



**Universal Health Coverage for Inclusive and
Sustainable Development**

Country Summary Report for Ghana

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Acronyms

CBHI	Community-based health insurance
DHMIS	District Health Mutual health Insurance Schemes
GDP	Gross Domestic Product
G-DRG	Ghana Diagnostic-Related Groups
GHS	Ghana Health Service
GNI	Gross National Income
HIPC	Highly indebted poor countries
HRH	Human Resources for Health
MDG	Millennium Development Goals
NGO	Non-governmental organization
NHIA	Ghana National Health Insurance Authority
NHIS	Ghana National Health Insurance Scheme
OOP	Out of pocket health spending
PPP	Purchasing power parity
SNNIT	Social security scheme
THE	Total Health Expenditure
UHC	Universal Health Coverage
VAT	Value-added tax

Preface

In 2011, Japan celebrated the 50th anniversary of achieving universal health coverage (UHC). To mark the occasion, the government of Japan and the World Bank conceived the idea of undertaking a multicountry study to respond to this growing demand by sharing rich and varied country experiences from countries at different stages of adopting and implementing strategies for UHC, including Japan itself. This led to the formation of a joint Japan–World Bank research team under The Japan–World Bank Partnership Program for Universal Health Coverage. The Program was set up as a two-year multicountry study to help fill the gap in knowledge about the policy decisions and implementation processes that countries undertake when they adopt the UHC goals. The Program was funded through the generous support of the Government of Japan.

This Country Summary Report on Ghana is one of the 11 country studies on UHC that was commissioned under the Japan–World Bank Partnership Program. The other participating countries are Bangladesh, Brazil, Ethiopia, France, Indonesia, Japan, Peru, Thailand, Turkey, and Vietnam. A synthesis of these country reports is in the publication “Universal Health Coverage for Inclusive and Sustainable Development: A Synthesis of 11 Country Case Studies,” available at:

<http://www.worldbank.org/en/topic/health/brief/uhc-japan>.

These reports are intended to provide an overview of the country experiences and some key lessons that may be shared with other countries aspiring to adopt, achieve, and sustain UHC. The goals of UHC are to ensure that all people can access quality health services, to safeguard all people from public health risks, and to protect all people from impoverishment due to illness, whether from out-of-pocket payments or loss of income when a household member falls sick. Although the path to UHC is specific to each country, it is hoped that countries can benefit from the experiences of others in learning about different approaches and avoiding potential risks.

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Country Summary Report for Ghana

Overview

Ghana is a country in West Africa with a population of about 25 million. The country is a stable democracy and achieved lower middle-income status in 2011 with a per capita gross national income (GNI) of \$1,410. Poverty remains high, however, at nearly 30 percent of the population. Life expectancy at birth, though only 65 years on average (Table 1), has seen a marked improvement over the past two decades. The prevalence of HIV/AIDS in Ghana is among the lowest in the Sub-Saharan Africa region, and this too makes its status related to life expectancy relatively better.

The government made a commitment to universal health coverage when it passed the National Health Insurance Scheme (NHIS) Law, Act 650, at the end of 2003. The law was revised in 2012 (Act 852) to bring the district insurance schemes into a single pooled fund, thus eliminating fragmentation. Act 650 established the National Health Insurance Authority (NHIA) to implement the NHIS and mandates that all residents of Ghana enroll in one of the accredited insurance schemes. The law does not specify consequences for failing to enroll, nor are residents automatically enrolled, so until now the NHIS has been operating as a de facto voluntary scheme.

With the 2003 NHIS law, the health financing system in Ghana is now a combination of supply-side subsidies for public and faith-based providers directly through the government budget, entitlement-based insurance coverage financed through a combination of earmarked taxes and individual-paid premiums, and direct out-of-pocket payments. The NHIS covers 36 percent of the population, or close to 9 million people.

