Oxfam's response to the Ghana National Health Insurance Authority's criticisms of joint NGO report: 'Achieving a Shared Goal: Free Universal Health Care in Ghana'
25 March 2011

On 9th March a joint NGO paper was launched calling for free health care for all in Ghana and critiquing the Ghana National Health Insurance Scheme (NHIS) as an inefficient and unfair barrier to achieving this goal. The paper welcomed the strong political commitment of the Government of Ghana to health but called for bolder steps to now implement free universal health care funded by tax. The paper was produced by Ghanaian NGOs ISODEC, the Alliance for Reproductive Health Rights and the Essential Services Platform with support from Oxfam.

On 17th March the National Health Insurance Authority (NHIA) issued a response to the paper which was dramatic but disappointing. The NHIA critique can be found on the following website: http://www.ghanaweb.com/GhanaHomePage/NewsArchive/artikel.php?ID=205271&comment=6595115#com

Ghanaian NGOs involved in the report have issued a number of their own responses to the NHIA. Oxfam was also directly criticised, and a number of misleading claims made. Responses to a number of the central claims by the NHIA are provided below:

Claim: The NHIA say that this was an 'Oxfam led' report

Response: Like the NHIS the report was home grown - and produced by Ghanaian NGOs with the support of Oxfam. The NHIA is therefore mistaken to call this paper an 'Oxfam report', as if no-one else was involved. The report is a response by Ghanaian national civil society to express collective concerns about the fairness and efficiency of the current health financing model in Ghana. A concern that Oxfam in Ghana shares. The NHIA is attacking Oxfam, instead of addressing the central arguments of the paper.

Claim: The NHIA claim that the introduction of a universal tax-funded system after Independence in Ghana was unsustainable.

Response: The NHIA's reference to the failed history of free health care in Ghana omits that the collapse of the health service in the 1970s and 1980s was due to a dramatic and widely criticised decision to reduce health spending to 20% of its former level. It is impossible to conclude that free care financed by taxation was an unsustainable model of health financing given this exceptional context.

Claim: That a call for free health care coverage without any risk sharing on the part of users of health care services is wrong

Response: The suggestion by the NHIA that health care free at the point of use financed by taxation is not a form of risk sharing by users of health care is perhaps of most significant concern. Taxation is of course the largest form of risk sharing available and holds greatest potential for cross-subsidisation of costs from rich to poor and from healthy to sick.

In this regard Ghana's NHIS is already 70% tax financed and is more akin to a tax financed system than social health insurance. However, as the report points out, despite every Ghanaian paying for their health care through taxes the paper estimates that less than one in five could be benefitting. The problem is that the health insurance system acts as a costly and inefficient barrier to people claiming the health care they have already paid for.

The paper is clear that there is much cause for optimism that Ghana can now afford a fully tax financed health care system free at the point of delivery with no reliance on premium incomes. The IMF predicts that by 2013 tax revenues will amount to 25.7% GDP. With 15% of tax and non-tax revenues allocated to health, and with the additional investments made through efficiency savings in health and good quality aid, the paper outlines clearly how Ghana can spend 200% more on health by 2015.

With such significant potential for increased investment in health it makes sense to focus attention on tax revenues as opposed to insurance premiums to pay for free health care for all citizens.

Claim: That the methodology used to arrive at the estimated coverage rate was flawed and lacked transparency

Response: The paper is very transparent about the methodology and data sources used. Annex 2 sets out clearly the steps taken to arrive at an estimated 18% NHIS valid membership coverage. This is a best estimate using the limited data available, for which the primary source is the NHIA's own annual report. The paper accepts the limitations of this estimate and calls for the urgent publication of evidence based accurate figures of current valid membership, i.e. the number of Ghanaians with a valid insurance card they can use at their local health facility now.

