance-based ones. Initially, many efforts were made to investigate the feasibility of a national health insurance scheme.

Proposals to set up and run a national health insurance scheme have in fact been around for a long time. Since the early 1980s, various experts, local and international, have been contracted by the MOH to study and make recommendations for setting up and running a national health insurance organization. The International Labor Organization, World Health Organization, European Union, and London School of Hygiene and Tropical Medicine have all visited Ghana and provided technical advice at the request of the Ministry. In August 1995, the MOH received definite proposals from a private consultancy group in a report entitled “A feasibility study for the establishment of a National Health Insurance Scheme in Ghana.”

The gist of this report was that a centralized national health insurance company should be set up to provide a compulsory “Mainstream Social Insurance Scheme” for (i) all contributors to the Social Security and National Insurance Trust (SSNIT) and (ii) all registered cocoa farmers.

The report also recommended pilot “rural-based community-financed schemes” for the non-formal sector but gave no further details or indication as to how the MOH was to do this. The major emphasis of the report was on the NHIS.

The key design features proposed were:

- (i) Inclusion of non-profit and for-profit health facilities in the scheme
- (ii) Reimbursement by capitation

- (iii) Contribution rates equivalent to 5 percent of salary for formal sector employees or a fixed levy per ton of cocoa produced (equal to 7.19 percent of the producer price)
- (iv) Enrollees to register with a single preferred provider

In 1997, the NHIS pilot project was formally launched in the Eastern Region, intended to cover four districts – New Juaben, Suhum/Kraboah/Coaltar, South Birim, and South Kwahu. The objectives were stated in the presidential sessional address of that year: “... the National Health Insurance Scheme will contribute to resolving the cost of health care. This year, a pilot insurance scheme will be implemented in the Eastern Region to test the work done so far. Its performance will be studied, as well as the performance of existing rural health insurance schemes ... so that problems can be identified and eliminated before implementation begins on a national scale.”

In that connection, a NHIS secretariat was set up to undertake the preparatory work and carry out the NHIS program. The preparatory work included:

- ▲ Appointment of a coordinator of the pilot NHIS and opening of a regional office in Koforidua
- ▲ Baseline studies on financial, social, and technical feasibility
- ▲ Cost analysis of utilization pattern and determination of premium for a comprehensive benefits package
- ▲ Accreditation of facilities following an accreditation exercise to choose providers meeting the minimum criteria required
- ▲ Adoption of capitation as a method of payment of health care providers
- ▲ Development of social marketing material
- ▲ Launching of public education program by the Minister of Health
- ▲ Community sensitization in four pilot districts
- ▲ Production of health care providers’ manual

At the same time, the NHIS secretariat began preparation for the nationwide extension of the pilot scheme by producing public educational materials including relevant brochures and pamphlets.

Soon after, the implementation of the pilot scheme stalled amid debates about the strategic direction of health financing policy generally and the pilot scheme in particular. There was no consensus among the technocrats in the MOH about a government-run insurance scheme, and it seemed ultimately that it was only a small minority in the MOH that favored such a strategy.



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### 3.2.2 Major Achievements

The main achievements of the pilot scheme as mentioned by the coordinator were that it:

- ▲ Increased community awareness about alternative health care financing mechanisms in the project area and elsewhere in the country
- ▲ Provided a basis for appreciation and tapping of native wisdom and creativity in the search for sustainable health care financing mechanisms
- ▲ Assisted the development of policy that reflects the needs and aspirations of communities

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### 3.2.3 Constraints and Challenges

Like all pilots, the NHIS encountered certain constraints and challenges:

- ▲ Lack of a clear definition of the role of the MOH in the whole process. Is the Ministry to be an implementer, a facilitator, or a promoter?
- ▲ Centralized administration and inappropriate management structures at lower levels
- ▲ Difficulty in determining appropriate design to address the large informal sector
- ▲ Inadequate mechanisms for community involvement and ownership to ensure sustainability
- ▲ Vertical implementation of certain components of the scheme, such as community education

Following from these, the MOH in 1999 re-examined the scheme and agreed that the Ministry's role in health insurance should be that of a promoter and facilitator and not an implementer. The Ministry would therefore continue to encourage creativity and innovation in this field throughout the country, in a new policy known officially as a "multi-scheme approach." The Ministry was also to provide a suitable policy framework, enabling environment, and encouragement for local, private sector, NGO, and community initiatives for the process. This would best be achieved by developing a national framework based on the collation of different individual experiences.

Additionally, the MOH and other government agencies were to:

- ▲ Provide technical support to emerging schemes and mobilize resources to support the evolution of the process. Essentially, communities were to be allowed to lead the process.
- ▲ Closely monitor and encourage networking among providers and schemes to identify, distill, and promote best practices
- ▲ Conduct applied and operational research
- ▲ Sustain education and advocacy on the key principles and benefits of the schemes

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### 3.3 The User Fee Exemptions Scheme

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#### 3.3.1 Background and Reasons for Scheme

The Hospital Fees Regulation, 1963 Legislative Instrument (L.I. 1277) was revoked and replaced in 1985 by the Hospital Fee Regulation, 1985 (L.I. 1313), mandating that fees be charged for consultation, laboratory, and other diagnostic procedures, medical, surgical and dental services, medical examinations, and hospital accommodation. L.I. 1313 also provides for exemptions in two categories, full and partial, including those in Table 3.1.

**Table 3.1 Full and Partial Exemptions**

<b>Full exemption</b>	<b>Partial exemption</b>
Leprosy and tuberculosis	Services to health personnel
Immunization against any disease	Antenatal and postnatal services
Cold storage of dead body at request of any State department/agency	Treatment at child welfare clinics
	Meningitis, chicken pox, yaws, etc.*

\* See Annex B for details.

The L.I. 1313 has not been revised, but over the past four years, the government has expanded the base for the exemptions to include pregnant mothers, the aged above 70 years, and children under five. The following diseases/conditions have also been added: Buruli ulcer, rabies, and snakebites.

A number of reasons can be assigned for the introduction of an exemption scheme in the country. Data gathered even *after* the exemptions scheme was re-introduced and expanded as directed in the President's sessional address to Parliament in 1997 show that a need clearly exists to provide funding for the poorest and most vulnerable people in the society.

For instance, data from the fourth round of the Ghana Living Standards Survey (GLSS) which presents information covering the period from April 1998 to March 1999 shows that older people and young children are most vulnerable to illness or injury. However, only 39 percent of children age five years and under had received, for example, postnatal care (though this phenomenon is not unique to Ghana, as it is difficult convince mothers to bring seemingly health children in for check-ups). The Ghana Demographic and Health Survey (GDHS), 1998, also shows that at least 16 percent of pregnant mothers had never visited an antenatal clinic or had been there only once. These are all contributing factors to the high rate of infant and child mortality in the country, which, according to the GDHS, 1998, stands at 57 and 108 per 1,000 live births respectively. The Core Welfare Indicators Questionnaire, which also estimates the poverty levels in the country, reveals that about 27 percent of Ghanaians live in extreme poverty, especially in the rural areas. A strict adherence to a cost-recovery regime would further prevent many more people from accessing health care and worsen the unacceptably high health indicators.

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### 3.3.2 Target Groups and Coverage

As has been indicated earlier, the exemption scheme is nationwide and intended to cover all the groups mentioned earlier. In addition, paupers, the elderly, and orphans are also to benefit from the scheme.<sup>4</sup> Giving an overview of the performance of the health sector during the 1997 fiscal year in the 1998 budget statement, the Minister of Finance said “the implementation of Government policy to exempt pregnant women, the aged, and patients with snakebites from payment of hospital fees was started.” In the 2000 budget statement, the Minister of Finance again indicated “Government has allocated ₵10 billion in the MOH budget to continue with the implementation of the policy of free medical attention for pregnant women, the aged, infants, and others suffering from specified ailments.” The focus of the exemption policy since 1997 has been on pregnant women, the aged, children under five years, paupers, and a few specified illness/ailments (Table 3.2)

**Table 3.2 The Exemption Scheme: Beneficiary Groups and Services**

<b>Groups</b>	<b>Exempted services</b>
Pregnant women or antenatal services	Consultation, basic lab services (see Annex B), essential haematanics, vitamins and antimalarials. NB: Delivery not exempted, antenatal visits limited to four
Children under 5 years	Immunizations, services at Child Welfare Clinics, outpatient and inpatient services
The aged (above 70 years)	Consultation, basic lab services, drugs for acute illnesses in both outpatient and inpatient situations. NB: Routine check-ups and drugs for chronic illnesses not exempted
Paupers	All services
All the population	Snakebite, rabies, Buruli ulcer, HIV/AIDS, treatment and management of epidemic illnesses during epidemics only

Source: Ghana Health Service, 2001.

Legislative Instrument 1313 of 1985, which re-introduced user charges at public health institutions,<sup>5</sup> made provisions for persons suffering from certain communicable diseases to be exempted. The scheme was designed so that patients would pay at two points: outside the consulting room where consultation fees and the cost of laboratory and other investigations would be paid; and at the dispensary where patients would pay for drugs. It was envisaged that the doctor, after settling the patient down and taking the history, would inform the patient what condition he most probably had; what investigations, if any, had to be carried out; and their cost plus any drugs that he would eventually have to buy. At this stage, the patient’s ability to pay for the services would be assessed and appropriate decisions made with the patient. Thus it is at this point that a patient requiring exemption would be identified.<sup>6</sup>

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<sup>4</sup> There did not appear to be a clear definition of “paupers” – the cause of much operational mischief later – but “elderly,” as noted above, was supposed to refer to those over 70 years.

<sup>5</sup> User fees were first introduced at public health facilities in 1969.

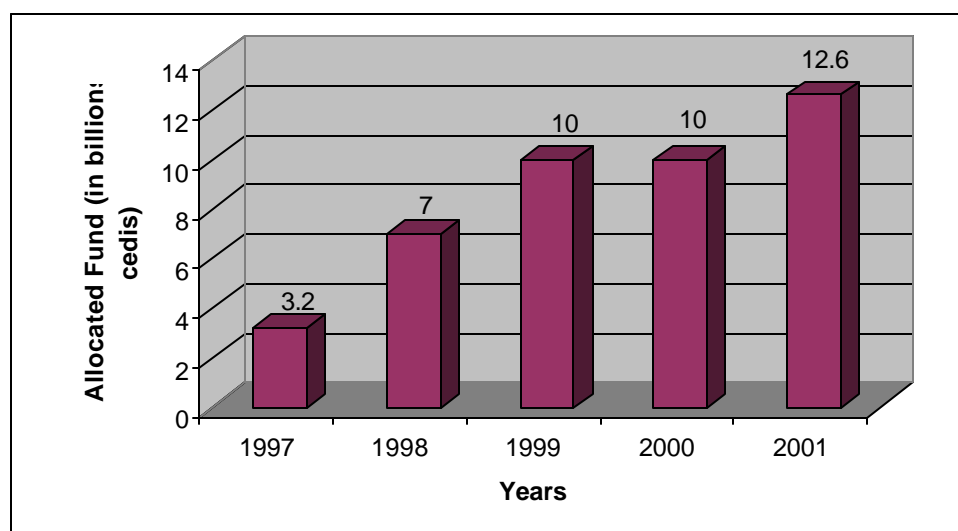
<sup>6</sup> The criteria for this identification were not specified.

In practice however, the system never worked this way. It appears that under the changes that came about with user charges (the so-called “cash and carry” system), the incentive was *not* to exempt if possible, and patients are asked to pay a “consultation fee” upon registering.

### 3.3.3 How Exemptions Are Financed

The funds for the exemption policy are usually allocated to the Ministry of Health in its Annual Estimates (Figure 3.1). In 1997, the total funds provided for exemption were ₵3.2 billion. This more than doubled to ₵7.0 billion in 1998. In 1999 and 2000, the allocation was ₵10 billion each year. The 2001 allocation is ₵12.6 billion (almost four times the 1997 provision).

**Figure 3.1 Funds Allocated for Exemption Scheme 1997–2001**



The funds generated from patient charges under the MOH’s “cash and carry,” system are shown in Table 3.3. The precise utilization of these internally generated MOH funds is not clear.

**Table 3.3 Internally Generated Funds, MOH 1997–2000**

Facility Levels	Internally Generated Funds (Hospital Fees) in Million Cedis			
	1997	1998	1999	2000*
Teaching/Psychiatry	7.49	10,305.72	12,967.58	14,345.06
Regional hospitals	0.49	6,401.92	8,557.82	8,986.36
District hospitals	7.22	11,502.21	17,028.95	18,527.03
Polyclinics/H. centers	8.70	7,962.04	12,441.11	7,467.03
<b>Total</b>	<b>23.91</b>	<b>36,171.89</b>	<b>50,995.46</b>	<b>49,325.48</b>

Source: MOH Finance Section  
\* January–September 2000 only

Allocation of funds for the exemption scheme for the aged and children under five is made according to the population of persons in each of those categories in each region, while that for antenatal is based on the number of women in fertile age (15–49 years) in the region. The allocation for paupers is derived from a percentage based on the incidence of poverty of the regions (Table 3.4). Before the allocations are made, 10 percent of the total exemption fund is set aside and distributed among the four poorest regions.

**Table 3.4 Poverty Incidence (P<sub>o</sub>) by Region, 1998/99 (Poverty line=¢900,000 cedis per annum)**

Greater Accra	5%
Western	27%
Ashanti	28%
Brong Ahafo	36%
Volta	38%
Eastern	44%
Central	48%
Northern	69%
Upper West	84%
Upper East	88%

Information on the actual number of beneficiaries in each of the exempt categories was not available, with the exception of the under fives category for 1999 (see Table 3.5). In the absence of the actual coverage figures over the years, it is impossible to discern whether the amounts being invested each year are yielding greater social benefit or that the number of beneficiaries is about constant while the cost of providing services is increasing over time.

**Table 3.5 Free Medical Services (antenatal, under fives and elderly), Actual Funds Disbursed to Regions for Exemption Policy, 1997–2000, Expressed in Real Terms (million cedis)**

Region	1997	1998	1999	2000*	Total to date
Gt. Accra	406.80	571.26	999.51	353.35	2,330.92
Central	242.30	353.14	628.14	209.87	1,433.45
Western	331.80	540.00	992.77	288.05	2,152.61
Eastern	426.50	607.19	1,069.22	369.82	2,472.73
Volta	234.00	362.67	657.65	202.40	1,456.73
Ashanti	674.50	842.15	1,421.57	585.75	3,523.97
Brong Ahafo	236.70	396.93	735.55	205.08	1,574.27
Northern	186.40	486.31	983.76	161.19	1,817.66
Upper East	180.80	331.48	628.08	156.67	1,297.02
Upper West	80.20	171.41	370.33	69.41	691.35
Total	3,000.00	4,662.53	8,486.59	2,601.58	18,750.70

Source: MOH Finance Section

\* January–May 2000 only

The data on exemptions disbursements to the regions from Table 3.5 give an overall average *real rate* of increase of 169 percent between 1997 and 1999 (the years for which complete data are available). Though it is tempting, and in one sense right, to conclude that the cost of the exemptions has been rising very fast during this period, such a conclusion must be tempered by the knowledge<sup>7</sup> that exemption funds have been running out frequently in several regions before the next allocation is due (Table 3.6). This implies that the demand for exemptions exceeds the supply of funds from the MOH. It is therefore likely that a large part of the recorded annual increases noted are related simply to catching up with the demand, occasioned partly by increasing public awareness of the exemptions scheme.

**Table 3.6 Budgetary Allocations and Actual Utilization on Antenatal, Under Five and Elderly 1997–2000 Expressed in Real Terms (million cedis)**

	1997	1998	1999	2000
Budgetary provision	3,200.00	5,901.00	8,620.00	9,756.00
Actual disbursement	3,000.00	4,662.57	8,486.63	2,601.60*

Source of inflation figures: Ghana Statistical Service, Statistical Newsletter No. B6/2001

Note: The 1997 figures are held constant while those for the other years are adjusted for inflation over the period.

Inflation figures: 1998=15.7%, 1999=13.8%, May 2000=18.7% (Inflation over 12 months)

\* Utilization is January–May 2000 only

It is observed that the yearly utilizations are a little bit lower than the budgetary allocations for the years to which they relate. Chief Accountant Mr. Alex Nartey explained that the balances might have been used to pay for the other free services, such as snakebites, Buruli ulcers, and rabies. Therefore it is important not to interpret the differences between provision and utilization as surpluses or unused funds remaining at the end of year.

An analysis of the figures shows that the three northern sector regions (Northern, Upper East, and Upper West) each recorded an increase of more than 100 percent in their allocations for the exemption policy between 1997 and 1998 (Table 3.7). While these regions again recorded higher allocations than the other regions between 1998 and 1999, it was only the Upper West that had an increase of more than 100 percent. The Ashanti Region recorded the lowest growth of allocated funds between the years. However, in terms of absolute figures, the Ashanti Region has consistently had the highest figures over the period. This may be understandable considering that it is the region with the highest population in the country.