Table 1. Data overview

Population	24.66 million (2010)
Gross domestic product (GDP)	\$32.9 billion
GNI per capita in purchasing power parity	\$1,410
GDP per capita, in US\$	\$1,150 (2010)
Total health expenditure (THE) as % of GDP	4.86% (2009)
THE per capita	\$54 (2009)
Public expenditure as % of THE	53% (2009)
Out-of-pocket expenditure as % of THE	37% (2009)
Life expectancy at birth	65 years
Hospital beds per capita	0.9 hospital beds per 1,000 population

Source: World Development Indicators, The World Bank, 2013.

Note: For 2011, unless otherwise noted.

As highlighted in the 2014 Budget Statement presented by the minister of finance to Parliament on November 4, 2013, the government is committed to increase membership of the NHIS by 9 percent to 10.15 million or about 42 percent of the total population in 2014. The government also committed to ensure that by 2014 people in the informal sector will constitute 35 percent of the total number of people enrolled in the NHIS.

PART I. UNIVERSAL COVERAGE—STATUS AND SEQUENCING

A. Overview of Current Status

1. Population Coverage

The NHIS covers about 8.9 million people, or 36 percent of Ghana's population (2012). Reporting of NHIS coverage figures changed in 2010 from a cumulative reporting system to one based on active membership, including only those members who currently have valid cards that entitle them to services in the reporting period. This change resulted in a downward adjustment of coverage estimates since coverage has been characterized by high levels of non-renewal. There are also challenges of delays in issuing cards once the premium is paid and the official three-month waiting period is completed, which has meant that some subscribers have been denied access to services. There are efforts under way to issue instant cards using biometric identification for rapid authentication of membership. A pilot membership authentication system showed a 17 percent increase in enrollment of indigent beneficiaries between 2012 and 2013. In 2014, the NHIS will scale up the implementation of enhanced membership authentication and e-claims systems across the country.

2. Benefits

The benefits included in the NHIS benefit package are comprehensive and are the same for all population groups. The NHIA has claimed that the benefits cover 95 percent of health conditions affecting the population (NHIS 2013). The benefits package, which is published on the NHIS website, includes most necessary outpatient diagnostic and curative services, medicines according to the published list, inpatient services, emergency care, maternity care, and oral health. The benefits package specifies excluded services, which are those that are not medically necessary (e.g. cosmetic treatments) and some high-cost services, such as most cancer treatments and organ transplant and parallel government programs such as TB and HIV/AIDS anti-retroviral medications.

In 2008, a policy was introduced exempting all pregnant women from paying the NHIS registration and premium fees (the Free Maternal Health Service Initiative). Enrollment entitles women to six antenatal visits, childbirth care (including complications), two postnatal visits within six weeks of childbirth, care of the newborn for up to three months, and other primary health care benefits. A recent evaluation of the initiative found a continuing trend of increasing use of health facilities for deliveries by pregnant women, with the share of supervised deliveries rising from 24.3 percent in 2012 to 37.5 percent in mid-2013. The rate of prenatal care rose to 46.3 percent.

3. Financial protection

The NHIS accounts for about 18 percent of total health spending in Ghana, while another 40 percent is paid directly by the government to public and faith-based health service providers.

Other than the excluded services, there are few formal limits placed on NHIS coverage. There is no cost sharing beyond premiums (i.e. no copayments, coinsurance, or deductibles), and no annual or lifetime limits. The population not covered by the NHIS pays fee for service for both government and private providers. Out-of-pocket spending is about 37 percent of total health expenditure. Only 1.4 percent of households had catastrophic health spending in 2006, defined as spending 10 percent or more of their total expenditures on health care (Scheiber et al. 2012). Informal payments and balance billing are anecdotally reported to be uncommon, but this has not been confirmed by research (Scheiber et al. 2012).

4. Governance

Ghana's approach to transitioning toward a uniform national insurance system was to build on the existing system of community-based health insurance (CBHI) schemes, which proliferated from 1995. In 2003, under Act 650, most CBHI schemes transitioned into district mutual health insurance schemes (DMHISs), which maintained a level of independence by having their own governance and management structures. Until 2012 Ghana had about 145 DMHISs (some with satellite offices) that were individually registered as companies limited by guarantee. These schemes were regulated and supervised by the NHIA, which also distributed subsidies to DMHISs for exempt enrollees.