The NHIA has not responded to the main challenge that their own estimate of 62% involves counting many people more than once, leading to an inaccurate and inflated coverage figure. It seems by their own admission the NHIA is counting every registration since the scheme began as new, despite many of these being repeat registrations by the same Ghanaians. Below is an abstract from the most recent 2009 Independent Health Sector Review, published by the Ministry of Health, to clarify this point:

"The total number of card holders increased from 10,417,886 in 2008 to 12,123,338 in 2009. This is, however, an accumulated figure of cards issued since health insurance started, and the actual number of individuals holding a valid NHIS membership card in 2009 is therefore expected to be lower due to health insurance dropout (e.g. lack of renewal, death and emigration). It has been specified by the NHIA that the figure represents an accumulation of individuals who were issued one or more cards and not the accumulation of cards issued, i.e. the figure increases every time an individual renews his or her membership card." (emphasis added)

In the NHIA's 2009 Annual Report it claims:
"The total number of subscribers with valid ID cards as at December 31, 2009 was 12,534,128, representing 86.37 % of the total registered members"

This figure implies that 86% of registered members have valid ID cards that they could use to access health care in 2009. However, when you look at the source of the data (Table 2 in the same Annual Report) the 86% figure is without any doubt derived from an aggregated figure of ID cards issued from 2005 to 2009. In short this means the NHIA is counting every card ever issued as a valid ID card whether this card was issued in 2009 and is valid or in 2005 and is now out of date.

It is unreasonable of the NHIA to strongly criticise an attempt by Ghanaian civil society to produce an estimate of valid membership of the NHIS using the limited data available when the NHIA's own figures are so seriously flawed. The organisations involved in producing this paper continue to wait for a comprehensive and evidence based response from the NHIA.

Claim: That the researchers of the report did not exhaust the possibility of accessing data direct from the NHIA

Response: This is not true. Annex 2 of the paper clearly documents the numerous attempts made by the report researchers to gain access to data from the NHIA dating back to September 2010. Despite numerous requests, data compiled by the data department of the NHIA for the authors was not authorised for release by senior management. During the course of the research it also became clear that different teams (ICT, Operations and Actuarial) within the NHIA had wildly different data figures relating to membership – a revealing fact in itself.

Claim: That the paper misquotes and misrepresents other reports and doctors data to suit its own purposes

Response: This claim is unsubstantiated.

We note with interest that the NHIA has drawn attention to the Ghana Demographic and Health Survey (GDHS) of 2008 which found that about 39% of women and 29% of men aged 15-49 were registered with the NHIS and of these 87.9% and 90.5% said they had valid NHIS cards respectively. Of these 26% of the women and 33.4% of the men were not able to produce a valid card. Taking this into account the data from the GDHS suggests that between 20.5% and 30% of the population were valid members of the NHIS in 2008. In the same year the NHIA publicly claimed coverage was 61%, more than double the figure identified by the GDHS.

The authors nevertheless apologise that due to human error, the paper incorrectly cites one figure from the National Development Planning Commission. As the NHIA correctly assert, the figure should have been 47.9% as opposed to 45%. We are happy to make this clarification.

Claim: The methodology used to arrive at the conclusions of the report is seriously flawed. This comes as no surprise as this is Oxfam's stock in trade.

Response: The NHIA critique of the methodology used in this specific paper has been responded to above. On the more general suggestion about the quality of Oxfam's research we would suggest the NHIA provide specific examples as we assume they would not make such an allegation without having specific, reliable evidence to substantiate.

Claim: That the allegation in the report that 45% of NHIS funds could not be accounted for in 2008 is 'as laughable as it is ludicrous'.

Response: Ghanaian civil society and Oxfam take the transparency and accountability of any public institution very seriously. The Independent Health Sector Review, a publication of Ghana's own Ministry of Health, in 2008 reported that 45% of the NHIA funds were unaccounted for.