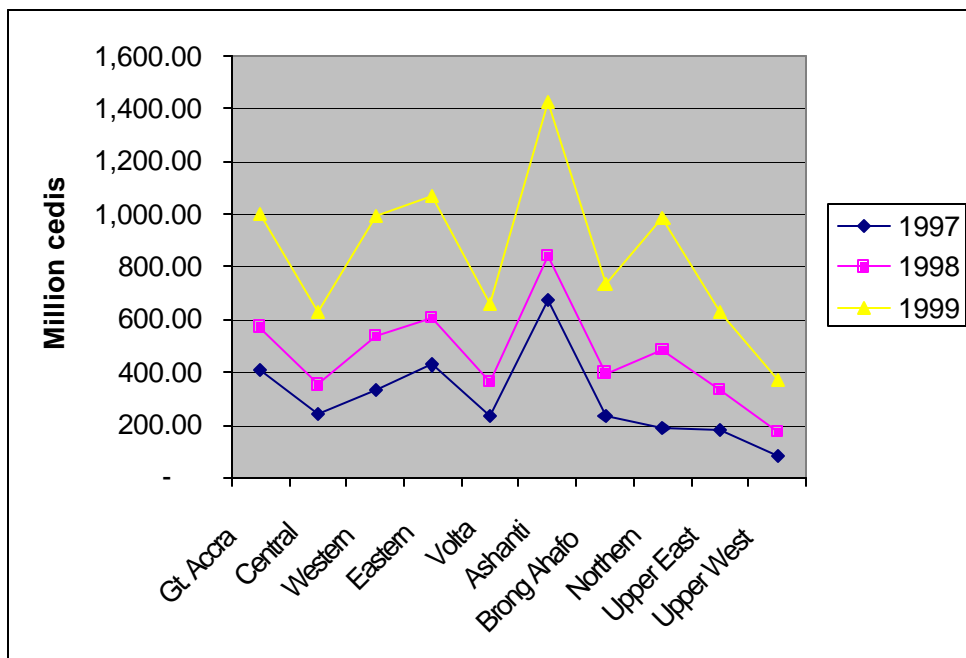
**Table 3.7 Percent Increases Between Yearly Allocations of Exemption Funds**

Region	1997–1998	1998–1999
Greater Accra	66.6	71.1
Central	72.9	74.0
Western	93.1	79.8
Eastern	68.9	72.2
Volta	83.9	77.3
Ashanti	48.1	65.1
Brong Ahafo	98.9	81.2
Northern	209.5	97.8
Upper East	117.5	85.3
Upper West	153.5	111.3

<sup>7</sup> Information from interviews with regional health directors, backed by anecdotal evidence from some health institutions.

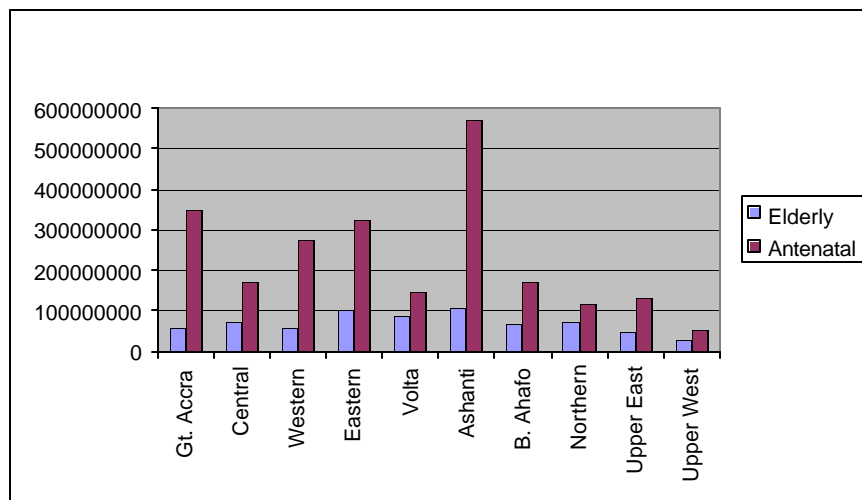
Figure 3.2 shows the yearly allocations between 1997 and 1999 in graph form.

**Figure 3.2 Yearly Exemptions Fund Allocations in Real Terms**

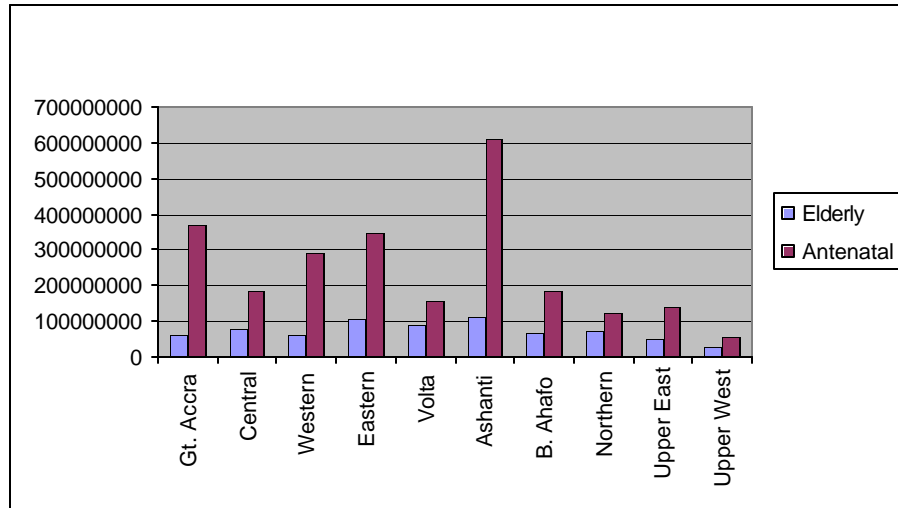


A comparison of Figures 3.3 and 3.4 shows that the proportionate distribution of the funds is the same for 1997 and for the first half of 2000. This is so because the formula for the allocation of the funds has not changed between the periods. For most of the regions, the allocation for the elderly is almost half of what was allocated for antenatal and under five care. In Ashanti, Eastern, Greater Accra, and Western Regions, however, the figures for antenatal care are far more than double that for the elderly.

**Figure 3.3 Exemptions Fund Disbursement 1997**



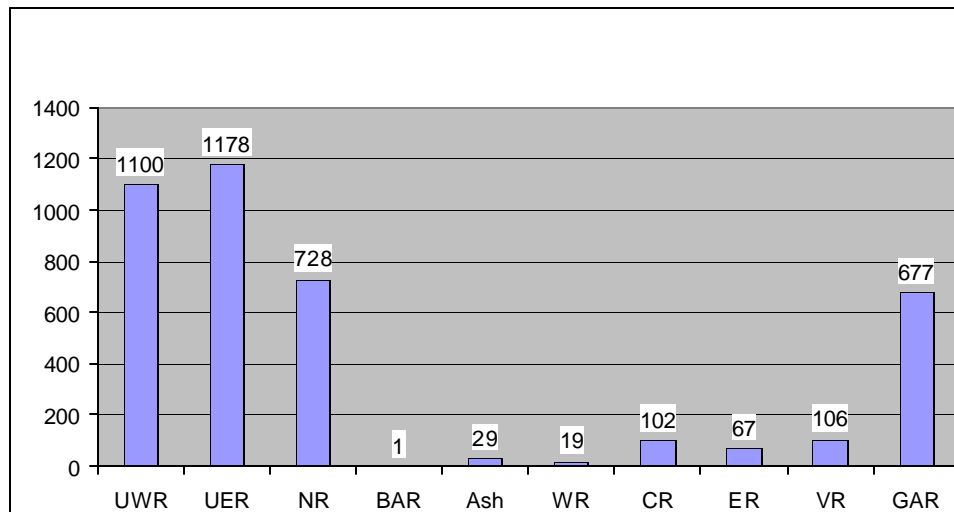
**Figure 3.4 Exemptions Fund Disbursement Jan–May 2000**



### 3.3.4 Exemption of Children Under Five

The 1999 Annual/Mid-Term Review Reports for all 10 regions in Ghana reflect some of the implementational difficulties of the exemptions scheme. The exemptions for under fives were considerably higher in the three northern regions, followed by the Greater Accra Region, but extremely low (in comparison) in Brong Ahafo, Western, Ashanti, Eastern, Central and Volta Regions (in that order, Brong Ahafo being the lowest) (Figure 3.5 and Table 3.8).

**Figure 3.5 Subdistrict Exemption per Child Under Five (in cedis)**



Source: 1999 Annual/Mid-Term Review Reports for Upper West, Upper East, Northern, Brong Ahafo, Ashanti, Western, Central, Eastern, Volta and Greater Accra Regions. Drafts reports from April 2000.

= Total amount of exemptions for children under five during 1999 / number of children under five years of age living in the region



**Table 3.8 Regional Distribution of Exemptions and Average Cost of Exemptions**

Region / Level	Exemptions for under fives (cedis)	% of total exemptions	Number of under fives exempted	Average cost of exemption	Population
Western- regional hospital	0	0 (104,348,070)	0		
*Western- subdistricts	6,650,306	46 % (14,523,290)	3,288	2,023	1,863,165
G.A.R.- regional hospital	0	0 (22,418,000)	0		
G.A.R.- district hospitals	210,533,730	54% (389,790,952)	34,486	6,105	
*G.A.R.- subdistricts	315,414,210	31% (1,013,139,000)	65,080	4,847	2,451,000
Central- hospitals	26,756,750	12% (231,663,000)	3,561	7,714	7,714
Central- district/subdistrict	31,890,250	14% (232,733,000)	10,295	3,098	1,640,135
Volta- old regional hospital	0	0 (20,873,100)	0		
Volta- district hospitals	12,061,440	3% (416,800,775)	17,713	681 ?	
*Volta- subdistricts	33,078,651	6% (533,460,097)	82,448	401 ?	1,639,686
UWR- regional hospital	8,572,900	8% (101,314,214)	1,314	6,524	
UWR- district hospitals	85,572,100	5% (169,405,986)	14,024	6,102	
*UWR- subdistricts	145,351,175	60% (243,392,877)	67,524	2,153	694,989
Ashanti- district hospitals	17,800,000	10% (171,044,000)	3,093	5,754	3,272,293
Eastern- regional hospital	6,671,000	17% (39,974,000)	123	54,235	
Eastern- district hospitals	40,100,000	11% (344,400,000)	12,413	3,230	
*Eastern- subdistricts	45,800,000	12% (390,900,000)	33,859	1,353	3,600,884
Brong Ahafo- regional hospital	0	0 (7,793,153)	0		
Brong Ahafo- district hospitals	0	0 (275,065,455)	0		
*Brong Ahafo- subdistricts	237,870	0.1% (180,000,000)	423	562	1,907,419
Northern- regional hospital	0	0 (57,966,572)	0		
Northern- district hospitals	313,880,676	69% (452,070,828)	38,995	8,049	
*Northern- subdistricts	288,913,045	48% (602,704,192)	82,485	3,503	2,097,348
Upper East- regional hospital	121,901,828	(194,761,709)	15,877		
Upper East- district hospitals	160,524,093	(336,419,203)	29,055		
Upper East- subdistricts	270,407,612	86% (315,365,799)	98,524	2,745	1,208,006

### 3.3.5 Current Status

The exemption policy is in operation throughout the country but there is no universality in the interpretations of the guidelines for the exemption policy. The implementation of the policy with respect to under fives, pregnant women, and the elderly appears from the start to have been dogged by various difficulties:

- ▲ Unclear or non-existent guidelines on how to implement the policy, including reimbursement procedures
- ▲ Uneven implementation leading to considerable variation within districts and between regions in the impact of the exemptions to target groups and health facilities

- ▲ Inadequate supervision and monitoring to ensure implementation of the policy
- ▲ Institutions claiming different amounts for similar services leading to differential average cost of the exemption to the MOH
- ▲ Frequent complaints that the budgetary allocation for exemptions is inadequate
- ▲ Lack of adequate information to the public about the exemptions scheme

For example, while the guidelines state that pregnant women should be given free consultation and basic laboratory tests, providers in some regions interpreted this to mean the provision of outpatient department (OPD) cards, routine drugs, and consultation. In other regions this was interpreted and limited to free consultation and few tests.

An interesting case of the use of discretion in the interpretation of the guidelines relates to the exemption for people above 70 years. In the Upper West region, it was realized that because of the extreme poverty and the very small numbers of people living up to that age category in the region, the regional health administration decided to reduce the threshold to 60 years in order to benefit more elderly people.

In a study conducted by the Ministry of Health, it was found that the guidelines were not readily available at some facilities while in other cases, all health providers were not conversant with the contents of these guidelines.<sup>8</sup>

In a situation where a policy document – in this case, the exemption policy – is not put in the public domain and the contents widely disseminated to both service providers and beneficiaries, there is bound to be misinterpretation and/or misapplication.

The exemption policy is structured on a “service before payment” process. This means that the health facilities are to provide service to any person who falls in the exempt category and submit claims for reimbursement to the appropriate authorities. The MOH study found that this arrangement was rather cumbersome and affected the supplies position of some facilities as they normally run out of stock due to delays in the receipt of reimbursable funds to replenish stocks. The main reason assigned to the problem of reimbursement was administrative bureaucracy.

The involvement of the private health sector in the implementation of the exemption scheme is very limited. Certainly the for-profit sector is not involved at all, and even the non-profit (mission) facilities appear to have a more limited involvement than the public facilities.<sup>9</sup>

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<sup>8</sup> Provisional results from research conducted by MOH around 1999 on the working of the exemptions scheme and financed by DANIDA (Ministry of Health, 2000).

<sup>9</sup> Like most other aspects of the exemptions scheme, there is an unevenness of mission facilities involvement by region. In the northern regions for instance, mission facilities appear not to have been excluded. On the other hand, in Brong Ahafo, the mission facilities were, at least initially, largely excluded from the scheme. In other words, the facilities could not recover exemptions money from the MOH for exempted patients reporting there; therefore they did not offer exemptions. But this is a changing picture with the increasing exemptions funds available and greater awareness.

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### 3.3.6 Abuses and Constraints

The exemption scheme had its own internal problems and some people exploited these to their advantage. One of the thorny issues had to do with determining the ages of beneficiaries, i.e., those over 70 years and children under five years. In a society where basic data on ages and births of people are not properly documented, it is difficult to validate the age of an individual.

Health providers and hospital authorities found themselves in a fix when a person clearly below the exempt age for the elderly comes to the facility and claims to be above the exempt age. Similarly, mothers brought over-age children, claiming that they were under the exempt age. Although statistics show that there are not many people in the age group of 60 years and over in the Upper West Region, there was a sudden rise in the number of 60+ year olds reporting at the hospital when the threshold was reduced in the region.

Another area of abuse of the system had to do with the proper definition of who a pauper is and how to identify one. People who could have paid for services sometimes presented themselves as paupers with the view of benefiting from the scheme. Some potential beneficiaries of the scheme were made to pay for services when indeed they should have been exempt. This was due partly to the wrong interpretation that health providers gave the guidelines and, in other instances, apparently willful disregard for the guidelines as a result of excessive delays in receiving the Government reimbursements for exempted persons.

As a case in point, it was reported in the Wednesday June 27, 2001, edition of the *Ghanaian Times* that the Dansoman Health Centre in Accra had put up a notice asking patients “including children under five years, pregnant women and the aged above 70 years, who qualify for exemptions to pay for those services.” The centre explained that this was due to its financial situation brought on by delays in receiving the reimbursements. It was also reported that the Deputy Minister of Health, who happened to be at the health centre on a familiarization visit, tore off the notice on grounds that it was contrary to government policy.

Yet there is evidence that this was no isolated incident. The practice of health facilities refusing to abide by the exemptions policy is apparently rampant. A more recent example is shown by a notice that one of the contributors to this report stumbled upon in August 2001 at the Osu Maternity Home, which is under the Osu Clotey Sub Metro Assembly. The notice was signed by Martha Mensah, Medical Assistant, and read: “I wish to inform you that with effect from today 16 March 2001 all the pregnant women who attend ANC should pay for all the medication and necessary services rendered to them except the consultation fee. These orders are from the Accra Metropolitan District Director of Health Services.”

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### 3.3.7 Recommendations: Dealing with Abuses

Some of the measures adopted to check abuses of the scheme include the following:

- ▲ Use of local community members who are familiar with local residents to identify those who are known to be real paupers
- ▲ Threat of publishing names of those who present themselves as paupers in the national papers. The fake ones objected to their names being published and withdrew their claim

- ▲ Use of “road to health chart” to determine age of children under five

Other possible recommendations flowing from the text and data presented, are:

- ▲ Monitoring the costs of exemptions by region, facility type, eligible group, and service
- ▲ Providing the public with more information about their eligibility for exemptions
- ▲ Studying and quantifying the rate of abuses with a focus on what could be done to reduce it
- ▲ Analyzing the method of reimbursing for exemptions for the incentives it creates
- ▲ Auditing the granting of exemptions

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### 3.4 The Civil Servants Health Care Scheme

All civil servants are currently entitled to free medical care for themselves, their spouses, and up to four children through the Civil Servants Health Care Scheme. The scheme covers virtually all services.

For the past four years, the Ministry of Finance has allocated ₵3.5 billion each year under the General Government Services vote to cater for the health care needs of civil servants. According to the Integrated Payroll and Personnel Database, as of the end of June 2000, there were a total of 76,703 civil servants. In per capita terms, each person is allocated ₵45,630 *per annum*.

The allocation of the Civil Servants Health Care funds to the regions is computed according to the proportion of civil servants in each region. The total amount is released annually to the Ministry of Health, which in turn allocates it among the various Regional Health Administrations (RHAs). Table 3.9 shows how the funds are distributed by region.

**Table 3.9 Civil Servants Health Care Funds Allocation**

Region	Allocation of Funds
Greater Accra	30%
Eastern	10%
Volta	7%
Central	7%
Western	9%
Ashanti	14%
Brong Ahafo	7%
Northern	7%
Upper East	5%
Upper West	4%
Total	100%

Any official of a ministry, department or agency (MDA) other than subvented organizations can seek medical attention at any Government health facility and present receipts for the payment of the services received for reimbursement. The receipts are usually presented for compilation to an officer of the MDA to which the patient belongs. They are then forwarded to the offices of the Civil Servants

Association (CSA) for transmission to the RHA. A medical officer at the RHA then vets the submitted receipts for authenticity and reasonableness in terms of the claims. After the medical officer is satisfied with the genuineness of the claims, a voucher is raised and when approved, cheques are prepared for payment. These are sent back to the offices of the CSA for disbursement to those who submitted claims. As at now, there is no ceiling on the total claim one can make in a year.

There are also instances where special emergency cases can be dealt with on their own merit. Where an emergency case arises, the affected official makes an application to the Ministry of Health through the MDA for which he/she works. The application is reviewed and forwarded to the Castle, which is the seat of Government, for approval. Following the approval, the applicant is then provided with the service for which the application was made without having to go through the CSA.