Under Act 650, the NHIA is governed by a board, which reports to the minister of health. The board includes representation of a wide range of stakeholders including the Ministry of Health (MOH), Ghana's public provider network (Ghana Health Service), private providers, insurance schemes, the National Insurance Commission, and consumers.

In 2012, the National Health Insurance Act of 2003 was replaced with the National Health Insurance Act 2012 (Act 852) which introduced governance, administrative, and operational reforms, a key part of which integrates all DMHISs into a unified NHIS creating a bigger risk pool and resolving some of the governance and administrative challenges of Act 650.

5. Financing

Since the NHIS was established in 2003, government health spending has increased in absolute and relative terms. The share of the government budget allocated to health increased from 8.7 percent to 12.1 percent between 2003 and 2010. The government now contributes around 56 percent of health financing. Of this, 28.8 percentage points is channeled through the NHIS (NHIA 2010). The share of GDP allocated to health has declined recently, however, most likely on account of the upward rebasing of GDP in 2010.

The NHIS is financed from a few main sources: 72.8 percent of NHIS revenue comes from a 2.5 percent levy added to the value-added tax (VAT); 17.4 percent from a 2.5 percentage point portion of social security contributions; 4.5 percent from premiums; and about 5.3 percent from investment income, grants, and other sources (NHIA 2012).

6. Service delivery

Ghana has a multilevel health system distributed throughout the country, with participation of the private sector comprising both faith-based nonprofit and for-profit providers. The delivery system is made up of public community-based CHPS compounds and health centers at subdistrict level, district hospitals, and regional and teaching hospitals. The private sector operates at the same levels. In the public delivery system, the country has separated policy making (the MOH) from service provision (Ghana Health Service or GHS) and decentralized health service management to district level. Private delivery of health care represents between a

third and a half of all services used and likely half or more of all out-of-pocket spending (Makinen et al. 2011). Private providers can be accredited and participate in the NHIS.

Ghana has a referral system that requires individuals to first seek care from a primary care provider, which is reinforced by the health insurance law. In practice, however, the referral system functions poorly, and there is widespread self-referral and “provider-shopping” (SEND-Ghana 2010).

Budgets for the public delivery system are formed in line with the country’s Medium-Term Expenditure Framework. Personnel costs—paid directly by the central government—consume about 54 percent of the government health budget. The remaining budget funds are allocated and managed at district level (Scheiber et al. 2012).

B. Current status of health financing

1. Fiscal space

In recent years, Ghana has experienced relatively stable macroeconomic growth, and the government used the opportunity to undertake rapid fiscal expansion between 2004 and 2008. Ghana’s GDP growth increased from 4 percent (2009) to 7.7 percent (2010). Over that period total public expenditure grew from 20 percent to 24 percent of GDP (World Bank 2011). Expansionary policies in 2004–08 contributed new resources to the health sector but almost led to a macroeconomic crisis. The stabilization program undertaken since 2009 has had effects on improving the overall health of the economy, but the gains remain fragile and the job of clearing arrears and strengthening overall public financial management is far from over (World Bank 2010).

As part of the fiscal expansion of 2004–08, the government increased expenditures for health particularly through the new resources dedicated to the NHIS. Ghana also benefited from the Highly Indebted Poor Countries (HIPC) initiative, and the health sector was allocated around 20 percent and 18 percent of poverty reduction–related funds in 2007 and 2008 (Seddoh et al. 2011). The HIPC funds were used to fund NHIS start-up costs related to establishing district health insurance schemes in all districts that did not have them in 2003 (Agyepong and Adjei 2008).