A recommendation of the same report is for the *'NHIA to foster transparency as a basis for mutual cooperation and trust'.* It was the findings of a peer-reviewed evaluation of the NHIS that routine NHIA data is treated as confidential; information on the DMHIS rarely filters up to national level; and annual and financial reports are not circulated in a timely way.[1]

At the time of their evaluation the same authors concluded that no NHIA planning documents are available and there appears to be no monitoring and evaluation.[2]

Claim: That descriptions of conflict between NHIA and the Ministry of Health and other stakeholders are part of a 'ploy' to drive a wedge between the NHIA and its stakeholders

Response: This is unsubstantiated and untrue. The report is simply referring to problems of fragmentation, poor co-ordination and internal conflict that have been documented in sources such as the Ministry of Health's Independent Health Sector Review. Other examples would include the numerous occasions the NHIA and its representatives have entered into fierce arguments with other health stakeholders including the Ghana Health Service on issues including claims payments on public radio or television in Ghana.

Claim: That the purchaser-provider split in health care financing in Ghana is in line with health sector reforms sweeping across the world and that it brings efficiency, transparency, quality assurance as well as accountability in health service provision.

Response: Some countries are indeed pursuing a purchaser-provider split model - but we would argue that the jury is definitely still out on whether theoretical benefits such as improved efficiency and transparency have been realised in practice. There is certainly no clear evidence that a purchaser- provider split is a pre-requisite to a better performing more equitable universal health care system . Indeed many historic success stories for health in low income countries, such as Sri Lanka, did not pursue this model. The paper sets out that for the example of health care financing in Ghana, efficiency, transparency, quality and accountability are ongoing challenges that have not been overcome by a purchaser-provider split.

Claim: DRG tariff creep is a well known phenomena in health insurance globally and is a problem the NHIA has identified

Response: The paper agrees that DRG tariff creep is a problem but goes further in its recognition of the evidence of cost escalation in health insurance programmes worldwide. The paper acknowledges and welcomes the government's efforts to address cost escalation including piloting with capitation payments and the one-time premium payment.

The paper argues that such reforms would render a great deal of the existing health insurance bureaucracy obsolete. Further savings could therefore be made by, overhauling the health insurance bureaucracy and retaining the functions of the NHIA that remain relevant under the Ministry of

Health. Cost savings from such moves would be large and as the government suggested in its election manifesto, they are savings that could be ploughed back into frontline services.

Claim: The report's claim that as much as GHc 65 million could be saved on medicine prices sounds incredible

Response: Incredible but true - according to sound calculations based on the findings of the 2009 Independent Health Sector Review. Claims for medicines amounted to GHc 129 million in 2009 and the Health Sector Review estimated that medicine costs could be reduced by 50%. Achieving this reduction is not easy given the power of pharmaceutical companies but is within Ghana's reach.

Claim: That the report does not take adequate account of Ghana's NHIS recognition and acclaim on the global stage

Response: Ghana's commitment to facilitating learning from its own health insurance experience should indeed be congratulated.

However, the central concern of the paper stands that the progress of health insurance in Ghana to extend health insurance coverage has not been as successful as the NHIA has suggested. More accurate evidence based figures about the schemes progress to date would help further facilitate learning on health insurance by other countries.

Claim: Oxfam has a 'blatant aversion to insurance'

Response: The report was produced by Ghanaian NGOs with the support of Oxfam – it is not an 'Oxfam report' alone.

Oxfam remains sceptical about the potential of health insurance to achieve universal coverage in low-income countries. Both taxation financing and social health insurance share welcome principles of universal coverage and equity but the evidence shows that it is only tax-based financing that has achieved these goals in low-income countries to date. High levels of poverty and informal economy employment are just two of the characteristics of low- and lower middle-income countries like Ghana that make it difficult to successfully implement social health insurance.

For more information on Oxfam's research on this issue please see our report 'Health insurance in low-income countries. Where is the evidence that it works?'
http://www.oxfam.org.uk/resources/policy/health/bp112_health_insurance.html

To access Oxfam's extensive list of health policy papers and reports please visit:
http://www.oxfam.org.uk/resources/policy/health/index.html

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[1] Witter, S. and Garshong, B. (2009) 'Something old or something new? Social health insurance in Ghana', BMC International Health and Human Rights 9: 20, http://www.biomedcentral.com/content/pdf/1472-698X-9-20.pdf, last accessed 28 February 2011

[2] ibid.