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### **3.4.1 Current Status/Constraints**

The scheme is still in operation, but the civil servants do not seem to be happy with its performance. In some cases, a submitted claim can take as long as six months to a year before reimbursement. Another complaint is that one may not be given the full amount of the claim submitted.

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### **3.4.2 Abuses**

Different types of abuses have occurred. Some employees, who previously did not have dependants, suddenly came up with a list of people they claim to be their spouses and children. Some employees, in collusion with some health service providers, submit fraudulent claims – there is no record of them having been seen at a health facility.

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### **3.4.3 New Directions for Civil Servants Medical Care**

In some regions, the CSA and the RHAs are now converting the Civil Servants Health Care Schemes into health insurance-based systems, using both dues deducted from the pay of civil servants and the health care subsidies allocated from the Government as funding sources. Two regions, Ashanti and Upper West, are pioneering this conversion process.

#### **The Ashanti Region Civil Servants Medical Care Scheme**

The Ashanti Region Civil Servants Association in conjunction with the Ministry of Health has established a mutual health insurance scheme for civil servants and pensioners in the region. The scheme will cover 13,000 civil servants. The idea was mooted about a year ago when it was realized that there were problems with the government arrangement of paying for medical services, since in some cases, people collected prescriptions and submitted them for claims that were not genuine.

With the establishment of the scheme, all civil servants and pensioners in the region are expected to contribute ₵5,000 a month to be deducted at source as from July 1, 2001. This will yield an amount of ₵80 million a year in addition to the ₵89.9 million provided to the region from the Government's free medical service scheme to start off the scheme.

The scheme is expected to benefit the civil servant, spouse, and up to three children under 18 years. DANIDA is supporting the association in setting up a Secretariat and doing the preparatory

work to get the scheme started. As part of the preparatory activities, regional and district boards for the insurance scheme have been set up while executive councils have also been put in place for the take off of the scheme. A seven-member regional executive committee, chaired by Dr Joseph Oduro, Offinso District director of health services, was elected at a meeting of the management committee of the association to manage the scheme. There is also a constitution to regulate the affairs of the scheme while identity cards are being issued to members to prevent impersonation.

With the financial support of the DANIDA health sector support office, a one-week workshop was planned for all executive members of the scheme and other organizations forming similar schemes.<sup>10</sup>

### **Civil Servants Health Care Scheme in the Upper West Region**

As mentioned earlier, all civil servants are currently entitled to free medical care for themselves, their spouses, and up to four children. This facility is available for virtually all services. Over the past four years, the Ministry of Finance has allocated ₵3.5 billion each year under the General Government Services vote to cater for the health care needs of civil servants, and this amount is distributed proportionally to each region. In the Upper West region, there is an agreement between the Ministry of Health and the Civil Servants Association for the MOH to manage the fund.

Mr. G.W Tuu of the CSA in Wa, Upper West Region, intimated that there are between 2,500 and 3,000 civil servants in the region. According to him, when they realized that the salaries of their members was not enough for them to pay for medical services upfront and submit claims for reimbursement, they decided to lodge the amount with the RHA and operate it as an insurance scheme.

The beneficiary is the civil servant and his/her spouse and up to three children below the age of 18 years.

Any member or dependant who is to attend hospital is given four forms to complete. One form is submitted to the facility where service is required, one is sent to the RHA, one to the CSA Office, while the member keeps the last one. Members get free service for virtually any complaint, without having to pay anything. Where the facility visited cannot offer the service required, a referral note is issued to the member, who goes to the next level of health care where such services are available.

When the person receives treatment, the bill is passed to the MOH (RHA) for settlement. There is no ceiling with regard to how much a member can use in a year.

The major problem facing the scheme is the inconsistent flow of cash into the fund, as in the case of this year, resulting in the delayed payment by the CSA to the various health institutions that provide services to the members. The regional medical officer for Upper West Region indicated in June 2001 that the CSA owes the MOH more than ₵100 million in unsettled medical bills resulting from the association's insurance scheme. He said this is affecting stock levels in the health care facilities since they do not have enough resources to restock supplies.

Other major problems of the scheme include fraud and abuses, and the associated difficulties in checking these practices.

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<sup>10</sup> Source: GNA and Daily Graphic June 18, 2001.

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### 3.5 Other Subvented Organizations/Public Service Organizations

Subvented organizations are those that are not mainline ministries but nonetheless are government organizations. They are supposed to generate some revenue to supplement what government provides to be able to run their organizations. Examples are the National Population Council Secretariat, Ghana Statistical Service, Ghana Institute of Management and Public Administration, State Enterprises Commission, National Development Planning Commission, Commission on Human Rights and Administrative Justice, etc.

For those organizations that do not fall strictly under the Civil Service Association's plan, they have their own internal organizational arrangements for their staff's health care financing. Most organizations have, as part of their conditions of service, free medical attention for staff, spouse, and a specified number of children (normally four) who are below a certain age, usually 18 years. The organization arranges for staff and their dependants to attend a hospital/clinic designated by it to receive treatment for their ailments. The hospital/clinic then submits a claim at the end of the agreed period (monthly or quarterly as the case may be) to the organization for settlement.

For a number of these organizations, a maximum ceiling is set beyond which the organization cannot provide free medical care. Any submission by the hospital/clinic in respect of any employee above this ceiling would have to be paid for by the employee concerned.

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### 3.6 Conclusions: Limitations of Public Sector Insurance Schemes

The public sector insurance schemes discussed above all tend to have the following limitations:

- ▲ They do not use deductibles to limit abuses
- ▲ They do not appear to have defined benefits packages
- ▲ They work mainly with public health facilities

By setting ceilings on the cover per member, they tend to eliminate catastrophic coverage, i.e., cover for the most serious illnesses, which have the potential to impoverish the average family when they occur.





## 4. Private Sector Initiatives: Private Companies Providing Health Insurance Cover on a Profit or Non-profit Basis

### 4.1 Introduction: Health Care Coverage for Private Sector Workers

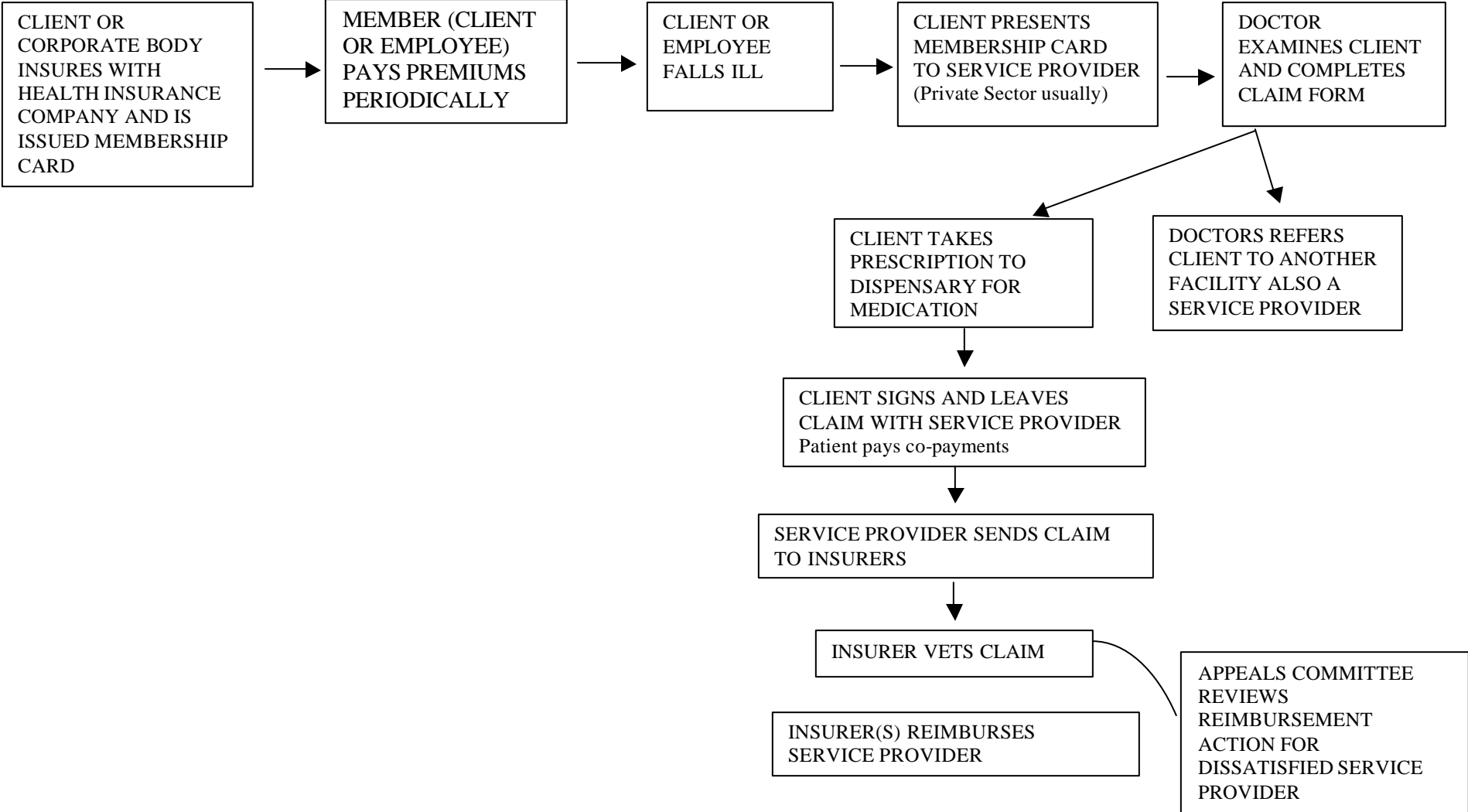
There is no known legislation covering health care for the private sector (e.g., some factory workers) in the country. The Department of Factories Inspectorate, Act – Factories, Offices & Shops Act, 1970, only enjoins factories and businesses to provide first aid boxes with the prescribed first aid items on their premises, which is inspected by the officers of the Department of Factories Inspectorate on their routine inspection (personal communication, Mr John Richter, Principal Inspector of Factories). Furthermore, the “Notice of Occupation of Factory” form completed by all factories operating in the Ghana, only requests information on the nearest clinic/hospital for cases of emergency (under sections 2 & 3 of the Factories, Offices & Shops Act, 1970).

However, for the majority of unionized workers in the private sector, there are collective bargaining agreements between employers and unions that enable the workers concerned to benefit from varying but usually generous health care cover. Management works out arrangements, in most cases, with private clinics to offer basic health services for their employees and their dependents. Some employers have also chosen to buy into private health insurance companies such as MetCare, described later in this report.

Anecdotal evidence suggests that some factory workers abuse this health privilege to the detriment of the instituted health care scheme. Thus, the majority of employers are reconsidering such gestures and are adopting various approaches, such as reimbursement of only genuine out-of-pocket health expenditures, and ceilings for refunds. This is also another reason that some employers are attracted by the packaged benefits and policies of the private insurance companies, such as those described below.

Figure 4.1 depicts how private health insurance works.

Figure 4.1 Schematic Diagram of How the Private Health Insurance Schemes Work



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## 4.2 Nationwide Mutual Medical Insurance Scheme

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### 4.2.1 Background/Origins

In 1992, the Society of Private Medical Practitioners, Ghana, requested Vanguard Assurance Company Limited to assist them in the development of a private medical insurance scheme. This led to the formation of the Nationwide Mutual Medical Insurance (NMMI) scheme in October 1993, when it commenced the business of writing medical expense insurance. This private scheme was the first of its kind to be established in Ghana.

The NMMI scheme was formed to pool the resources of many, by the collection of premiums, to pay for the medical expenses of subscribers who became ill. The scheme was termed *mutual* because any accrued income surplus would be passed on to subscribers through discounts and rebates on premiums and through improved health care facilities. The scheme's policyholders were largely corporate entities that purchased medical expense insurance to cover employees and dependants; hence, it was mainly a private scheme.<sup>11</sup> It operated over a five-year period and reached a subscriber base of 20,000 within this time.

In 1997, the scheme ran into technical solvency problems with the National Insurance Commission and its insurance license was suspended in May 1998.

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### 4.2.2 The NMMI Benefit Package

The scheme was basically a managed indemnity plan where the subscriber was indemnified for medical services provided to them in exchange for a premium. It established a benefit structure based on benefit levels varying from A to F according to the category of medical services. The corporate subscriber paid premiums annually, half yearly, or quarterly in advance. The premiums were calculated based on the benefit level selected. A limit was applied regarding expenditure for each category. The service providers consisted of clinics, hospitals, pharmacies, and laboratories that provided services at discounted rates

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### 4.2.3 Constraints and Abuses

An August 2000 comparative study of health insurance schemes found that the NMMI scheme ran into difficulties as a result of the following:

#### **Inadequate manual processing procedures**

During the five years of operation, the volume of generated claims from service providers rose sharply, to the point where the manual procedures for processing claims was unable to cope with the sheer volume of claims. In the absence of a computerized claims procedure, a backlog of unprocessed claims was generated, and this had a profound negative effect on the efficiency of the entire process.

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<sup>11</sup> Because of its collapse in 1998, and the consequent difficulty of accessing relevant documentation, it has not been possible to ascertain how many corporate entities were involved in the scheme.

### **Dissatisfied clientele**

As a result of delays in claims payments and questionable vetting of claims, the service providers began to under-serve the scheme's subscribers. This meant that the required protocols of care were not entirely adhered to by the service providers and the frustrated subscribers pulled out their support for the scheme.

### **Benefit utilization**

Control of benefit utilization was an important feature of the scheme. As the volume of unprocessed claims rose, the company was unable to compile the benefit utilization of the subscribers and thus subscribers were able to claim well above their benefit limits. The resulting financial strain was detrimental to the success of the scheme. Assumptions made in the premium rating could also not be justified.

### **Fraudulent claims**

Two forms of fraudulent claims were submitted: subscriber fraud and service provider fraud. Substantial subscriber fraud meant that clients tried to claim for reimbursement for drugs supplied outside the scheme's pharmacy network. The service providers also tried to increase their profits by over-servicing patients, i.e., they performed procedures and tests that were uncalled for in order to boost claims.

### **Premium inadequacy**

Inherently, the calculations for appropriate premiums were inaccurate because of the lack of morbidity rates and premium adjustments were not applied. Thus the premiums collected fell short of the administrative processes set up to underpin the scheme.

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#### **4.2.4 Potential for Future Success**

The scheme was suspended in May 1998 and additional capital injection deferred pending a review to ascertain the appropriate infrastructure required to ensure efficient operations. The review was to identify the strengths and weaknesses of the nationwide scheme and to restructure it. The objectives of the review were to:

- ▲ Compile and settle outstanding claims – a three year backlog of approximately 25,000 claims
- ▲ Run off the unexpired contracts
- ▲ Compile benefit utilization of the subscribers to be distributed to clients
- ▲ Propose an appropriate administrative set up while retrieving relevant documentation and files
- ▲ Establish a premium-rating basis for the future of any other medical insurance scheme

Various lessons were learnt from the review. The first was that it is imperative to establish an appropriate administrative infrastructure for a successful health insurance scheme, and, second, the application of a suitable information system is critical due to the extremely high transaction volume.

In this regard, appropriate medical insurance administration software was recommended to perform the following:

- ▲ Record and update data defining a group
- ▲ Record and update relevant subscriber data
- ▲ Register and update service provider information
- ▲ Update the essential services list and essential drug lists
- ▲ Define and update the benefits package and premium calculations
- ▲ Process and pay claims
- ▲ Define, monitor, and update insurance plans
- ▲ Plan and update the procurement and distribution of medical supplies to the service providers
- ▲ Generate relevant management and statistical reports
- ▲ Generate benefit utilization reports

In addition, service provider software was necessary to:

- ▲ Record and update information on both insured and non-insured patients, such as rate of utilization of medical services and type of services used
- ▲ Manage drug and medical consumables data of the service provider
- ▲ Update essential services lists and
- ▲ Record billing and claims

It was also noted that for future success, it is important for goodwill between the health service providers and the scheme holders. Detailed and comprehensive management of the current health care delivery process would reduce and contain cost and improve the standard of health care. Finally, knowledgeable personnel are a prerequisite to drive the scheme forward.

A revised scheme known as the Medisave Medical Scheme has been proposed, though it has not been launched yet. Three benefit levels are proposed for this scheme namely; Essential, Standard and

Premier. The scheme will not provide cover for sexually transmitted diseases, AIDS, alternative and traditional medicine, and self-medication.<sup>12</sup>

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## 4.3 Metropolitan Health Insurance Plan–MetCare

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### 4.3.1 Background/Origins

MetCare was launched in November 1997 and is underwritten by the Metropolitan Insurance Company Limited. It is designed to provide health insurance largely to co-corporate clients and to individuals. In other words, it is a private scheme. The MetCare Insurance plan was based on the Commercial and Industrial Medical Aid Society health insurance scheme that operates in Zimbabwe. It currently has 15,000 registered members on full cover and 25,000 members on partial cover. More than 100 companies in Ghana subscribe to it.

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### 4.3.2 The MetCare Benefit Package

The plan offers four different benefit packages: Classic, Premier, Executive, and Prestige. All packages offer premiums for groups, families, and individuals. The Classic package covers services provided by both government and private health facilities. It offers up to ₵2 million per annum for outpatient care and ₵5 million per annum for admissions for inpatient service. MetCare Premier offers an extensive cover and provides exclusive health care benefits that range from ₵3 million per annum for outpatient care to ₵8 million per annum for admissions for inpatient services. MetCare Executive offers the similar benefits but with priority based on patient comfort and quality care. It offers benefits up to ₵5 million per annum for outpatient care and ₵10 million per admission for inpatient treatment. The MetCare Prestige provides the most comprehensive package with the highest premiums.

There is also MetCare Sankofa package which has virtually unlimited cover and is available to Ghanaians or those living abroad who require cover for their relatives living in Ghana.