Earmarking a share of the VAT and social security contributions has been an important factor in preserving and expanding fiscal space for NHIS coverage even during the economic downturn of 2009 (Scheiber et al. 2012). Overall government spending on health increased from 0.93 percent of GDP in 2004 to 1.68 percent in 2008 (World Bank 2011).

2. Cost management and value for money

The NHIS is widely credited with increasing access to and utilization of health services (Nguyen et al. 2011; Scheiber et al. 2012). The growth in utilization and exponential increase in total claims, however, also pose challenges for cost management and sustainability of the NHIS. The average cost of total claims per member per year more than doubled between 2007 and 2009 (NHIA 2010). Expanding coverage to more poor and vulnerable households will likely spur further cost escalation.

The NHIA in consultation with providers and with the approval of the minister of health establishes provider payment systems. Act 650 specifies the provider payment methods that are permitted under the NHIS are fee for service, capitation, diagnosis-related groups, or any other payment system determined by the board. At the inception of the NHIS, the NHIA adopted an itemized fee-for-service system, paying providers for each service and each prescription. In

addition to the natural incentive of fee-for-service payment to increase utilization with no lever to contain costs, the tariffs used by different district schemes were not uniform, and inequities emerged, as different facilities were reimbursed at different rates for treating the same condition. However, over time, the NHIA has come up with standardized service and drug prices that are used by all service providers, although service prices differ for public, faith-based, and private providers to account for the government subsidies given to private (and to a lesser degree faith-based) providers.

In response to the challenges created by the itemized fee-for-service system, the NHIA implemented the Ghana Diagnosis Related Groups (G-DRG) payment system, a form of DRG, in 2008. Under the G-DRG payment system, providers are reimbursed the same fixed tariff for cases that fall into the same diagnostic category. There are about 500 G-DRGs, including bundled payment for outpatient services. The G-DRG payment system has not, however, contained costs, particularly for outpatient services, with outpatient claims now accounting for about 90 percent of total NHIS claims volume and over 70 percent of total claims costs. NHIA is piloting a capitation payment system for primary care services in one region to better manage costs among other objectives.

Pharmaceutical spending is another significant source of inefficiency and threat to the sustainability of the NHIS. Pharmaceuticals account for some 50 percent of NHIS spending. There are major issues concerning not just prices and spending, but also quality, prescribing patterns, patient expectations and medicine consumption behavior (Scheiber et al. 2012). The NHIA covers medicines based on a medicines list drawn from the essential medicines list. Until recently NHIA reimbursed providers for whatever drug charges they claimed; however, now standardized prices are in place and transparently reported on NHIA website.¹ These prices are determined from median retail prices from market surveys. This combination of policies has not, however, had much influence on the growth of NHIS claims payments for medicines, and the NHIA is exploring other options to manage drug expenditure growth.

3. Equity and redistribution

A recent study shows that Ghana's health care financing system is progressive, driven largely by the progressivity of general taxes, which make up the bulk of the revenue sources for the health sector. The national health insurance levy (which is part of the VAT) is mildly progressive. The incidence of total benefits from both public and private health service utilization, however, is pro-rich. Public sector district-level hospital inpatient care is pro-poor and benefits of primary-level health care services are relatively evenly distributed (Akazili et al. 2012).

In terms of the equity of the NHIS itself, the results are mixed. Some research has shown that the wealthy are up to 50 percent more likely to enroll in the NHIS than the poorest residents (Jehu-Appiah et al. 2011). The financial protection effect and the impact on utilization, however, tend to be greater among the poor (Scheiber et al. 2012; Nguyen et al. 2011).

The premium is considered progressive because of geographic differences (ranging between 7.20 and 48 cedis per person per year) and the wide range of premium exemptions. Exempt population groups include all seniors aged 70 and above, retirees who contributed to the social security (SNNIT) scheme, all children under 18 years of age with both parents enrolled in the NHIS, and indigents.² Act 852 has removed the requirement for both parents of children to be registered members of the NHIS for eligibility. It has also added pregnant women, persons with

¹ NHIS Medicines List. Effective October 2009. <http://www.nhis.gov.gh/?CategoryID=158&ArticleID=1096>

² An indigent is defined by law as follows: is unemployed and has no visible source of income; does not have a fixed place of residence according to standards determined by the scheme; does not live with a person who is employed and who has a fixed place of residence; and does not have any identifiable consistent support from another person.

mental disorders and categories of disabled persons determined by the minister responsible for social welfare as exempt from payment of premiums. As a result, more than 1,000 residents of two large psychiatric hospitals were recently enrolled in the NHIS.

