PRIMARY HEALTH CARE AND PROGRESS TOWARD UHC
GHANA

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The 2015 Sustainable Development Goals (SDGs) spurred momentum behind the drive for universal health coverage (UHC). UHC means providing all people with access to quality health services while ensuring the use of these services does not cause financial hardship.[1] As countries invest in health systems strengthening to increase access and provide financial protection, strengthening primary health care (PHC) systems will be a critical component of that effort.

Over the past two decades, Ghana has committed to increasing both access to health services and financial protection in pursuit of UHC through targeted health service delivery and financing reforms. In 2005, the national government developed a close-to-client health care delivery system, called the Community-based Health Planning and Services Strategy (CHPS) to minimize geographic barriers and reach remote populations with primary health care. Around the same time, the government implemented a national health insurance scheme to boost financial protection. Key health indicators have improved over time.[2] (Table 1) Despite the recent progress, out-of-pocket spending on health, poor coverage of promotive and preventive services, workforce shortages and increasing expenditure in the health insurance system remain a challenge.

TABLE 1: KEY HEALTH INDICATORS[3,4]	2005	2015
Life expectancy at birth (M/F)	58/59	61/64
Infant mortality rate (per 1,000 live births)	57	43
Under-five mortality rate (per 1,000 live births)	87	62
Maternal mortality ratio (per 100,000 live births)	376	319

COMMUNITY-BASED HEALTH PLANNING AND SERVICES (CHPS)

To promote equity in access to health services, the CHPS initiative targets remote areas of high need to deliver cost-effective and quality primary care services to individuals and households, while also engaging the community in the planning and delivery of services.[5] Each CHPS compound is designed to serve a population of 5,000. A dedicated community health nurse serves as the first point of contact and offers limited preventive and curative health care services. While the initiative reduces travel time and distance within high-need rural and impoverished areas, the main challenge is the cost to implement the program country-wide.[6]

HEALTH FINANCING IN GHANA

The largest portion of total health expenditure (THE) comes from the government, with 47% of current government health spending dedicated to primary health care. The remainder of THE is from external and private resources, of which more than two-thirds is out-of-pocket spending (OOPS). (Table 2) Since 2010 OOPS has spiked, while external funds and government expenditure on health declined. This shift has placed a disproportionate financial burden on individuals seeking care.

NATIONAL HEALTH INSURANCE SCHEME (NHIS)

Ghana's primary risk pooling scheme is a national health insurance model. The government established the National Health Insurance Scheme (NHIS) in 2003 as a step toward universal health coverage, and unified the risk pool in 2012 to eliminate fragmentation. Participation in the NHIS is mandatory (except for the Ghana Armed Forces and Ghana Police Service) and the scheme incorporates both the formal and informal sectors, where both groups must pay premiums.

The NHIS is financed primarily through tax revenues, through a value-added tax, which is unique. The National Health Insurance levy, provides 74% of the NHIS revenue, Social Security and National Insurance Trust (SSNIT) deductions provide another 20%, and premiums provide 3%. Those who are exempt from

SNAPSHOT OF MAJOR HEALTH POLICIES:

- Ghana Shared Growth and Development Agenda II: 2014-2017
- The Strategic Framework for the Health Sector: 2014-2017
- National Community Based Health Planning and Services (CHPS) Policy
- National Health Insurance Act 650 (2003) and Act 852 (2012)
- Private Health Sector Development Policy (2013)

paying premiums include the indigent, people below the age of 18 and above the age of 70, pensioners of SSNIT, pregnant women, and persons with mental disorders. The financial sustainability of the NHIS, however, is uncertain as expenditures have outpaced revenue, resulting in a deficit.[7]

PROGRESS TOWARD UHC

Ghana has made progress toward achieving universal health coverage by increasing financial risk protection and access to essential health services. Despite this progress, gaps in coverage remain.