MetCare is also prepared to design benefit packages to suit particular circumstances. For example, in 2001 MetCare designed a scheme for educational sector workers, and the scheme has worked collaboratively with the Ministry of Defense to design a package for the Military Hospital staff in Accra. MetCare sees these initiatives as its social responsibility and does not view them as significantly income-generating.

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### 4.3.3 Constraints and Abuses

An August 2000 comparative study of health insurance schemes in Ghana found that collusion between the client and service provider occurs frequently and checks and balances will be necessary to reduce this form of abuse.

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<sup>12</sup> The lack of cover for sexually transmitted diseases and HIV/AIDS must be considered as regrettable from a social viewpoint.

Currently there is an increasing demand for traditional medicine, and, as this shift from conventional treatment progresses, some clients will be lost. This threatens future expansion.

The increasing awareness of the importance of health insurance in Ghana may be an advantage but possible competition from the proposed Government Health Insurance Scheme will be a constraint.

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#### **4.3.4 Potential for Future Success**

MetCare is currently operational but due to the high volume of claims, there is a need to build relevant capacity to cope with the demand.

Furthermore, there is need to expand administrative software, because the present system and software cannot accommodate further large increases in claims and subscriptions.

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### **4.4 Ghana Healthcare Company**

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#### **4.4.1 Background/Origins**

The Ghana Healthcare Company was established by the SSNIT in 1999, initially as a company limited by guarantee and later as a private company limited by shares, to provide an alternative source of funding for affordable health care delivery in Ghana. Currently the Ghana Healthcare Company Board has decided to change the company into a mutual company because the SSNIT, the main shareholder, views the concept of mutuality as being in line with its vision. Furthermore as a mutual company, management would be accountable to a large number of people resulting in increased efficiency, and surpluses would be reinvested in the company for growth over time.

The scheme has been designed with the overall objective of seeking to reduce and control the cost of health care provision through tariff negotiations with service providers, i.e. medical institutions, laboratories, pharmacists, etc. The company hopes to reinvest its surpluses into hospitals and clinics in order to improve technology and update equipment.

The Government of Ghana pledged to support the company at that time by registering the majority of its 180,000 employees, with the company in order to achieve savings on the health care budget for government employees. Ghana Healthcare projections were thus based on large membership lists and low premiums.

Presently, SSNIT is the sole shareholder of the company. The scheme is currently not operational.

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#### **4.4.2 Management Structure**

The highest decision-making body is the Board of Directors and the current proposal is for a nine-member body with the director general of the SSNIT acting as the board chairman.

An executive management team headed by a chief executive officer is in place. There are also positions of chief operations human resources officer/solicitor secretary, and chief finance officer. Currently the last three positions are unfilled.

The main departments are Human Resource and Administration, Operations, Finance, and Management Information Systems.

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#### **4.4.3 The Ghana Health Care Company Benefit Package**

The benefits will be offered directly to individuals or through their employer. Spouse and dependants can also participate in the scheme. Three different packages have been proposed, namely General Care, Premier Care, and Super Care. The General Care package will give access to basic health care facilities at affordable contributions. Service providers will include all Government hospitals, i.e., the health stations: district, regional, and psychiatric hospitals, as well as leprosaria.

The Premier Care package is expected to provide access to some private health facilities in addition to the service providers in the General Care category while the Super Care scheme will also ensure treatment at private health centers countrywide in addition to the benefits offered in the General Care and Premier Care packages. Premiums are to be paid in advance – annually, semi-annually, quarterly, or monthly.

The proposed premiums (pending actuarial review) are ₵20,000 for the General Care Policy, ₵40,000 for the Premier Care Policy, and ₵80,000 for the Super Care Policy.

Other products are currently being developed for fishermen, cocoa farmers, and other identifiable groups in the informal sector.

The Ghana Healthcare Company has carried out extensive surveys in Ghana of government, mission and private health facilities. This has provided information on the number of facilities available, types of medical specialities, utilization rates, consultation fees, etc.

Furthermore, accreditation criteria have been designed based on the MOH's criteria for a National Health Insurance Scheme. Thus, geographical spread has been considered with the aim of providing for those in deprived areas. Discussions are taking place in such areas to advise on the availability of basic facilities prior to accreditation of the scheme.

To date, approximately 200 private hospitals and clinics have been inspected and about 130 accredited. Accreditation criteria for pharmacies and other service provider facilities are being developed.

A comprehensive list of medical, surgical, and dental procedures are also ready and have been derived from the CPT (Current Procedural Terminology) international codes to enable the comparison of prices internationally and locally for consultation fees, pharmaceutical costs, and procedures. A comprehensive drug list has also been prepared, informed by the MOH Essential Drug List and other pharmaceuticals used countrywide.



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#### 4.4.4 Constraints and Abuses

The 2000 comparative study of health insurance schemes suggests that there are significant issues that must be resolved prior to the launching of the Ghana Healthcare Company. These are:

##### **Funding of initial capital**

In-depth feasibility studies indicate that the company would require an initial capital of approximately US\$5.7 million to make the scheme operational. The SSNIT has invested in the company and has provided approximately US\$2.6 million, leaving a significant shortfall. Thus, funding is a problem that will have to be tackled to ensure commencement of the health scheme. It has been suggested that GHC may require the financial assistance of Government.

##### **National Insurance Commission (NIC) registration**

Unlike other financing schemes, e.g., MetCare and Med X, the Ghana Healthcare Company is required to register with the NIC in accordance with the laws for insurance. (The other schemes mentioned operate under the insurance certificates from parent insurance companies, specifically Metropolitan Insurance and Provident Insurance Companies, respectively.) Needless to say, the registration process is complex.

##### **Final decisions on the appropriate management information system to employ**

A critical factor to the operation of a health insurance scheme is the establishment and effective utilization of a management information system (MIS). Thus various negotiations continue to finalize the requirements for such a system. It is believed, for example, that the recently procured computerized claims management system can manage 16 million subscribers with accompanying quick processing of claims.

##### **Absence of historical data**

It is essential for current and accurate mortality rates to be available to facilitate the appropriate pricing of premiums. Calculations of premium levels, etc., in the current private schemes are not backed by adequate historical or statistical data. The non-standardization of treatment protocols also presents difficulties.

##### **Unclear national policy**

Presently, Government policy on health insurance is unclear, and this serves as a constraining factor that looms large on the future and prospects of the scheme. There is, for instance, no guarantee that the previous Government's pledge to enroll its employees with the company will be honored. Moreover, it is not clear how the Government's pledge to enroll its employees with the company relate to concurrent efforts to establish a separate civil servants' insurance scheme, or a teachers' scheme, for that matter. Additionally, the viability and certainly the efficiency of the company have recently been brought into serious question by press reports of allegedly unnecessary management expenses.<sup>13</sup>

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<sup>13</sup> Newspaper reports in May 2000 have suggested that top managers of the company connected with the SSNIT have used its funds to make very expensive foreign trips and undertake other frivolous expenses even before the official launch of the company.

Competition from traditional practitioners due to increasing demand will imply some client loss. This may be a future threat.

Because the scheme is not yet operational, it is difficult to predict abuses that may occur. By the very design of the scheme, however, and past experience with private and public sector schemes of this nature, it would not be unreasonable to speculate that the abuses observed in the operations of other health schemes may occur here as well.

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#### **4.4.5 Potential for Future Success**

Having the SSNIT as an investor implies nationwide coverage, and this would serve as a distinct potential for growth for the Ghana Healthcare Company.

Community-based schemes could be viewed as more than an activity at the community level. Ghana Healthcare Company could set up networks to link these community entities into larger pools, thus enhancing their insurance function.

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### **4.5 Provident Xpress Care Medical Plan**

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#### **4.5.1 Background/Origins**

Provident Insurance Company and Medex, South Africa, was established in June 2000. The Provident Xpress Care Medical Plan is administered by MedX Ghana, part of MED X Africa, a health management company that develops and manages the process of health care funding, specializing in third-party administration.

The administration of a medical scheme is a key factor to its success. Although actuarial techniques may be applied to determine viable premium rates, abuse of the scheme as a result of poor administration or fraud can threaten the viability of a scheme, as the experience of Nationwide Mutual shows.

The particularity of MED X Africa is that they boast a special expertise and capacity to aid in the administration of insurance products, offering services such as claims management and cost control of medical insurance products sold by in-country insurance companies. This includes all aspects of third party administration, from receipt and assessment of claims, to the payment of service suppliers and the production of reports.

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#### **4.5.2 The Xpress Care Benefit Package**

The medical package consists of three adult packages; the Gold, Silver, and Bronze, and three packages for children, again, the Gold, Silver, and Bronze. The same annual benefit limits apply to both adults and children. There is a 25 percent child discount policy, which is attractive to clients.

The scheme provides an international evacuation, hospitalization, and repatriation cover, offered in conjunction with their partner Netcare, in South Africa. (For details, see Annex C.5.)

Membership is open to individuals and employer groups between 0 and 65 years.

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### **4.5.3 Constraints and Abuses**

The issues of fraud may still apply here although the scheme is highly technologically driven with appreciable administrative expertise and financial support from partner companies.

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### **4.5.4 Potential for Future Success**

Perhaps the greatest strength of this scheme is the solid experience of its international partners with regards to insurance administration. This enhances the chances that they will avoid the fate that befell Nationwide Mutual Insurance.

However, greater customization of benefit packages would encourage enhanced coverage. There is also a need to create market awareness of this scheme.

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## **4.6 Conclusions: The Need for an Adequate Legal Framework for Private Health Insurance**

The interviews carried out made it apparent that there is no legal framework specific to private health insurance initiatives. In all cases, companies resolve issues of abuse and fraud by members and/or service providers internally. For example, at MetCare, a Medical Review Board discusses and resolves all cases of insurance malpractice.

At a more general level, the National Insurance Commission forms the umbrella for all private insurance companies, to which fraudulent practices of huge dimensions are reported, and where the general insurance laws of the country apply. It would appear that health insurance companies have not yet had recourse to the NIC. Tighter administrative control mechanisms are needed to reduce the incidence of abuse.



## 5. Community-based Initiatives: Inventory of MHOs and Illustrative Case Studies of Three Models of MHO Development

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### 5.1 Mutual Health Organizations in Ghana

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#### 5.1.1 Introduction

This section is based on an inventory of MHOs carried out by the Partnerships for Health Reform project from March to June 2001. See Annex D for a comprehensive presentation of data on individual MHOs investigated for the inventory.

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#### 5.1.2 Basic Data on MHOs in Ghana

Information on a total number of 47 MHOs was collected during a nationwide survey of MHOs in Ghana carried out by PHR. The geographic distribution of these MHOs, located in 34 of Ghana's 110 districts, is shown by region in Table 5.1. Of the 47 MHOs surveyed, 14 (30 percent) are currently fully functional while the remaining 33 (70 percent) are at various stages of gestation, ranging from planning and community sensitization, to the conduction of surveys and registration of members.

About 29 percent (13) of the schemes were targeted to cover the total population of the entire district, while 72 percent of them are small localized schemes whose targets vary in size and nature, from community-level schemes through small professional associations, to ethnic or religious groups.

An analysis of the duration of existence of these MHOs shows that their proliferation in the country has been concentrated within the last two years; as many as 80 percent of them were formed during this period. This period, incidentally, coincides with the time that PHR started its technical assistance program in Ghana, by convening the first-ever workshop on MHOs in the country at Sunyani in July 1999. At that time, there were only four MHOs – both functional and proposed scene.

An analysis of registered members of various MHOs, both at the time of creation of the MHOs and the time of this survey, shows that MHOs older than two years have not increased in size significantly more than recently established ones, as mean growth rates were recorded at 96.3 percent and 94.7 percent, respectively. The large increase in enrollment of the Nkoranza Health Insurance Scheme, which rose from around 40,000 in 1999 to more than 48,000 in 2001 following PHR and DANIDA Health Sector Support Office interventions in 1999–2000, has had a positive impact on the net growth of MHOs belonging to the group of those older than two years. It is likely that more recent MHOs, if given similar technical support, will experience a faster rate of growth.

**Table 5.1 Number of MHOs by Region and Current Status of Operation**

Region	No. of MHOs	% of total	# at gestation	# fully functional	Total enrollment	Mean size of MHOs	# MHOs with members >5000	# MHOs with members <5000
Eastern	14	29.8	11	3	14,582	4,860	1	2
Northern	8	17.0	5	3	19,606	2,914	2	1
Brong Ahafo	7	14.9	4	3	48,441	16,147	1	2
Ashanti	3	6.4	1	2	4,158	2,079	0	2
Greater Accra	3	6.4	2	1	-	-	-	-
Western	4	8.5	4	0	-	-	-	-
Upper East	2	4.3	2	0	-	-	-	-
Upper West	4	8.5	2	2	-	-	-	-
Central	1	2.1	1	0	35	35	0	
Volta	1	2.1	1	0	-	-	-	-
National*	47	100	33	14	86,822	6,679**	4	7***

\* The figure for total number of MHOs (proposed and existing) is probably an underestimate given that the primary methodology for collecting the data relied on MHOs identified for participation in regional seminars; as three regions (Ashanti, Greater Accra and Volta) did not have those seminars before this survey was complete, it is safe to conclude that the inventory did not capture all MHOs in the country.

\*\* This figure for MHO average membership is well above the threshold of 5,000 stated by Bill Hsiao of the World Bank as the minimum required for a viable insurance scheme in terms of the statistical law of large numbers.

\*\*\* Total membership of three MHOs were not known at the time of survey.

The mean male-female ratio of MHO members is 1:1.3 (Table 5.2). This is not surprising, as women are known to bear more responsibility for health care in many households in Ghana, and therefore more readily enroll in MHOs than men. Unfortunately, the sex composition of the Nkoranza Community Health Scheme, which constitutes about 56 percent of all MHO members in Ghana, was not known at time of survey. The trend however, is not expected to change much even when this is added.

**Table 5.2 Sex Composition of MHOs in Ghana**

Sex	Freq	Mean Number	Total Number	% Composition
Male	9	1000	8,997	43.6
Female	9	1294	11,649	56.4
Total	9	2,294	20,646	100

Note that the computation of the mean here excludes five MHOs whose sex composition was not known at the time of survey, including the biggest MHO in Ghana (Nkoranza Community Health Insurance Scheme.)

About 50 percent of all MHO members are farmers, with the remaining 50 percent distributed among different occupations such as industry workers, artisans, civil servants, and petty traders.

Services covered at 100 percent by most MHOs are drugs, laboratory, X-ray services, hospitalization, and complicated delivery (Table 5.3). Family planning, normal delivery, and health center care usually are not covered. While only 28.6 percent of MHOs cover the full cost of normal delivery, about 71.4 percent do so for complicated delivery. About 22 percent of MHOs however, provide cover for only a percentage of hospitalization costs, i.e., less than 100 percent of the total cost.

**Table 5.3 Services Offered by Existing MHOs in Ghana.**

Type of Service	Freq	Percentage of MHOs Offering Service		
		Not offering	Offering some coverage	Offering all coverage
Medical Consultations	8	25	0.0	75.0
Health Facility Care	7	85.7	0.0	14.3
Hospitalization	9	11.1	22.2	66.7
Normal Delivery	7	71.4	0.0	28.6
Complicated Delivery	7	28.6	0.0	71.4
Family Planning	7	100	0.0	0.0
Laboratory Services	9	11.1	0.0	88.9
X-Ray Services	8	12.5	0.0	87.5
Drugs	9	0	0.0	100
Transport	7	71.4	0.0	28.6
Other Services	7	85.7	0.0	14.3

Interpretation of data: 11.1 percent of schemes offered no coverage of hospitalization in their benefit package, and a similar percentage offered coverage less than 100 percent of the cost of the service; 56.6 percent cover the service at 100 percent of the cost.

While a considerable number of MHOs provide social services for their members, the benefits are most often a flat sum of money paid to beneficiaries in the form of marriage grants, child allowances, and funeral contributions (Table 5.4). This is to be expected, because the main business of these organizations is health.

**Table 5.4 Social Services Offered by MHOs in Ghana**

Type of Service	Freq	Percentage of MHOs Offering Service		
		Not offering	Offering some coverage	Offering all coverage
Marriage Grant	9	66.7	33.3	-
Child Allowances	8	87.5	12.5	-
Funeral Contributions	8	75.0	25.0	-
Other Social Services	9	100	0	-

As Table 5.5 shows, providers are generally not involved in the management and other administrative functions of the MHOs, though there are notable exceptions, such as Nkoranza. The trend is toward more participatory, community-managed MHOs rather than the facility-based and controlled MHOs of the Nkoranza type (before it also decided to move away from that model) (Atim, 1998). Evidence from other parts of Africa suggests that MHOs that are independent of and sign contracts with providers may tend to negotiate quality and price of care for their members. Almost two out of every five organizations also pay the providers directly (Table 5.6).

**Table 5.5 MHO Relationships with Providers**

Type of Relationship	Freq	Proportion of MHOs in Relationship	
		Yes	No
Any Relations With Provider	13	69.2	30.8
Provider Involved in Management	13	38.5	61.5
Contract with Provider	13	30.8	69.2
Negotiates Price with Provider	13	30.8	69.2
Negotiates Quality with Provider	13	30.8	69.2

**Table 5.6 Payment Methods**

Payment Method	Freq	Number using method	% Using method
Pays Provider Directly	13	8	61.5
Reimburses Members	13	2	15.4
Other Method (e.g., flat rate or combination)	13	3	23.1

Regularity of meetings is a common feature of the MHOs, as four out of five of them claimed to meet regularly. One in every two meet monthly (Table 5.7).

**Table 5.7 Meetings**

Periodicity of Meetings	Freq	Percent of MHOs that meet
Members meet regularly	29	86.2
Meets monthly	24	54.2
Meets quarterly	24	20.8
Meets yearly	24	8.5
Meets weekly	24	12.5
Other	24	4.2
Presence of General Assembly	29	54.5



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### 5.1.3 External Support for MHOs

As Table 5.8 shows, some of the MHOs said they have had logistic, cash, and technical support at various times from PHR, DANIDA, Memisa, and the Ministry of Health (Table 5.8).