During a review of NHIS enrollment, about 68 percent of NHIS registered beneficiaries were found exempt from paying premiums. The rest of the population is expected to pay registration fees and premiums. The exempt population groups are required to enroll, however, so many individuals entitled to fully subsidized coverage may still be uncovered by the NHIS. There also are concerns that the targeting is not specific (Scheiber et al. 2012). It is likely that there are wealthy individuals receiving fully subsidized premiums, and that poor are excluded because of the restrictive definition of indigent and subjective criteria, and lack of outreach (Seddoh et al. 2011). A common targeting mechanism to be used to identify the entitled population in all of Ghana's social assistance programs, including the NHIS indigent coverage, is being piloted in 10 districts across the country.

The premium revenue that was collected by the DMHISs was retained at the district level, and the revenue from all other sources is accumulated by the NHIA for redistribution across district schemes in the form of subsidies for exempt population groups. With the reforms introduced by Act 852, however, premiums are paid into a central pool from which payments are made to district offices based on need.

C. Current status of human resources for health (HRH) policies

Compared with other countries of similar income and health spending, Ghana does not fare too badly in its overall health worker ratios, and access to health workers has generally improved. However, distribution favors urban areas, and hospitals not clinics. Health worker density is highest in Greater Accra, Ashanti, and Volta regions, and lowest in the north.

Table 2. Current status of HRH

	Number per 1,000 population	Entry					
		Qualifications	# of course entrants per year	Number of years of education	Number of years of mandatory internship	Means of accreditation/qualification	# of newly accredited HRHs per year
Physicians	0.1	High school graduate	260	4+ years	2 years	National exam	About 7,500-8,000
Nurses	0.39	RN: high school graduate or LPN LPN: Junior-high graduate	2220	RN: 3 years+		National exam	
Midwives	0.15	High School graduate for 3 year or RN enrollee for 2 year	685	2-3 years		National exam	
Community Health Worker	Not available	N/A	N/A	N/A		N/A	

Source: Appiah-Denkyira, et al., 2012, and Ghana MOH, "Human Resources for Health Country File 2011 Edition"

The public sector employs the greatest proportion of health workers (65,000 in 2009). The MOH's health staffing has increased due to an increase in enrollment of new trainees, a result of MOH plans to improve staffing distribution and to replace forthcoming retirees, especially among some key cadres. The increase in trainees was sharp after wage reforms of 2006. Recruitment of health workers, especially physicians, remains a challenge, however, although the present situation represents a reversal of an earlier trend. The 2006 wage reforms also appear to have contributed to a decline in physicians emigrating overseas.

Despite these efforts, training of physicians remains inadequate for the country's needs, and a shortage of midwives also exists. A more egalitarian distribution exists among nurse-midwives and pre-service nurse-midwife training institutions are also more widely distributed in the country, but pre-service training for physicians is concentrated in a few cities. To rectify that, the government is setting up training grounds for physicians in regions and districts in addition to tertiary teaching hospitals.

Retention of health workers, especially in rural and remote areas and in the northern regions, remains a persistent challenge. The government has offered several incentive packages, including housing, additional allowances, and career opportunities; however, it still faces

shortages outside large cities. There is a new five-year bonding scheme with service commitments to high-priority areas in exchange for preservice support.

On another dimension, quality of care and health workers' competencies and productivity are also rated low. These are factors that deter patient access. Although absenteeism is modest, health workers' attitudes toward clients are reported to be poor and motivation low (Appiah-Denkyria, 2012). The government increased salaries to improve worker productivity but its impact remains uncertain. Many health workers appear not to be performing up to standard, particularly in rural areas, among the poor, and in the northern region.