Breadth of coverage

As of 2014, the NHIS covered 10.5 million people, or 40% of Ghana's population, falling short of the goal of 70% coverage.[9] Participation is mandatory, but enrollment is not automatic. There is no consequence for failing to enroll. Some studies indicate that premium cost hinders NHIS registration, especially for the informal sector, which may help explain why coverage is still low.[10] Even those who are eligible for fully subsidized premium payments must still enroll, so many who are eligible still may not have coverage.[11] The NHIS also has low renewal levels.

Depth of coverage

According to the National Health Insurance Authority, Ghana's NHIS benefits package covers 95% of diagnosed disease conditions, and all related outpatient, inpatient, and emergency care.[12] In 2008, the government introduced a policy eliminating registration and premium fees for pregnant women and included antenatal visits, childbirth care (including complications), postnatal visits, care of the newborn, and other primary health care services.[13] The scheme explicitly lists excluded conditions, though it is not clear if the lists of covered services and excluded services are exhaustive—for example, coverage regarding family planning is not on either list. The benefits package includes all of the medicines listed on the National Health Insurance Scheme Medicines list, which reflects the World Health Organization's Essential Medicines List. However, availability of essential medicines isn't consistent across all facilities.

Height of coverage

NHIS members pay no out-of-pocket costs for services or medicines included in the benefits. Because there is no cost sharing beyond premiums, members pay no copayments, coinsurance, or deductibles, and there are no annual or lifetime limits.[14] Despite that, over one-third of those covered by the NHIS still paid out of pocket for medicines and services.[15] Those who are not covered by the NHIS pay a fee for service for both public and private providers.[16] Together, this may explain why the out-of-pocket expenditure, at 27 percent, is so high.

Equity

Though the NHIS was designed to be pro-poor and to increase access to health services, those in the wealthiest households are more likely to be covered by the NHIS than the poorest households.[17] Expanding coverage to the poor and vulnerable will require more intentional investment. In addition, service prices differ between public, private, and faith-based providers. This has larger implications for equity, and can also affect access.

TABLE 2: GHANA HEALTH EXPENDITURE DATA[8]

INDICATORS	2010	2011	2012	2013	2014
Total Health Expenditure (THE) % Gross Domestic Product (GDP)	5	5	5	5	4
General Government Health Expenditure (GGHE) as % of Total Health Expenditure	72	74	66	70	60
Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE)	28	26	34	30	40
External Resources on Health as % of Total Health Expenditure (THE)	18	15	12	9	15
Social Security Funds as % of General Government Health Expenditure (GGHE)	20	18	25	21	32
Out of Pocket Expenditure (OOPS) as % of Total Health Expenditure (THE)	18	16	27	20	27
Out of Pocket Expenditure (OOPS) as % of Private Health Expenditure (PvtHE)	65	63	77	67	67
Private Insurance as % of Private Health Expenditure (PvtHE)	9	9	5	2	2

OPPORTUNITIES

The following opportunities exist to strengthen the primary health care system and drive progress toward the achievement of universal health coverage:

REDUCE OUT-OF-POCKET PAYMENTS BY INCREASING ENROLLMENT IN THE NHIS

Because NHIS coverage is still low, and out-of-pocket payments are high, devoting attention to increasing enrollment in the NHIS will help reduce out-of-pocket payments.

INCREASE ATTENTION TO PROMOTIVE AND PREVENTIVE SERVICES AT THE PHC LEVEL

In alignment with the tenets of UHC, including promotive and preventive services at the primary care level in NHIS coverage is critical. A recent study found that the NHIS prioritizes curative services which does not serve the purposes of promoting key principles underlining UHC and PHC, and that including services such as family planning and health education would be beneficial.[18]

STRENGTHEN THE PHC SYSTEM WITH GOVERNMENT INVESTMENT

Some argue for improving efficiency of primary health care facilities for additional fiscal space, in recognition of the many funding asks in the health sector and limited resources.[19] There is also an opportunity to shift some of the spending at the tertiary level to PHC.

PROVIDE GUARANTEED UNIVERSAL PACKAGE OF PRIMARY HEALTH CARE SERVICES

In 2016 the President's technical committee issued this recommendation following the review of the National Health Insurance Scheme (NHIS). This approach increases the population coverage, ensuring access to the poorest and most vulnerable.

ENDNOTES

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