All regions have received technical support from PHR in the form of training. Resource persons, constituting a national technical resource pool have been developed, and are operational. More than 70 percent of the inventoried MHOs have had at least one person participate in PHR technical training and use the PHR Training of Trainers Manual (Atim, 2000), and approximately two MHOs have received direct comprehensive technical assistance in the form of training, evaluation, or both. Similar assistance was scheduled to start for two other MHOs at the time this report was being completed.

The DANIDA Health Sector Support Program in Ghana currently provides logistical support to every region to promote the development of MHOs. More than 80 percent of all listed MHOs have directly benefited from DANIDA support.

Two MHOs (Damongo and Nkoranza) have received substantial support from external NGOs, from the planning stages to the initial stages of implementation.

**Table 5.8 Donor Support for MHOs**

Type/Nature of Support	Freq	Proportion of MHOs that receive support (%)
Ever received donor support	45	22.2
Cash support	45	15.6
Technical support	45	22.2
Equipment support	45	13.6
Training	45	24.4

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### 5.1.4 Problems Encountered by MHOs

The following were mentioned as the common problems that MHOs face in the performance of their duties:

- ▲ Lack of transport for mobilization and coordination
- ▲ Lack of funds or logistical support
- ▲ Lack of technical knowledge of managing MHOs
- ▲ Members not yet trained or sufficiently informed
- ▲ Lack of regular contributions by all members
- ▲ Transfers of public sector workers causing instability in membership and contributions
- ▲ Poor attendance at meetings

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### 5.1.5 Lessons from Experience of MHO Development in Ghana to Date: Implications for Key Actors

This section applies to MHOs in Ghana the lessons learned from research and available literature on MHOs in West and Central Africa, notably Atim (1998).

- ▲ As a relatively new phenomenon in Ghana, MHOs face a number of challenges common to health insurance schemes: moral hazard, adverse selection, fraud, underestimation of dues, cost escalation, etc. As seen from their general design, most MHOs lack adequate risk management mechanisms. Building the knowledge and capacity to manage these risks remains the biggest challenge facing MHOs in Ghana.
- ▲ As most of the MHOs are in their infancy, many will continue to experiment with new ideas and methods, even as they draw lessons from others' experiences and build on their strengths. This experimentation is crucial for evolving the best practices and enabling the young movement to acquire its independence and confidence vis a vis other parties, and should not be stifled by too hasty or too stiff regulation.
- ▲ Notwithstanding the apparently large mean size (6,679) of MHOs in the country, many individual MHOs are very small; in fact, only four MHOs have more than 5,000 members. Though this could be an advantage in terms of simplicity in management and control, they do not provide an adequate base for risk pooling and risk sharing.
- ▲ Inadequate quality of care, especially at public health facilities, is a key factor constraining the growth of MHOs. Quality here refers to public perceptions about how MHO members are received and handled by health personnel, availability of drugs, cleanliness of the facilities, overcrowding, and waiting times. Unless quality is improved, many people will have no incentive to join MHOs – this is a harsh fact that should be emphasized as much as possible to all actors in this field, especially to providers and the MOH.
- ▲ Relations of MHOs with providers are largely cordial in nature, as seen earlier in the report. This is not surprising, given that the Ministry of Health has cooperated in the establishment of most of these schemes. This adds to the credibility of the MHOs, but the schemes need to guard their autonomy and independence jealously, as experience elsewhere shows that domination, even ownership of the MHO by the provider can lead not only to loss of MHO negotiating power, but also to inability to check the invoices submitted by the provider, achieve efficiencies, and leverage quality improvements on behalf of members.
- ▲ Few MHOs have any contractual relations with their providers, the very basis of negotiating price and quality for their members. This, however, might be due to the fact that most of the MHOs are very small and lack the capacity to negotiate such contracts.
- ▲ Though the majority of the MHOs pay for services directly to providers, a good number of them do so by reimbursement to individual members. This opens the MHOs to risks of fraud and abuses, and could cripple their growth.
- ▲ All MHOs currently pay on a fee-for-service basis, which is the least preferred of the numerous payment methods available. This method opens the MHO to serious cost escalation risks, as providers have an incentive to over-prescribe and over-treat, or bill for as many services as possible. It would be better to explore more efficient alternatives including budget payments and capitation.

- ▲ Most MHO management personnel lack suitable skills, including insurance-specific technical knowledge, financial management, risk management, community mobilization and participation methods, and monitoring and evaluation of MHOs.

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### 5.1.6 Implications for the Ministry of Health and the Ghana Health Service

- ▲ The MOH and GHS currently officially encourage the setting up of MHOs, and officials have been willing to lend their technical and moral support to the process. They should continue to play this facilitating role and maintain an atmosphere conducive to the continued development and growth of the MHOs, for example, by encouraging providers to consider innovative contractual arrangements and relationships with MHOs.
- ▲ There is the need to improve quality of care, which experience shows is a strong incentive for MHOs to continue to grow. Help with quality improvement is one of the most important contributions the MOH and GHS can make to MHOs. The most critical and urgent aspect of quality now is probably client relations, or the manner in which patients are received and handled at the health facilities.
- ▲ To this end, a system of facility accreditation that includes specific quality standards, coupled with regular monitoring of performance and updating of the accreditation, will assist MHOs in their contracts and negotiations with health providers.
- ▲ The MHO should adopt a more systematic approach to coordination, monitoring, documenting and disseminating experiences of the MHOs, while allowing continued autonomy of individual MHOs. Precipitate attempts to provide stiff regulatory procedures or to set up a regulatory body for MHOs could hamper their growth.

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### 5.1.7 Recommendations for Reinforcing the Feasibility and Sustainability of MHOs in Ghana

To address some of these issues concerning the relatively small size of MHOs, the precariousness of the financial situation of most of their members, and their long-term sustainability, it is proposed that:

- ▲ MHOs should be encouraged and assisted to come together in district and regional federations so that, while retaining the participatory character and risk management advantages of their small size, they could also benefit from the economies of scale and insurance advantages of large size. The regional federations would negotiate collectively with providers on behalf of individual MHOs, and provide other services that individual MHOs would not be able to provide, or would not be able to do so as cheaply.
- ▲ Each region should be encouraged to put in place a regional social reinsurance fund, with the regional health administration playing a leading role. The principal objective of this fund would be to contribute to the viability and long-term sustainability of the individual MHOs being set up spontaneously all over the country. The fund would have the following specific functions:

- a) financial reinsurance for the district, village, and other smaller schemes being set up in the region to cover health care costs beyond a certain level for all schemes, as well as referrals to, for example, the regional hospital or teaching hospital in Kumasi or Accra
- b) promotion of scheme set-ups in various districts and villages by providing technical assistance for feasibility studies, and if necessary, seed money for setting up
- c) aid to schemes in difficulty – financial and technical assistance where required to get ailing schemes back on their feet
- d) financial assistance for schemes could be in the form of soft loans to encourage responsibility and to avoid depletion of the fund; grants may be offered in exceptional cases
- e) support for health education as well as preventive and promotional activities such as sanitation, immunization campaigns, mosquito control (impregnated bed nets, clearing of swamps and standing water, etc.) to help improve standards of health generally in the region
- f) support for setting up the regional coordination or federation of the small schemes and reinforcing their capacity to negotiate with health providers
- g) employment of medical professionals (doctors, pharmacists, nurses) on a full-time basis and making these available to individual MHOs to strengthen their negotiating capacity with providers as well as to help MHOs vet the pricing and quality of health care received – all of which would help the MHOs avoid the fate that befell the first private health insurance company in Ghana, as described earlier in this report

The last two functions, f) and g), above may be considered as medium- to long-term goals of the fund.<sup>14</sup>

The funding for these social reinsurance schemes could come from:

- ▲ Contributions from all the existing schemes themselves (it is important to enable them have a significant voice in the utilization of the funds)
- ▲ Contributions from well-to-do individuals, companies, organizations, citizens living abroad, etc., in the same way the educational funds are being financed
- ▲ Specific fund-raising activities
- ▲ Government contributions

A national health fund set up by Government (with possible donor contributions) could underwrite the regional health funds, and transfer funds to regions to ensure equity and coverage of vulnerable groups, etc. It has also been suggested that such a fund could help ensure that all MHOs cover a defined basic package of health services for their members, an important objective of national health policy. As described, such a fund would therefore have reinsurance, risk equalization, and equity functions.

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<sup>14</sup> For more on social re-insurance in the context of MHOs, see Dror and Preker (eds.), September 2001, especially the article by Bennett and Gotsadze, "The Role of Social Re-insurance in Building Capacity and Strengthening Implementation."

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## 5.2 Illustrative Case Studies

- ▲ Nkoranza: provider initiated, covering hospitalizations and moving towards community co-ownership
- ▲ Tiyumtaaba: purely community initiated and managed, and highly adapted to context and skills of illiterate and very poor rural community, including in its method of financing of health care through soft loans
- ▲ Dodowa: purely provider initiated and managed providing primary health care coverage for rural population

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### 5.2.1 The Nkoranza Community Health Insurance Scheme

#### A. Introduction

The Catholic Diocese of Sunyani initiated the Nkoranza Community Health Insurance scheme in 1989, in response to reduced access to health care services by the general population following the introduction of user fees in Ghana in 1984. People who could not pay for health care costs delayed going to the hospital each time they fell sick until their conditions advanced to complicated stages. This negatively impacted the health status of the people, and had attendant consequences on productivity. The inability of many to visit the hospital also had undesirable consequences on the financial performance of the St. Theresa Hospital at Nkoranza (the district hospital), owned and operated by the Catholic Church. The scheme was formally launched in C1992, having drawn inspiration from the famous Bwamanda scheme of Zaire. It is the first community health insurance scheme in Ghana, and has been an example for others throughout the country. It targets the whole population of the Nkoranza district in the Brong Ahafo region, with a population of over 160,000 people.

Memissa, a Christian charity NGO based in the Netherlands, pledged financial support to the scheme for, among other things, meeting any deficits incurred during its first three years of operation.

The main objectives of the scheme were to:

- ▲ Encourage the people of the Nkoranza district to pool their financial resources together to pay for hospitalization needs
- ▲ Improve the district population's access to curative care by making health care delivery more affordable

#### B. Performance overview

As stated earlier, this scheme is the first MHO in Ghana, and in many respects serves as a model for groups and individuals in other parts of the country who want to form MHOs. It was the scheme's desire to achieve the highest possible coverage of its target population from the beginning. However, due to managerial and logistical constraints, the scheme could barely attain an annual coverage of 30 percent between 1992 and 1999. The scheme could not sustain itself on membership contributions alone during the first three years, and often had to fall on the buffer fund provided by Memissa to service outstanding claims. An evaluation conducted in 1999 by PHR (Atim and Sock, 1999) established that the rate of adverse selection was high, and was probably an important factor in the

financial performance of the scheme. By the sixth year, however, the scheme was able to cover most of its costs, besides the salaries of hospital staff seconded to the scheme and transportation provided by the hospital. It has also made quality health care available to a high percentage of vulnerable households in the district. By its mere survival, it has in no uncertain terms demonstrated the feasibility of a community-based approach to risk sharing and resource pooling.

Despite these achievements however, the research admitted that the 30 percent average annual coverage of the scheme between 1992 and 1999 was disappointingly low. The annual registration figures during the period did not show a tendency towards an increase in coverage of the target population. The research discovered that some of the reasons behind the consistently low coverage included:

- ▲ An inappropriate registration period
- ▲ Widespread misconceptions in the community about the scheme
- ▲ Massive adverse selection

Following these revelations, some recommendations were made, and, with the assistance of DANIDA, most of these recommendations have been implemented, resulting, for the first time in the history of the scheme, in a tremendous increase in coverage during 2001, with over 48,000 members registered.

### **C. Organizational and functional structure of the scheme**

The highest authority of this scheme is the Catholic Bishop of Sunyani, to whom the Diocesan Health Committee is also answerable. The Diocesan Health Committee directly oversees the operations of the scheme, through the Diocesan Primary Health Care Coordinator. There is a management team for the scheme, comprising all members of the hospital management team (namely administrator, senior medical officer in charge of the hospital, the hospital matron and the accountant), the district director of health services, the manager of the scheme, the coordinator and assistant coordinator of the scheme, and the chairman of the Insurance Advisory Board.

There is an Advisory Committee that serves under the insurance management team, vested with the moral authority to resolve conflicts. This committee, however, has not been effective in the past.

Field workers have been contracted to carry out social mobilization and public education for the scheme. They are also responsible for registering members on a commission basis. They have been provided with bicycles to help them perform their tasks.

Registration is on family basis. This means that once a person (often a key member of the family) decides to join, the whole family must register. This is to avoid the risk of adverse selection. A family card is issued to a family that has registered, with personal data of each member of the household provided on the form, as well as a photograph of each member.

### **D. Management**

A management committee manages the scheme, and is answerable to the Health Insurance Advisory Board. There is also an advisory board that provides technical advice to the Board and the scheme on matters that affect the operations or well being of the scheme.

Notwithstanding the name “Community Health Insurance Scheme,” this scheme has been, in reality, a provider-based and -managed scheme.

The scheme is housed in the St. Theresa’s Hospital at Nkoranza, which has also provided key staff for the management of the scheme. Until recently, the scheme lacked its own accountant, so all its finances were handled by the St. Theresa’s Hospital accountant. For these and other reasons, the scheme has lacked the autonomy necessary for an effective MHO.

It should be noted, however, that the Nkoranza scheme management has exhibited a rare degree of openness and courage in tackling the problems bedevilling the scheme, especially in their acceptance and ongoing implementation of the recommendations of the 1999 evaluation. Because of this managerial (read: Diocesan) innovation, the Nkoranza scheme is embracing a higher degree of community participation and a new management structure reflecting the increased roles of key stakeholders, especially of the grassroots membership. Methods of community mobilization and participation have also been enhanced with training from the Centre of the Development of People, a local NGO based in Kumasi. It can be said that the Nkoranza scheme is well on the way to becoming a co-managed rather purely provider-managed scheme, a model worth following closely in the future.

#### **E. Services offered**

The scheme offers 100 percent coverage for all costs associated with hospitalization, including medical consultations, drugs, laboratory services, surgery, X-ray services, admission fees, and complicated delivery. Outpatient costs for snakebites are also covered. The scheme, however, does not cover ailments related to alcoholism and complications arising from criminal abortions. Members who are referred from the St. Theresa’s Hospital to other hospitals outside Nkoranza are paid a sum equivalent to the average inpatient cost for the month that the referral took place, less expenses already incurred at the St. Theresa’s Hospital. All members reporting ill to the hospital must present their membership cards, which are cross-checked with their family registration cards at the hospital.

#### **F. Provider payment**

Bills for services consumed by beneficiaries are compiled at the end of each month, on a fee-for-service basis. The hospital keeps records of bills of members admitted to the hospital, and at the end of the month, the hospital accountant (who is also accountant to the scheme) prepares the bill and forwards it to the scheme for settlement. On receipt of a bill, the scheme writes a check for the settlement of the outstanding sum. The scheme routinely cross-checks bills submitted to it for settlement, facilitated by the computerization of the scheme and training of the staff, which was carried out after the 1999 evaluation. When a member of the scheme is admitted to the St. Theresa’s hospital, a sum equivalent to the average inpatient bill for that month is paid to the patient, less costs already incurred at St. Theresa’s hospital.

#### **G. Risks**

According to an external (PHR) evaluation conducted in 1999 (Atim, and Sock, 1999), the major risks facing this MHO are:

- ▲ Adverse selection, which was described as massive
- ▲ Moral hazards, from both member and provider point of view

## **H. Risk management**

### **H.1 Adverse Selection**

Registration on a family basis has been the major management technique for this scheme, but membership information was never compiled by household. To enforce this, the evaluation recommended that family registers be compiled for every community before the registration period to gather information on potential enrollee households.

### **H.2 Moral Hazard**

It was recommended that doctors not ask the insurance status of patients before or during consultation, as, according to members, this influences the type of treatment doctors prescribe.

Co-payments and/or deductibles have also been proposed for patients who refuse to pass through a health center before coming to the hospital.

### **H.3 Fraud**

Payment directly to the provider substantially reduces the risk of fraud, according to members.

## **I. Constraints**

Major problems include policyholders' failure of to understand the concept of risk sharing, and thus a tendency to withdraw from the scheme when they have not benefited from the package after a few years. The scheme still encounters some moral hazards, arousing serious concerns.

## **J. Achievements**

Major achievements of the Nkoranza scheme include increased access to health care for its clients as reflected in the hospital admissions records, as well as outpatient records. The hospital's defaulting rates have reduced, which is attributed to patients' increased ability to pay for services as a result of the scheme. Another major achievement of the scheme is its ability to sustain itself for the past three years without any external financial support.

Finally, the openness and courage of the management in embracing changes that might diminish their influence but help the growth of the scheme are to be highly commended, as these are rare qualities that bode well for the scheme, and have contributed to the renewed spirit of optimism and dynamism that can be sensed within this scheme, when the atmosphere was not so hopeful just a few years ago.