The balance of skills mix and the choice of specialties among the newly recruited health workers will warrant further review. Most popular specialties for physicians are obstetrics, internal medicine, and surgery. The University of Ghana's School of Public Health offers preservice professional training in public health and four short courses in malaria, HIV, and epidemiology for district health officers, and management for district health officers. The security of a career ladder in public health practice at district level is unknown. In view of the growing interest toward medical specialties among new health workers, there may be a need to ensure a balanced recruitment and retention among other key health workers, including public health specialists.

D. Sequencing of reforms

The NHIS has grown out of a pilot, scale-up, and ultimate national integration of CBHI schemes. Ghana started experimenting with such schemes as far back as the early 1990s through pilot projects. It began taking serious steps toward establishing its NHIS in 2001 in fulfillment of a 2000 election campaign promise. There was a strong mandate to replace out-of-pocket fees at point of service with a more equitable and pro-poor health financing policy (Agyepong and Adjei 2008). Ghana's choice of establishing the NHIS and focusing premium subsidies on the poor was a direct result of the negative history of user fees imposed on free public health services as part of a structural adjustment program in the mid-1980s. The user fees, which became popularly known as the "cash and carry" system, led rapidly to serious financial access barriers to care. Between 1995 and 2003 health service utilization fell by 25 percent (Seddoh et al. 2011).

In 1997, the government established a task force and appointed a Director of Health Insurance within the MOH to oversee the establishment of an NHIS. The number of CBHI schemes increased from fewer than five in 1991 to 47 by 2001 and to 168 in 2003.

By 2003 when the NHIS was being designed, there did not appear to be any serious opposition to the insurance approach in general. There were, however, major disagreements on the task force established by the new government to design the scheme about the structure. In particular there were disagreements about whether the new system should build on the existing community-based and district level schemes by centralizing insurance fund and purchaser, or have multiple schemes serving different population groups (Agyepong and Adjei 2008). Also, when the time came to agree on the sources of funding, disagreements emerged from different stakeholders, such as organized labor groups opposed to channeling a portion of their social security contributions to the NHIS. In Parliament, the majority party opposed increasing taxes to fund the NHIS, and VAT in particular. The contentious issues were resolved through compromises such as exempting formal sector workers from paying NHIS premiums if they also contributed indirectly through the social security earmark to the NHIS (Agyepong and Adjei 2008).

PART II. Lessons To Be Shared

A. Current policy priorities, challenges, and opportunities

The NHIS and progress toward universal coverage are at a critical stage, as highlighted by heated debates captured by the press during Ghana's recent presidential and parliamentary elections (*Ghana Times* 2012; Afedo 2012; NPP Ghana 2012) and the conference marking the 10-year anniversary of the NHIS (NHIS 2013). The NHIS boasts many achievements and popular support, but there are also some fundamental concerns about the current design and implementation of the system.

The NHIS has been unable to reach much of the informal sector, and population coverage rates have stagnated. The inefficiencies in provider payment systems combined with a generous benefits package, high cost and overutilization of medicines, and operational inefficiencies create an ongoing threat to the scheme's viability and sustainability (Scheiber et al. 2012). The president has publicly stated that the government will critically review the efficiency in the use of health resources as it considers options for increasing funding to the NHIS to expand coverage while ensuring sustainability (NHIS 2013).

B. Lessons to be shared

Ghana has embarked on an approach to universal coverage that after 10 years offers many lessons to be shared. Although it built its national insurance system on a foundation of community-based insurance schemes, several key decisions have helped avoid the fragmentation and inequity that often comes with expanding coverage through multiple insurance schemes. It has also taken an innovative approach to financing the NHIS, creating a diversified funding base with the largest share coming from general taxation, which tends to be more progressive and equitable. Ghana's experience also shows the importance of investing in human resources for health to ensure that the supply of health services can keep up with increased demand as financial access barriers are reduced.

The country's experience also, however, provides lessons related to the challenges of reaching the informal sector with coverage that is in effect voluntary and relies on active enrollment by the individual. It is now facing the challenges created by the political compromises that are needed to get universal coverage programs off the ground, but that open the door for cost escalation in the future.

1. Avoiding fragmentation of the insurance pool

Ghana used CBHI schemes that were gaining popularity as a starting point for the NHIS, with the national health insurance law, Act 650, mandating the establishment of district mutual schemes in every district. The NHIA licenses and regulates the district mutual health insurance schemes. To avoid fragmentation and ensure equity, however, the district mutual schemes were brought together under the NHIS to follow a national policy framework, ensure cross-subsidization across the district-level schemes, and to begin to build a single purchaser. The consolidation of the pooling and purchasing functions of the NHIS has been undertaken step-by-step, which also may have helped navigate the political and technical challenges of integrating multiple schemes. Act 650 specified a system with highly decentralized management. The district mutual schemes collected the premiums from the self-paying enrollees and had wide discretion in payment to providers. The NHIA provided subsidies to the district schemes to cover exempt groups, which led to a high degree of cross-subsidization among the district schemes. The 2012 revision to the law (Act 852) further centralizes the collection of premiums at the

national level and therefore enhances pooling, and also standardizes provider payment systems and other aspects of purchasing, making the NHIA a single purchaser managing a single pool of funds.

Although fragmentation has been avoided *within* the NHIS, overall health financing remains fragmented in Ghana, since more than half of government financing continues to be channeled through supply-side subsidies.

2. Diversified funding with emphasis on general taxation

The NHIS in Ghana is funded through a diversified mix of funding sources, but almost three-quarters of the funding comes from earmarked general taxation. This earmarking of the VAT is widely considered to be a health financing innovation. The funding arrangement has the benefit of relying on a more progressive and efficient general tax, while the earmark has ensured a stable and predictable funding stream. The small share of funding for the NHIS that comes from premium contributions does, however, continue to pose a barrier to enrolling a larger share of the informal sector.

3. Investing in human resources for health to ensure the supply of services can meet increased demand

Ghana has made a concerted effort to address supply constraints and shortages of health workers, as well as to slow the out-migration of qualified medical personnel. It has invested in training, significantly increasing salaries, and incentive packages for health personnel working in rural and remote areas. As a result, trends in the health worker shortages and supply constraints in the service delivery system have begun to improve. Nonetheless, ensuring an adequate supply and distribution of health workers who have the capacity to deliver high quality services remains a challenge in the move toward universal health coverage.

4. Continuous innovations to improve expenditure management, but need for greater capacity to manage complex purchasing arrangements

When the NHIS was established, some compromises were made that built in almost inevitable cost escalation. The comprehensive benefits package with no-cost sharing combined with fee-for-service payment to providers have contributed to ongoing cost escalation and financial sustainability challenges. In fact, claims per beneficiary have increased by at least 20 percent every year since the NHIS was established. Ghana has made serious efforts to address expenditure management, particularly provider payment innovations, but these efforts are often hindered by difficult politics with health care providers and constraints in the NHIA's capacity to manage new payment systems and other strategic purchasing strategies.

The lesson from Ghana is that political compromises will have to be made to get universal coverage programs off the ground and to expand coverage. It is therefore critical to invest in the systems and capacity needed for strategic purchasing and effective provider payment systems and to constantly update the systems and approaches as experience is gained and challenges evolve.

Ghana's NHIS is at a critical juncture, and at this moment of reflection and course correction, the NHIS experience shows that the path to universal coverage is not linear. Steps have been taken, compromises made, and experience gained. The country is now at a moment of learning from this experience and making adjustments to address the pressing challenges of expanding coverage to all those entitled to subsidized coverage as well as to the informal sector, and effectively balancing revenues and expenditures to ensure financial sustainability of the NHIS.

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