**Table 5.9 Summary Information on Nkoranza Scheme**

Type of Scheme	Date and reason(s) formed	Target group(s)	Benefit package	Current premium paid	Current status	Constraints of scheme	Abuses & control mechanism(s)	Potential & condition of attainment
Community Health Insurance Scheme	<ul style="list-style-type: none"> <li>- Initiated 1989</li> <li>- Launched 1992</li> <li>- Alternative to "Cash and Carry"</li> <li>- Improve financial access to curative and preventive care</li> <li>- Reduce the level of unpaid bills at the St. Theresa's Hospital by patients who abscond after treatment because they cannot afford the cost</li> <li>- Improve financial performance of the St. Theresa's Hospital at Nkoranza through increased utilization</li> </ul>	<ul style="list-style-type: none"> <li>- People of Nkoranza district</li> <li>- Total pop. of about 160,000</li> <li>- Registration period: 3 months</li> <li>- Whole family registration</li> </ul>	<ul style="list-style-type: none"> <li>- All services associated with hospitalization, including:               <ul style="list-style-type: none"> <li>Drugs</li> <li>Consultations</li> <li>X-Ray</li> <li>Laboratory tests</li> <li>Admission fees</li> <li>Complicated delivery</li> <li>Surgery</li> <li>Referral</li> </ul> </li> <li>OPD cases involving snakebite</li> </ul>	<ul style="list-style-type: none"> <li>- ¢12,000 per member per year</li> </ul>	<ul style="list-style-type: none"> <li>Fully functional, with more than 48,000 members</li> <li>Still the biggest MHO in Ghana</li> </ul>	<ul style="list-style-type: none"> <li>- Perceptions of some members about the quality of care they receive as compared to other patients</li> <li>- Inadequate autonomy hinders scheme's ability to negotiate quality and cost of care with provider</li> <li>- Some moral hazards</li> </ul>	<ul style="list-style-type: none"> <li>- Too early to assess abuses</li> </ul>	<ul style="list-style-type: none"> <li>Proposed summary reporting statistics are;               <ul style="list-style-type: none"> <li>- Total annual premium paid</li> <li>- No. of adults contacts for care</li> <li>- No. of children contacts for care</li> <li>- No. of under 5 years visits</li> <li>- Total drug cost per household</li> <li>- Total days of adult admission for each household</li> <li>- Total days of child admission for each household</li> <li>- Total days of under 5 admission for each household</li> <li>- No. of referrals</li> <li>- Total fee charged at referral hospital</li> </ul> </li> </ul>

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## 5.2.2 The Tiyumtaaba Welfare Association

The Tiyumtaaba Welfare Association is a community-managed MHO in the Sagnerigu health subdistrict of the Tamale district of Northern Ghana. The MHO, which comprises eight different communities, sprang up almost spontaneously in response to problems faced by community members in accessing health services. With the assistance of a staff of the Ministry of Health, these communities quickly formed self-help pools into which members contributed and from which they could borrow to meet their health care needs whenever the need arose.

Management of this scheme is decentralized to the community level. Every community decides on the detailed design, dues, contributions, and the type of services to be offered. Community management committees have been formed. Each community has a five-member committee, elected during a community meeting. All communities have included village health workers as automatic members of the committee. They also agree that no person from the chief's compound should be on the committees, to promote accountability<sup>15</sup> and enable chiefs to more easily and fairly exercise justice and judge disputes when there is need. The composition of the committees takes gender considerations into account. In almost all cases communities entrust the responsibility of keeping members' contributions to women, as, according to them, women are more prudent in handling money.

### A. Contributions

Different communities are responsible for deciding how much and how often members have to contribute to the fund. Available arrangements include:

- ▲ Weekly contributions of ¢100/person for all adult members of the community – two communities
- ▲ Monthly contributions of ¢5000/compound – one community
- ▲ Monthly contributions of ¢1000/per adult – four communities
- ▲ Monthly contributions of ¢2000/man and ¢1000 cedis/woman – one community

Meetings are held weekly or monthly. During these meetings, members are expected to pay their contributions. Community members also take the opportunity to discuss other community problems, such as water and sanitation. It is mutually agreed that these contributions are made based on the ability to pay. In this scheme, there is hardly any defaulting, for though people may not have been regular at meetings they still send their contributions. The entire village has a common understanding that people should pay when they can do so, under their own free will, because they all have no steady source of income.

In the past, the association operated on oral constitutions maintained at each individual community level, but as a result of training provided for these communities by PHR during December 2000, they are now in the process of preparing written constitutions. Each community has a five-member executive committee made up of a chairman, secretary, treasurer (all male), and two women representing the traditional birth attendants and the women's groups.

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<sup>15</sup> It is more difficult to hold people from the chief's house accountable for their actions than other persons.

## **B. Managing finances**

The treasurers have in the past had sole responsibility for keeping track of the contributions, but now communities are in the process of opening bank accounts. A great deal of trust has been put in the treasurers and it is believed by the community members that “only the devil can influence the treasurer negatively.” Some money is still kept with the treasurer at home, so that members can have access to it anytime a serious health problem is encountered, especially at night and non-banking hours.

## **C. Services offered**

Notwithstanding minor differences existing among member communities in terms of services offered to its members, the following are generally adopted as the services that the association offers:

- ▲ Inpatient bills
- ▲ Drugs
- ▲ Ambulance/transport
- ▲ Delivery
- ▲ Laboratory

## **D. Payment methods**

Three payment methods are offered currently, with the first one being the most practiced. These are:

- ▲ Cash payment by the association directly to the health facility in case of admissions.
- ▲ Cash disbursement to the family of an admitted member presenting prescriptions from an approved health facility
- ▲ Cash advance to members in case of labor, snakebite, and other life-threatening conditions.

The association generally does not cater for OPD cases, neither does it make advance cash payments to members to attend hospital except in the situations specified above. Negotiations with health providers on pricing and quality of care are being planned.

## **E. Potential risks**

1. Cost escalation: Future rises in health care costs could make it difficult for the association to meet the needs of its members in situations such as where many people present ill at the same time, or in serious cases of illness such as conditions requiring surgery.
2. Default in repayment: Failure of members who have borrowed money to pay back within the stipulated time was seen as a major risk facing the association, though no bad experience in relation to this has been encountered yet.
3. Death: Beneficiary members who die in the course of their illness are considered a major risk, since the association will absorb that bill for solidarity reasons.

Other threats facing the association include:

- ▲ The possible withdrawal of members who feel discriminated against because the association is unable to give them adequate assistance due to lack of money, or feel aggrieved for other reason, or who feel that they are not benefiting from the services of the association.
- ▲ The possibility of members halting contributions because they do not have enough funds.

Generally, adverse selection, which is considered a common risk associated with most MHOs, is very minimal with this scheme, due to the idea of compulsory membership by every member of the community.

#### **F. Risk management techniques**

1. Compulsory membership by every community member, since other community members cannot turn their back on a neighbor in need
2. Exclusion of members of the chief's compound from handling money to avoid abuses (it is more difficult to hold members of the chief's family to account for misuses of community funds)
3. Insisting that women keep custody of the money in most cases
4. Limiting the use of funds only to conditions of ill health that communities consider reasonably critical
5. Paying money directly to health providers for services rendered instead of through individual members
6. Benefits in the form of credit line, to avoid frivolous uses and abuses
7. Encouraging members to report early to hospital with ill health to reduce the chances of death
8. Making special contributions either at the family or community level to pay back the loans of members who may die in the course of their illness.
9. Educating people to understand that solidarity is the basic principle underlying the scheme so as to minimize discontent among members who may not benefit from the association's services for a long time.

#### **G. Achievements**

The association has successfully assisted more than 40 members to meet their health care costs since March 2000. The highest amount given out has been ₵110,000 and the lowest has been ₵20,000. Members pay back as soon as they return from the hospital. Preparations for repayment often start while the patient is still in the hospital, and the money is paid back in most cases even before the patient is discharged. Repayment is flexible and can be paid in installments. Usually no interest is charged on money lent and there is not set time period given for repayment. Experience so far has shown that all monies have been repaid within one month.

#### **H. Challenges/Problems**

Most communities feel that the weekly/monthly contributions cannot adequately meet their needs in times of multiple health crisis for the following reasons:

1. The cost of hiring a means of transport in times of emergency is very high and is a major drain on their resources in the fund.
2. The lack of a nearby health facility to give first line treatment to members before transferring to hospital only when necessary is also a major concern and challenge.
3. The insecurity (in case of fire or theft) surrounding the money kept by the treasurer.
4. The falling value of the Cedi and the dollarization of the economy is a threat to the survival and growth of the fund.

**Table 5.10 Summary Information on Tiyumtaaba Welfare Association**

Type of Scheme	Date and reason(s) formed	Target group(s)	Benefit package	Current premium paid	Current status	Constraints of scheme	Abuses & control mechanism(s)	Potential & condition of attainment
Community Health Financing Scheme	- In 1999, as a result of persistent financial difficulties that confronted communities during emergency ill-health situations. People who had foodstuffs or animals to sell were cheated by middle-men/women; and those those who went borrowing often got frustrated.	People of Sagnerigu health subdistrict, in the Tamale district. Total pop. of 46,000 - Currently 8 of the 22 communities in this subdistrict. Membership is compulsory for all community members once a community decides to join.	-Transport provided for acute emergencies - All expenses associated with hospitalization	- ¢1000/month	Fully functional; now in the process of strengthening documentation accountability mechanisms, and expansion to include other communities	Transport and logistics for the imitators who are facilitating the expansion to cover other communities that have expressed interest to join	- Too early to assess abuses	Proposed summary reporting statistics are: - Total annual premium paid - No. of adults contacts for care - No. of children contacts for care - No. of under 5 years visits - Total drug cost per household - Total days of adult admission for each household - Total days of child admission for each household - Total days of under 5 admission for each household - No. of referrals - Total fee charged at referral hospital

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### 5.2.3 The Dodowa (Dangme West) Community Health Insurance Scheme

About the same time that the MOH was exploring the feasibility of the NHIS, it commissioned a research project “to provide policy-makers with relevant data on the demand for, and feasibility of, health insurance schemes that are designed primarily to cater for populations outside the formal employment sector (MOH, undated). The project was undertaken by the Health Research Unit of the MOH and the Health Economics and Financing Programme of the London School of Hygiene and Tropical Medicine, with fieldwork in a rural subdistrict in Dangme West. This involved development of a methodology for establishing affordable household contributions and predicting financial performance of a health insurance scheme.

The findings of this research were discussed at a workshop in August 1994. The main recommendation was to pilot voluntary district health insurance schemes and the MOH responded by drafting a district health insurance scheme pilot for the study area.

After a considerable period of preparatory activities, the Dodowa (Dangme West ) Health Insurance Scheme began in 2000 with a lot of expectations and considerable (mainly donor) financial investment. Among the donors supporting the scheme were the European Union and DANIDA. During its inception, the MOH tried to promote it as a model for community-based schemes that would be rolled out after the pilot period into other districts.

By February 1999, a total of ₵53,500,000 had been received for intervention activities such as health education durbars/fora, a drug study, and equipment for workshops and durbars. Other funds estimated at about \$140,000 were also to made available for intervention activities such as in-service training of health workers and management, supportive supervisory visits, preparation and implementation of the health solidarity associations and the insurance scheme, and the appointment of an expert consultant for the project.

The scheme has just barely taken off. In the first year, it was projected that 40–50 percent of the district population of 96,000 would subscribe to the scheme. Final enrollment, however, was barely 5,000. In a progress report of the activities of the scheme covering the period August 2000–January 2001, the following were identified as challenges facing it:

- ▲ Difficulty in access to remote areas due to lack of transport
- ▲ Unforeseen financial implications which had not been budgeted for
- ▲ Lack of permanent staff, which made the health staff combine their normal district work with those of the scheme
- ▲ Being the first such scheme implemented from scratch

Some of the above problems (and the low enrollment rates) point to possibly more fundamental issues:

- ▲ Inexperience of the district medical scheme spearheading the project and lack of requisite managerial skills for running an insurance scheme
- ▲ Possibly inappropriate social marketing and community mobilization techniques

- ▲ Inadequate levels of community involvement and ownership (facility-based scheme)
- ▲ Problem of quality of care – complaints of the public



**Table 5.11. Summary Information on Dodowa Scheme**

Type of Scheme	Date and reason(s) formed	Target group(s)	Benefit package	Current premium paid	Current status	Constraints of scheme	Abuses & control mechanism(s)	Potential & condition of attainment
Community Health Insurance Scheme - Dangme Hewami Nami Kpee (Dangme Good Health Association)	<ul style="list-style-type: none"> <li>- 10 Oct 2000</li> <li>- Alternative to out-of-pocket expenditure</li> <li>- Improve financial access to curative &amp; preventive care</li> <li>- Improve quality of care</li> </ul>	<ul style="list-style-type: none"> <li>- People of Dangme West district</li> <li>- Total pop. of 96,000</li> <li>- Registration period: 3 months</li> <li>- Selective family registration attracts double premium payment</li> </ul>	<ul style="list-style-type: none"> <li>- Free OPD care</li> <li>- Transport provided for acute emergencies</li> <li>- Basic lab tests</li> <li>- Antenatal care</li> <li>- Delivery &amp; postnatal care</li> <li>- Family planning</li> <li>- Child welfare and immunization</li> <li>- Referral</li> </ul>	<ul style="list-style-type: none"> <li>- ₵12,000 for people age 6–69 years (non-exemptables)</li> <li>- ₵6,000 for children (0-5 years) &amp; the elderly 70+ years</li> <li>- ₵24,000 for non-group family members</li> </ul>	<ul style="list-style-type: none"> <li>Just started operating this year. Total membership between 4,000 – 5,000</li> <li>No review yet</li> </ul>	<ul style="list-style-type: none"> <li>Quality of care problems (health workers discriminating against the insured)</li> </ul>	<ul style="list-style-type: none"> <li>- Too early to assess abuses</li> </ul>	<ul style="list-style-type: none"> <li>Proposed summary reporting statistics are;</li> <li>- Total annual premium paid</li> <li>- No. of adults contacts for care</li> <li>- No. of children contacts for care</li> <li>- No. of under 5 years visits</li> <li>- Total drug cost per household</li> <li>- Total days of adult admission for each household</li> <li>- Total days of child admission for each household</li> <li>- Total days of under 5 admission for each household</li> <li>- No. of referrals</li> <li>- Total fee charged at referral hospital</li> </ul>



# Annexes



## Annex A: List of Persons Contacted

Adjei, Sam (Dr.), Deputy Director-General, Ghana Health Service

Coleman, Nii Ayite, (Dr.), Ministry of Health

Dakpallah, George (Mr.), Ministry of Health

Dzikunu, Helen (Ms.), Danida, Health Sector Support Office

Gadzekpo Helen (Ms.), Civil Servants Association, Accra

Gyapong, Margaret (Dr.), Health Research Unit, Ministry of Health

Kawawa Joris (Mr.), Civil Servants Association, Accra

Kluyitse, Ian, (Dr.), Med X

Kyeremeh, George Kumi (Mr.), National Health Insurance Scheme

Opong, Sylvester (Dr.), MetCare

Richter, John (Mr.), Department of Factories Inspectorate

Tuu, G.W. (Mr.), Civil Servants Association, Wa, Upper West Region



# Annex B: Legislative Instrument (L.I.1313) without the Schedules

## Annex B.1 Hospital Fees Regulations, 1985

In exercise of the powers conferred on the Secretary responsible for Health by section 11 of the Hospital Fees Act, 1971 (Act 387), and with the approval of the Provisional National Defence Council, these regulations are made this 19<sup>th</sup> day of July, 1985

1. Subject to the provisions of the Hospital Fees Act, 1971 (*Fees payable*) (Act 387) and these regulation, the basic fees specified in the First Schedule to these Regulations shall be payable in respect of services rendered in a hospital and specified in the First Schedule to these Regulations shall be payable in respect of services rendered in a hospital and specified in relation to those fees.
2. (2) Patients suffering from Leprosy or Tuberculosis are exempted from payment of all fees.
3. (2) No fees other than cost of prescribed drugs shall be paid in respect of services rendered in a hospital to any person suffering from:-
  - Meningitis
  - Chicken-pox
  - Cholera
  - Diphtheria
  - Malnutrition (Protein – Calorie – Malnutrition and Marasmus)
  - Measles
  - Onchocerciasis
  - Poliomyelitis (acute)
  - Relapsing fever
  - Schistosomiasis
  - Smallpox
  - Tetanus
  - Trachoma
  - Trypanosomiasis
  - Typhus
  - Veneral disease
  - Whooping-cough
  - Yaws
  - Yellow fever
  - Sickle cell disease
  - Viral hepatitis
  - Haemorrhagic fevers
  - Rabies

(3) No fees other than hospital accommodation and catering services shall be paid in any Government hospital or clinic in respect of –  
Ante-natal and post-natal services;  
Treatment at Child Welfare Clinics

(4) No fees shall be paid for any immunization against any disease except for vaccination certificates for international travel.

4. No fees (other than fees for special amenities) shall be paid in respect of services rendered in a hospital to any health services personnel including trainees.

(1) The person liable to pay for the cold storage of a dead body shall be the person requesting the service.

(2) No fees shall be paid for the cold storage of a dead body at the request of any department of state.

(3) The Medical Officer concerned may in his discretion waive the fees payable for cold storage of a dead body where there is delay in releasing the body of relatives due to post-mortem examination, the coroner's report of difficulty in tracing the relatives of the dead person.

5. The Hospital Fees Regulations, 1983 (L. I. 1277) are hereby revoked.

6. These Regulations shall be deemed to have come into force on the 1<sup>st</sup> day of June, 1985.

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## **Annex B.2 Operating the Exemptions Policy: Culled from "Ghana Health Service (2001). Operating the Exemptions Policies in the Ghana Health Service"**

Over the years the scope of the exemption facility has undergone changes that have been accepted within the health sector and the interpretation of the provisions have also been modified through several circulars and accepted norms - Currently the Ministry operates six clearly defined exemption facilities. These are:

1. Exemptions for disease of public health importance
2. Exemptions for antenatal services
3. Exemptions for the children under five years
4. Exemptions for the elderly (aged)
5. Exemptions for paupers and indigents
6. Exemptions for snake bites and bites by dogs suspected or confirmed to be rabid

### **1. Exemptions for disease of public health importance**

These currently cover the treatment and management of any of the epidemic prone disease when an epidemic occurs. When patients present with such diseases at other times they are expected to pay for all services including drugs. This category has been expanded to include HIV/AIDS and Buruli ulcer. These diseases should be exempted from all fees including investigation and treatment, immediately diagnosis is made.



## **2. Exemptions for antenatal services**

Exemptions for antenatal services cover consultation, basic laboratory services (haemoglobin estimation, sickling status, blood film for parasites and routine urine testing) and essential haematanics, vitamins and antimalarials. Even though it is estimated that patients will attend an average of four clinics during the term of pregnancy, it is expected that these services are provided until term. Pregnant women will therefore par for delivery services.

## **3. Exemptions for children under five years**

All immunization services under the EPI and services at child welfare clinics will be provided free. Children under the age of five years (or who are yet to reach their sixth birthday) who attend hospital on outpatient basis or are admitted will enjoy free services.

## **4. Exemptions for the elderly (aged)**

Exemptions for the elderly will apply only to people aged seventy and above. It will cover consultation, basic laboratory services and drugs for acute illness. The facility covers both outpatient and inpatient services. The facility will not cover routine check ups and drugs for chronic illness.

## **5. Exemptions for paupers and indigents**

Patients who are identified as paupers are exempted from all fees payable in the health facility.

## **6. Snakebites and rabies**

A patient who presents with a snakebite or who has been bitten by a rabid dog will receive free anti-snake or anti-rabies vaccine.



# Annex C: Private Sector Schemes – Detailed Benefits Packages

## Annex C.1 Summary of MetCare Benefits as at March 2001

	PRESTIGE	EXECUTIVE	PREMIER	CLASSIC
<b>OUTPATIENT CHARGES</b>				
Doctors' and Specialist Consultation Fees	100% Coverage	100% Coverage	100% Coverage	100% Coverage
Prescription Drugs	100% Coverage for Drugs from CDL	100% Coverage for Drugs from CDL	100% Coverage for Drugs from CDL	100% Coverage for Drugs from CDL
Diagnostic Tests & X-rays	100% Coverage	100% Coverage	100% Coverage	100% Coverage
Emergency Care	100% Coverage	100% Coverage	100% Coverage	100% Coverage
Dental Care (Limited to policy conditions and exclusions)	100% Coverage	100% Coverage	100% Coverage	100% Coverage
Optical Care – Eye Testing (Prescription Spectacles Optional)	100% Coverage	100% Coverage	100% Coverage	100% Coverage
Maternity Care (Optional)	100% Coverage	100% Coverage	100% Coverage	100% Coverage
<b>TOTAL MAXIMUM OUTPATIENT BENEFIT p.a</b>	10,000,000.00	5,000,000.00	3,000,000.00	2,000,000.00
Optional Benefit for Spectacles	500,000.00	400,000.00	300,000.00	300,000.00

<b>INPATIENT CHARGES</b>				
Surgical and Medical Treatment	100% Coverage	100% Coverage	100% Coverage	100% Coverage
Diagnostic Tests & X-rays	100% Coverage	100% Coverage	100% Coverage	100% Coverage
Drugs used in Hospitals	100% Coverage	100% Coverage	100% Coverage	100% Coverage
Hospital Accommodation	100% Coverage	100% Coverage	100% Coverage (Semi-Private Ward)	100% Coverage (General Ward)
Total maximum in-patient-benefits <i>per admission</i>	25,000,000.00	15,000,000.00	8,000,000.00	5,000,000.00

CDL – Comprehensive Drug List

## Annex C.2 MetCare Plan Details

### Annex C.2.1 MetCare Group Rates (annual)

PACKAGE	OPTION – I	OPTION – II	OPTION – III	OPTION – IV
<b>PRESTIGE</b>				
Adult	809,000.00	869,000.00	842,000.00	902,000.00
Child	605,000.00	655,000.00	-	-
<b>EXECUTIVE</b>				
Adult	644,000.00	699,000.00	671,000.00	732,000.00
Child	484,000.00	523,000.00	-	-
<b>PREMIER</b>				
Adult	413,000.00	457,000.00	446,000.00	490,000.00
Child	308,000.00	347,000.00	-	-
<b>CLASSIC</b>				
Adult	325,000.00	363,000.00	358,000.00	391,000.00
Child	248,000.00	275,000.00	-	-

#### Legend

- OPTION I – Standard package. Does not cover provision of Spectacles and Maternity services  
 OPTION II – This package provides cover for Spectacles in addition to the standard benefits  
 OPTION III – This package provides cover for Maternity Care in addition to the standard benefits  
 OPTION IV – This package provides cover for Spectacles and Maternity care in addition to the standard benefits

\* These premium rates may change without prior notification.

### Annex C.2.2 MetCare Classic

#### ANNUAL PREMIUM RATES

PACKAGE	OPTION – I	OPTION – II	OPTION – III	OPTION – IV
<b>GROUP</b>				
Adult	325,000.00	363,000.00	358,000.00	391,000.00
Child	248,000.00	275,000.00	-	-
<b>FAMILY</b>				
Adult	341,000.00	Not Available	Not Available	Not Available
Child	259,000	-	-	-
<b>INDIVIDUAL</b>				
Adult	358,000.00	Not Available	Not Available	Not Available
Child		-	-	-

#### Legend

- OPTION I – Standard package. Does not cover provision of Spectacles and Maternity services  
 OPTION II – This package provides cover for Spectacles in addition to the standard benefits  
 OPTION III – This package provides cover for Maternity Care in addition to the standard benefits  
 OPTION IV – This package provides cover for Spectacles and Maternity care in addition to the standard benefits

\* These premium rates may change without prior notification.

### Annex C.2.3 MetCare Premier

#### ANNUAL PREMIUM RATES

PACKAGE	OPTION – I	OPTION – II	OPTION – III	OPTION – IV
<b>GROUP</b>				
Adult	413,000.00	457,000.00	446,000.00	490,000.00
Child	308,000.00	347,000.00	-	-
<b>FAMILY</b>				
Adult	435,000.00	Not Available	Not Available	Not Available
Child	325,000.00	-	-	-
<b>INDIVIDUAL</b>				
Adult	451,000.00	Not Available	Not Available	Not Available
Child	-	-	-	-

#### Legend

OPTION I – Standard package. Does not cover provision of Spectacles and Maternity services

OPTION II – This package provides cover for Spectacles in addition to the standard benefits

OPTION III – This package provides cover for Maternity Care in addition to the standard benefits

OPTION IV – This package provides cover for Spectacles and Maternity care in addition to the standard benefits

\* These premium rates may change without prior notification.

### Annex C.2.4 MetCare Executive

#### ANNUAL PREMIUM RATES

PACKAGE	OPTION – I	OPTION – II	OPTION – III	OPTION – IV
<b>GROUP</b>				
Adult	644,000.00	699,000.00	671,000.00	732,000.00
Child	605,000.00	523,000.00	-	-
<b>FAMILY</b>				
Adult	677,000.00	Not Available	Not Available	Not Available
Child	506,000.00	-	-	-
<b>INDIVIDUAL</b>				
Adult	710,000.00	Not Available	Not Available	Not Available
Child	-	-	-	-

#### Legend

OPTION I – Standard package. Does not cover provision of Spectacles and Maternity services

OPTION II – This package provides cover for Spectacles in addition to the standard benefits

OPTION III – This package provides cover for Maternity Care in addition to the standard benefits

OPTION IV – This package provides cover for Spectacles and Maternity care in addition to the standard benefits

\* These premium rates may change without prior notification.

## Annex C.2.5 MetCare Prestige

### ANNUAL PREMIUM RATES

PACKAGE	OPTION – I	OPTION – II	OPTION – III	OPTION – IV
<b>GROUP</b>				
Adult	809,000.00	869,000.00	842,000.00	902,000.00
Child	605,000.00	655,000.00	-	-
<b>FAMILY</b>				
Adult	847,000.00	Not Available	Not Available	Not Available
Child	638,000.00	-	-	-
<b>INDIVIDUAL</b>				
Adult	875,000.00	Not Available	Not Available	Not Available
Child	-	-	-	-

#### Legend

OPTION I – Standard package. Does not cover provision of Spectacles and Maternity services

OPTION II – This package provides cover for Spectacles in addition to the standard benefits

OPTION III – This package provides cover for Maternity Care in addition to the standard benefits

OPTION IV – This package provides cover for Spectacles and Maternity care in addition to the standard benefits

\* These premium rates may change without prior notification.

### Annex 3.3 Nationwide Mutual Medical Insurance Scheme – Benefit Structure<sup>16</sup>

BENEFIT LEVEL	A	B	C	D	E	F
Outpatients Benefits	₴	₴	₴	₴	₴	₴
Doctors Consultation Fees	60,000	50,000	45,000	40,000	35,000	30,000
Diagnostic Laboratory Tests	135,000	100,000	85,000	70,000	45,000	40,000
Special Investigation: ECG	120,000	90,000	75,000	60,000	40,000	35,000
Radiological Investigations: X-rays	120,000	90,000	75,000	60,000	40,000	35,000
Prescribed Drugs:	275,000	200,000	150,000	120,000	90,000	80,000
Basic Dental Treatment	200,000	150,000	125,000	100,000	75,000	65,000
Inpatient Benefits						
Consultation or Medical Specialists Fees	65,000	50,000	45,000	40,000	35,000	30,000
Surgical treatment	275,000	200,000	150,000	120,000	90,000	80,000
Laboratory Tests	135,000	100,000	85,000	70,000	55,000	45,000
Special Investigation: ECG	120,000	90,000	75,000	60,000	40,000	35,000
Radiological Investigations: X-rays	120,000	90,000	75,000	60,000	40,000	35,000
Hospital Accommodation	300,000	225,000	187,000	150,000	115,000	85,000
Prescribed Medicines and Drugs	300,000	225,000	187,000	150,000	115,000	90,000

<sup>16</sup> The cedi amounts under the different benefit levels are the limits of expenditure by the scheme on the corresponding medical benefit.

## Annex C.4 Ghana Healthcare Company Benefit Package

TYPE OF BENEFIT	REMARKS	ANNUAL LIMITS		
		GENERAL PACKAGE	PREMIER PACKAGE	PRIVATE PACKAGE
		Gov't & Mission health facilities	Gov't, Mission & Private health facilities	
GP Consultation and Outpatient Services	Full payment but only from a GHC service provider.	NO LIMIT	NO LIMIT	NO LIMIT
Specialist Consultation	Based on a referral from a GHC service provider.	¢84,000.00	¢140,000.00	¢350,000.00
Prescribed Drugs	100% payment for generic drugs but co-payment for branded drugs.	¢180,000.00	¢300,000.00	¢750,000.00
Laboratory and Other Investigations	At the request of a GHC service provider.	¢120,000.00	¢200,000.00	¢500,000.00
X-ray and Ultrasound (Scan)	At the request of a GHC service provider.	¢72,000.00	¢120,000.00	¢300,000.00
Inpatient Accommodation	Covers boarding and lodging Private members entitled for laundry services in addition.	¢120,000.00	¢200,000.00	¢500,000.00
Medical and Surgical Procedures	Covers drugs and consumables used.	¢300,000.00	¢500,000.00	¢1,250,000.00
Maternity Services	Covers antenatal, normal delivery and post natal.	¢132,000.00	¢220,000.00	¢550,000.00
Family Planning	Permanent methods of contraception are covered under medical & surgical procedures.	¢30,000.00	¢50,000.00	¢125,000.00
Blood Transfusion	Given at a GHC recognized health facility.	¢30,000.00	¢50,000.00	¢125,000.00
Dental Care	Excludes bridges, inlays, dentures and root canal treatment.	¢90,000.00	¢150,000.00	¢375,000.00
Optical Care	Excludes spectacles	¢48,000.00	¢80,000.00	¢200,000.00
Ambulance Services	Emergency use only	¢84,000.00	¢140,000.00	¢350,000.00
Speech Therapy	Prescription by a recognized medical practitioner.	¢48,000.00	¢80,000.00	¢200,000.00
Physiotherapy	Prescription by recognized medical practitioner	¢48,000.00	¢80,000.00	¢200,000.00

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## Annex C.5 Premium Rates For The Provident Xpress Care Medical Plan

<b>ADULT</b>			
<b>Types of Package XPRESS CARE (Adult)</b>	<b>Monthly Premium (¢)</b>	<b>Annual Premium (¢)</b>	
Bronze	30,000	360,000	
Silver	43,200	518,400	
Gold	66,500	798,000	
<b>CHILDREN</b>			
<b>Type of Package XPRESS CARE (Child)</b>	<b>Monthly Premium (¢)</b>	<b>Annual Premium (¢)</b>	<b>CHILD DISCOUNT (%)</b>
Bronze	22,500	270,000	25%
Silver	32,400	388,800	25%
Gold	49,900	598,800	25%



# **Annex D: Inventory of Mutual Health Organizations in Ghana**

March - June 2001

## Annex D.1 Distribution and Characteristics of MHOs in Ghana by Region

NAME OF MHO	REG	DISTRICT	YEAR STARTED	STAGE	GENERAL FEATURES/INFORMATION	TOTAL MEMB	DUES	SOCIO-ECONOMIC XTICS
DUA YAW NKWANTA DAGABA WELFARE SCHEME	B/A	TANO	1995	Fully Operational	Migrant ethnic solidarity group Source of funds is monthly contributions Provides credit for members to access health care Loans paid back over 6-month period with no interest	96	1000 /Month	Mostly migrant farmers, Civil servants
HWIDIEM/KENYASI DAGAABA SONGTAA	B/A	HWIDIEM	1996	Fully Operational	Migrant ethnic solidarity group Source of funds is monthly contributions Provides credit for members to access health care Loans paid back over 6-month period with no interest	60	2000 /Month	Mostly migrant farmers, civil servants craftsmen
NKORANZA COMM HEALTH INSURANCE SCHEME	B/A	NKORANZA	1989	Fully Operational	Initiated by the Catholic church. Oldest community insurance scheme in Ghana Targets entire district Provider owned and co-managed (recent development) Membership registration is by family Covers only inpatient care costs	48000	10000 /Annum	Mostly farmers, but also traders, salaried workers, craftsmen
Tano District Health Insurance Scheme	B/A	Tano	1999	Still at gestation	Community initiated scheme, facilitated by a health worker. Started a systematic process of community sensitization, education and participation last year Working group formed to work out detailed design Organized the first ever IGM in Ghana among its stakeholders in June 2001 Propose to cover only inpatient care Contributions to start soon			
Asutifi Community Health Scheme	B/A	Asutifi	2001	Still at gestation	Initiated by a Catholic sister. Currently at sensitization stage			
Berekum Health Insurance Scheme	B/A	Berekum	2001	Still at gestation	Initiated by a district health director. Currently at sensitization stage			
Jaman District Health Insurance Scheme	B/A	Jaman	1999	Still at gestation	Initiated by the district hospital, managed by the Catholic church. Currently at sensitization stage			
St. Rose's Students Health Scheme	E/R	Kwaebibirem	2000	Fully operational	A student-centered scheme co-managed by the PTA and the district hospital Parents pay premiums as a top up of school fees Full coverage for OPD and admissions	153		Senior secondary school students
Sawmillers Credit Facility	E/R	Birim South	1997	Fully operational	An agreement between sawmill employers and the district hospital to offer treatment to employees at any time Bills are reimbursed at end of month			Industry workers
GPRTU Health Scheme	E/R	New Juabeng	2000	Waiting period, registration of	A trade union association of commercial vehicle drivers, station guards, other staff and their relatives Covers only admissions, with a ceiling of ₵250,000 per annum	150	12000 /Annum	Commercial vehicle workers

				members				
Afa Emergency Health Scheme	E/R	New Juaben	2001	Still at gestation	Initiated by an individual Plans to cover only inpatient care			
Akwatia Technical School	E/R	New Juaben	2001	Gestation	Student centered scheme			
Assesewa Health Scheme	E/R	Manya Krobo	2001	gestation	Community level scheme, promoted by Plan International			
Asemankese School Health Scheme	E/R	West Akim	2001	Gestation	Student-centered scheme			
New Abirim Susu Scheme	E/R	Birim North	2001	Still at gestation	Traditional savings and credit scheme, which covers health care for members			
Kwahu South Health Scheme	E/R	Kwahu South	2001	Still at gestation	District -wide scheme, initiated by the hospital. Currently at sensitization stage			
Antenatal Mothers Health Scheme	E/R	Akuapim North	2001	Still at gestation	Initiated by women for antenatal care only Just started with premium collections			
Dwenase Community Health Scheme	E/R	Kwaebibrim	2001	Still at gestation	Initiated by local community members. Plans to offer inpatient and ambulance services Contributions in progress			
Asuom Community Health Scheme	E/R	Kwaebibrim	2001	Still at gestation	Initiated by local community members Plans to offer inpatient and ambulance services			
Methodist Church Health Scheme	ER	Regional	2001	Still at gestation	Initiated by the Methodist church Covers all church members, including children Weekly contributions, as part of church offertory 20% of total collections to be set aside for inpatient care for members Collections to begin soon			
Nkwa ye Adonkwatya-Akwapim	E/R	Akwapim North	2001	Still at gestation	Initiated by local community members Plans to offer inpatient and ambulance services			
Damongo Health Insurance Scheme	N/R	West Gonja	1994	Fully functional	Initiated by the Catholic Church in 1994 District-wide target, but implementation was phased, starting with communities within 1 Km radius of Damongo hospital (Approx 30% of district population) Covers only inpatient care No ceilings, co-payments or restrictions on health condition, except criminal abortion Provider owned and managed Received substantial financial support from donors initially, but now relies solely on dues and premiums Currently in process of reviewing design			95% farmers 5% traders, civil servants, etc.
Bunkpurugu/Tigobdia	N/R	East Mamprusi	2001	Still at gestation	Originally called Mutok-Lafia Initiated by a political leader Provides interest -free credit to members Minimal community participation, lack of accountability and transparency led to early collapse of scheme. New initiative by community members based on the original design. Now adopted new name, called "Tigobdia" Currently at sensitization stage			
Saboba/Chereponi Health Scheme	N/R	Saboba/Chereponi	2001	Still at gestation	Initiated by a local NGO, Integrated Development Center (IDC) District -wide scheme Now in process of sensitization and detailed design			
Tiyumtaaba Welfare Association	N/R	Tamale	1998	Fully functional	Community-initiated scheme, comprising communities within Sagnerigu health subdistrict.	5700	1000 /Month	Farmers

					Community pays for health care costs of members who fall seriously ill Beneficiaries pay back when they recover, over any convenient period of time, with no interest. Membership is compulsory for every community member Management decentralized to each individual community who form their own management committees			
Savelugu Health Scheme	N/R	Savelugu/Nanton	2001	Still at gestation	Initiated jointly by the District Health Director and Community members Just completed a rapid assessment of the general environment At planning stage			
Tihasuma Health Scheme	N/R	Tamale	2001	Still at gestation	Community-initiated scheme, comprising communities within Vittin health subdistrict. Contributions in progress Plans to cover only inpatient care, antenatal services, ambulance, snakebite and severe child mal conditions	128	1000 /Month	95% farmers 5% traders
Nawunzoya Health Scheme	N/R	Tamale	1992	Fully functional	Initiated by a youth group in Tamale district Covers inpatient care, and social events including marriage, childbirth and funerals Contributions are paid weekly	40	100 /Week	60% traders 40% farmers
Tisungtaaba Health Association	N/R	Tamale	2001	Still at gestation	Community-initiated scheme, comprising communities within Ch oggu health sub district. Plans to cover inpatient care, labor and snakebite			
Manhyia Susu Scheme	ASH	Kumasi	2000	Fully functional	Initiated by a medical officer. This scheme involves mostly women traders. Covers mostly delivery and maternal care costs. Contributions are made year round, and members pay when they have.	158	-	Traders and housewives
Maternal Mortality Prevention Scheme	ASH	Ejisu-Juaben	1996	Fully functional	Initiated by a rural community near Ejisu who experienced so many maternal deaths in 1993/94. Many pregnant women died due to lack of money to seek delivery at the hospital, or procure ambulance services for women in labor. Community instituted a revolving fund through communal fund raising activities, from which antennal care and ambulance costs are financed on credit basis to members.	4000	-	80% farmers 20% petty traders
Civil Servants Medical Refund Scheme	ASH	Regional	1995	Functional	Medical care allowances for civil servants in the Ashanti region have been pooled into one common fund. Members who incur health care costs at approved hospitals get refunded from this fund, upon presentation of receipts, prescriptions and relevant documentation.			100% salaried workers
Integrity Associates Scheme	G/A	Accra	2001	Gestation	This scheme is a private initiative targeting mostly traders. Still at the planning and sensitization stage.			
GNTDA Health Insurance Scheme	G/A	Accra	-	-	-	-	-	-
Dangme West Health Insurance Scheme	G/A	Dangme West	1998	Fully functional	Initiated by the Ministry of Health, with the original idea of testing the demand for, and feasibility of community-based health insurance schemes. Went through a systematic process of surveys, planning and education. Preparations started in 1999, and finally took off in 2000. Targets 40-50% enrollment of total district population for 2001. Encourages family registration. Selective family registration attracts double the premium.	5000	12000 /Annum	Farmers, traders and salaried workers.
Amenfi District Health Insurance Scheme	W/R	Amenfi	2001	Gestation	Initiated by the district director of health services, envisaged to cover entire district. Still at planning stage.			
Juabeso Community Health Scheme	W/R	Sefwi-Juabeo	2001	Gestation	Initiated by the district director of health services, envisaged to cover entire district. Still at planning stage.			

Sefwi Wiawso District Health Scheme	W/R	Sefwi Wiawso	2001	Gestation	Initiated by a member of the District Health Management Team, envisaged to cover entire district Still at planning stage			
Organisation of Women and Devt.	W/R	Sekondi	1999	Gestation	Strictly speaking not an MHO in itself, but currently in process of planning to incorporate MHO component into their traditional community-based and microcredit programs that target mostly women.			
Bawku East District Health Scheme	UER	Bawku East	2001	Gestation	Initiated by a member of the District Health Management Team, envisaged to cover entire district. The district director of health services and the Regional Health Administration actively support the scheme. Still at the planning stage.			
KANADA Community Health Scheme	UER	Bolgatanga	2001	Gestation	Initiated by a community development worker from a rural area near Bolgatanga. A revolving fund has been established to support emergency health situations for community members. Community now in process of working out contribution rates and detailed operational modalities.			
Civil Servants Medical Refund Scheme	UWR	Regional	1995	Functional	Medical care allowances for civil servants in the Upper West region have been pooled into one common fund. The fund is lodged with the Ministry of Health, and members who fall sick report the health facility with an approved by Ministry of Health, and counter endorsed by the head of department of the patient. After treatment, the bill is debited against the pool fund.			100% salaried workers
Funsi Community Health Scheme	UWR	Wa	2000	Gestation	Initially started by community members of 4 rural communities near Wa, with support from the Regional Health Administration. Now covers 3 health subdistricts in the Wa district. Community has sent members to Damongo to under study their scheme, and are in process of fixing dues and accountability mechanisms. Registration of members to start soon.			
Poentanga Community Health Scheme	UWR	Wa	2001	Gestation	Initiated by community members and motivated by the subdistrict health staff. Outcome of regional MHO program carried out by the health authorities in the region. Initiative immediately followed a workshop organized in the region to disseminate PHR products on MHOs in Ghana.			
Teachers Welfare Fund	UWR	Regional	1995	Functional	The Upper West Regional branch of the Ghana National Association of Teachers initiated this scheme, using the medical allowances paid to teachers by government. The fund is lodged at the regional education office, and covers teachers and their families, including wives and up to 3 children each. A ceiling of 25,000 cedis is set, and no member can exceed this amount in a given year.	-		Teachers
Ahausena Susu Health Scheme	C/R	Birim North	2001	Gestation	A community initiative, to contribute towards health care. Membership is not compulsory. Contributions have begun; service package has been determined, but actual provision yet to start.			
Akatsi District Health Scheme	V/R	Akatsi		Gestation	Initiated by the District Health Management Team. Hopes to cover entire the entire district. Still under preparation			

Legend

1. E/R = Eastern region
2. N/R = Northern region
3. B/A = Brong Ahafo region
4. Ash = Ashanti region
5. G/A = Greater Accra
6. W/R = Western region

7. UER = Upper East region
8. UWR = Upper West region
9. C/R = Central region
10. V/R = Volta region
11. REG= REGION

## Annex D.2 Services Offered, Payment Mechanisms and Provider Relations of MHOs in Ghana (fully functional MHOs only)

Name of MHO	Age	# Members	Date Services Begun	Services Provided	% Cov.	Payment Method	Provider Relations
1. Nkoranza Comm Health Insurance Scheme	11	48,285	Jan 1992	Inpatient care. Generally excludes OPD services except snakebites. Following hospitalization components are offered:		Directly to provider, on a fee for service basis, on a monthly basis.	<ul style="list-style-type: none"> <li>- Provider initiated and managed. Now shifting towards greater community participation and management</li> <li>- Does not negotiate quality or price with provider.</li> <li>- No contract signed with provider due to greater provider role in management</li> </ul>
				1. Medical Consultations	100		
				2. Admission Fees	100		
				3. Complicated Child Delivery	100		
				4. Laboratory Analysis	100		
				5. X-ray Services	100		
				6. Drugs	100		
7. Referral	<sup>17</sup>						
2. Duayaw Nkwanta Dagaaba Scheme	6	96	1995	Generally takes care of inpatient care, of the following components:		Members are reimbursed for costs, or may receive cash advance during admission	No formal relationship is maintained with any provider.
				1. Medical Consultations	100		
				2. Admission (Hospitalization) fees	100		
				3. Drugs	100		
				4. Marriage Grant	Flat		
5. Funeral and Burial Allowance	flat						
3. Hwidiem & Kenyasi Dagaaba Scheme	5	60	1996	Generally takes care of inpatient care, of the following components:		Members are reimbursed for costs, or may receive cash advance during admission	No formal relationship is maintained with any provider.
				1. Medical Consultations	100		
				2. Admission (Hospitalization) Fees	100		
				3. Drugs	100		
				4. Marriage grant	Flat		
5. Funeral and Burial Allowance	flat						
4. St. Rose's Students Health Scheme	1	153	2000	May cover OPD services depending on severity, but mostly inpatient care, of the ff components		Pays directly to provider, on a fee for service basis	<ul style="list-style-type: none"> <li>- Provider is not involved in management of MHO, but relates strongly with provider in the following ways:</li> <li>- Price and quality negotiated.</li> <li>- Signs contract with provider</li> <li>- Payment on monthly basis</li> </ul>
				1. Medical Consultations	100		
				2. Admission (Hospitalization) Fees	50		
				3. Laboratory Analysis	100		
				4. X-ray Services	100		
				5. Drugs	100		

<sup>17</sup> A flat sum, equivalent to the highest cost incurred on a client during the preceding month is paid

Name of MHO	Age	# Members	Date services Begun	Service Provided	% Cov.	Payment Method	Provider Relations
5. Damongo Health Insurance Scheme	6	13,738	January 1996	Covers only inpatient care, (it except criminal abortion) in the following aspects		Pays directly to provider, on a fee for service basis; on a monthly basis	Initiated and fully managed by the provider No opportunity for price and quality negotiations, nor signing of contract
				1. Medical Consultations	100		
				2. Admission fees	100		
				3. Complicated Child Delivery	100		
				4. Laboratory Analysis	100		
				5. X-ray Services	100		
				6. Drugs	100		
7. Referral	<sup>18</sup>						
6. Tiyumtaaba Welfare Association	2	5,700	October 1999	Except for snake bite, no OPD services are covered. Covers inpatient care relating to the ff components:		Community pays cash directly to provider, during each episode of illness	No formal relationship with provider yet. Now in the process of formal relationship with provider.
				1. Admission fees	100		
				2. Complicated Child Delivery	100		
				3. Laboratory Analysis	100		
				4. X-ray Services	100		
				5. Drugs	100		
6. Ambulance services	100						
7. Manhyia Susu Scheme	1	158	February 2001	Covers inpatient care cost of members as ff:		Pays provider through individual members through each episode of illness	Has a cordial non contractual relationship with provider. No formal negotiations on price or quality.
				1. Admission fees	-		
				2. Complicated Child Delivery	-		
				3. Laboratory Analysis	-		
				4. X-ray Services	-		
5. Drugs	-						
8. Maternal Mortality Prevention Scheme	5	4000	January 1995	Covers mostly maternal related illness, and very critical general conditions on the ff aspects:	100	May pay provider directly or through individual members during each episode of illness, but has an informal agreement with provider to treat members reporting ill even when spot payment is not possible.	Has an informal cordial relationship with provider, to enable members to receive care even when payment is not immediately possible. No contractual relationship
				1. Normal Child delivery	100		
				2. Complicated Child Delivery	100		
				3. Laboratory Analysis	100		
				4. X-ray Services	100		
				5. Drugs	100		
6. Ambulance services	100						
9. Civil Servants Medical Refund Scheme (ASH)				Covers both OPD and inpatient care		Members are reimbursed on presentation of receipts and prescriptions, but sometimes fund is lodged with provider from which treatment costs of beneficiaries are deducted on a case-by-case basis.	Fund sometimes lodged with provider, and drawn on a case-by-case basis. No contractual relationship No formal negotiations on care quality and price of care
				All health episodes presenting for care	100		

<sup>18</sup>A flat sum, equivalent to the highest cost incurred on a client during the preceding month is paid

Name of MHO	Age	# Members	Date services Begun	Service Provided	% Cov.	Payment Method	Provider Relations
10. Dangbe West Health Insurance Scheme	3	5000	January 2001	Covers both OPD and inpatient care, including ambulance services. The following are covered:		Provider, with some community involvement, manages scheme. Payment is made on case-by-case Basis	Provider manages scheme. Limited opportunities for quality and cost negotiations.
				1. OPD Services	100		
				2. Basic Laboratory Services	100		
				3. Antenatal Care	100		
				4. Family Planning	100		
				5. Delivery and Postnatal	100		
				6. Child Welfare Services & Immunization	100		
				7. Ambulance Services	100		
11. Civil Servants Medical Refund Scheme (UWR)	4+			Covers both OPD and Inpatient care		Members are reimbursed on presentation of receipts and prescriptions, but sometimes fund is lodged with provider from which treatment costs of beneficiaries are ducted on a case by case basis.	Fund sometimes lodged with provider, and drawn on a case by case basis. No contractual relationship. No formal negotiations on care quality and price of care.
				All health episodes presenting for care	100		
12. Teachers Welfare Fund	4+			Covers both OPD and inpatient care		Fund is lodged with the Ministry of Health, from which care costs of members are deducted on a case-by-case basis.	Though no written agreement, a contract does exist between teachers and the Ministry of health for the management of funds and provision of care.
				All health episodes presenting for care	100		



### Annex D.3 Participation, Accountability, Risks and Risk Management Techniques of MHOs

NAME	INITIATOR	GENDER COMPOSITION			DUES	MECHANISMS FOR INVOLVEMENT AND ACCOUNTABILITY					FEEDBACK MECHANISMS			MAJOR RISKS & Problems	RISK MANAGEMENT
		M	F	TOT		IGM	AGM	MEETINGS	DIVISION OF MGT. ROLES	CONSTITUTION	REPORTS	EVALUATIONS	CLIENT SATISFACTION SURVEYS		
1. Nkoranza Comm Health Insurance Scheme	Catholic Church	<sup>19</sup>		48,285	10,500	No	Yes <sup>20</sup>	No regular meetings involving stakeholders	Solely managed by provider.	Yes	Available, but not shared	Once, in 1999	None	1. Moral hazards 1. Adverse selection 3. Fraud & abuses 4. Inaccurate billing	1. Family registration 2. Issue of ID cards 3. MIS 4. Co-payment <sup>21</sup>
2. Duayaw nkwanta Dagaaba Scheme	Community	55	41	96	1000	-	Yes	Yes	Yes	Yes	-	-	-	1. Cost escalation	
3. Hwidiem & Kenyasi Dagaaba Scheme	Community	25	35	60	2000	-	Yes	Yes	Yes	Yes	-	-	-	1. Cost escalation	
4. St. Rose's Students Health Scheme	School PTA	-	-	153	10 % of school fees	-	No	Yes	Yes, School/Provider		-	No	No	1. Fraud 2. Abuses	None
5. Damongo Health Insurance Scheme	Catholic Church	<sup>22</sup>		13,738	8,000	No	Yes <sup>23</sup>	No regular meetings involving stakeholders	Solely managed by provider.	Yes	Available, but not shared	Yes	No <sup>24</sup>	1. Moral hazards 1. Adverse selection 3. Fraud & abuses 4. Inaccurate billing	1. Family registration 2. Issue of ID cards
6. Tiyumtaaba Welfare Association	Comm. Health Worker	3725	1975	5000	1000	-	No	Yes	Yes, elected executive present	N <sup>25</sup>	No	Not yet	Not yet	1. Cost escalation 2. Fraud	1. Compulsory membership 2. Credit only
7. Manhyia Susu Scheme	Medical Officer	10	148	158	-	-	No	No	-	No	No	No	No	--	-
8. Maternal Mortality Prevention Scheme	Community	<sup>26</sup>		4000	N/A	-	-	Yes	Yes, elected executive present	No	No	No	No	-	-
9. Civil Servants Medical Refund Scheme (ASH)	Civil servants	<sup>27</sup>			N/A	No	-	Yes	Yes	-	-	-		-	-

<sup>19</sup> Gender breakdown of this scheme was not known at the time of compiling this report.

<sup>20</sup> The first time in the 11-year history of the scheme that an AGM was ever held was in 1999, only after DANIDA and PHR recommendations.

<sup>21</sup> Now in the process of implementing co-payment, following PHR recommendation from a technical evaluation

<sup>22</sup> Gender breakdown of this scheme was not known at the time of compiling this report.

<sup>23</sup> The first time in the 6-year history of the scheme that an AGM was ever held was in 1999, only after DANIDA Recommendation.

<sup>24</sup> A small bit of this was incorporated in the first evaluation of this scheme

<sup>25</sup> Now in the process of preparing a written constitution

<sup>26</sup> Gender breakdown of this scheme was not known at the time of compiling this report.

10. Dangbe West Health Insurance Scheme	Ministry of Health	<sup>28</sup>		5000	12,000/24,000 <sup>29</sup>	No	Not yet	Yes	Solely Provider managed	Yes	Yes, but not shared	No <sup>30</sup>	Not yet	1. Moral hazards 1. Adverse Selection 3. Fraud & Abuses 4. Inaccurate Billing <sup>31</sup>	1. Family registration encouraged 2. Penalty for individual registration
11. Civil Servants Medical Refund Scheme (UWR)	Civil servants	<sup>32</sup>			N/A	No	-	Yes	Yes	-	-	-		-	-
12. Teachers welfare Fund.	Teachers	<sup>33</sup>			N/A	No	-	Yes	Yes	-	-	-		-	-

IGM=Interim General Meeting; Refers to the very first general meeting that the working group of an MHO organizes with its members to present to them the constitution and the detailed design of the scheme for public comments, amendments and approval. Members of the governing board and other committees, may also be elected during the IGM.

AGM=Annual General Meeting; Refers to annual (or biannual) events or meetings involving all members of an MHO, during which the financial statement and overall performance, of the MHO during the previous year(s) is read to members. Members have the opportunity to express their satisfaction, approval or disapproval for all or portions of the report. Major changes in policy and the constitution can only be effected by the AGM.

M= Male members

F= Female members

TOT= Total Membership

MGT= Management

PTA = Parent-Teacher Association

<sup>27</sup> Gender breakdown of this scheme was not known at the time of compiling this report.

<sup>28</sup> Gender breakdown of this scheme was not known at the time of compiling this report.

<sup>29</sup> Members who register on individual basis pay 12,000 per annum, but members who register on family basis pay 12,000 per annum.

<sup>30</sup> A technical assessment by PHR is pending

<sup>31</sup> Prone to, but not yet encountered

<sup>32</sup> Gender breakdown of this scheme was not known at the time of compiling this report.

<sup>33</sup> Gender breakdown of this scheme was not known at the time of compiling this report.

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