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Viewpoint

When the 'non-workable ideological best' becomes the enemy of the 'imperfect but workable good'

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Summary This brief paper addresses some of the difficulties inherent in international ideological approaches to solving the complex problems of health care financing and delivery in poor countries using Ghana as an example. It concludes with an appeal for problem solving approaches involving informed debate as to optimal ways forward to solve low income country health financing woes that are open minded about possible options rather than vested in particular positions.

keywords National Health Programs, Ghana, National Health Insurance, non-US, International Cooperation

Introduction

The objective of this viewpoint is to highlight potential dangers of country and international ideologically and politically driven rather than evidence-informed debates in health sector reform in low- and middle-income countries (LMIC) and prescribing ideal solutions without factoring in a clear understanding of what is feasible in implementation given the country context. The Ghana national health insurance (NHI) scheme and the current debates around proposed reform are used as the platform.

Equitable approaches to financing health services involve some form of pooling of revenues from citizens in relation to ability to pay and payment for services in relation to need from this pool. Most wealthy countries have evolved health financing mechanisms on this principle either through tax or insurance financed health systems or a combination e.g. Canada (Evans 1992), United Kingdom (Culyer & Meads 1992), Japan (Ikegami 1992), Germany (Schulenburg 1992), Sweden and Malaysia (Savedoff 2004). They also have high quality and reasonably geographically accessible services. The combination of equitable financing and reasonable levels of service quality and availability have ensured more or less universal health coverage for their citizens. On the other hand, with a few exceptions such as Thailand (Viroj & Pongpisut 2004), many LMIC are still struggling to evolve such systems. Out of pocket fees at point of service use remain an important source of health financing in such countries despite the availability of evidence, indicating that they act as a deterrent to needed utilization especially by the poorest and may exacerbate poverty (Palmer *et al.* 2004; van Doorslaer *et al.* 2006). The difficulties that LMIC face in implementing equitable health financing mechanisms are lack of robust tax bases, low institutional capacity to effectively collect taxes and large non-formal sectors (Carrin *et al.* 2005). User fees are regressive, but as Gilson and McIntyre (2005) observe, the importance of the resources they generate for keeping health systems in poor countries viable means that they are not so easily done away with. In most low income countries, user fees tend to account for a significant share of the resources required to pay for non-personnel costs (Bitran & Giedion 2003).

After several attempts to establish democratic governance that were cut short by military coups, Ghana, a low income country, successfully established a democratic governance system with 4-year election cycles in 1992 under the fourth republic. There have been four back-to-back elections with peaceful transfer of power from government to opposition in two cases. Democratic governance and the need to return to the electorate every 4 years for a mandate to rule has meant increasing civil society awareness of the power the vote gives the electorate and increasing concerns by government to be seen by the electorate demonstrating dependability through, among

other things, fulfilment of election promises. In late 2003, the then government passed a NHI law (Republic of Ghana 2003) as part of efforts to fulfil their popular 2000 election promise to replace health service user fees introduced in the 1980s as part of World Bank supported structural adjustment programs with health insurance as a more equitable financing system. At the time private sources of financing mainly through out of pocket payments by households accounted for 61% of total health expenditure (Bitran R. & Giedion 2003), and exemptions were often not awarded despite the existence of exemptions policies (Nyonator *et al.* 1996; Garshong *et al.* 2001). The Ghana NHI is described in several publications (Atim 1999; Baltussen *et al.* 2006; Agyepong & Adjei 2008; McIntyre *et al.* 2008; Ansah *et al.* 2009; Witter & Garshong 2009), and only a summary is provided here.

The law defines a basic benefit package that covers about 80–90% of the most common clinical conditions in Ghana. It makes health insurance compulsory, and every Ghanaian is required to register with a mutual health organization. In practice, it is not possible to enforce compulsory registration because of the large non-formal sector and weak administrative capacity. The NHI scheme is funded predominantly by a central national health insurance fund (NHIF). The NHIF is about 70–75% from a Value added tax (VAT) and 20–25% from formal sector Social Security and National Insurance Trust (SSNIT) contributions. SSNIT contributions are similar to classical social health insurance funds with employer and employee contributions proportional to income (Boateng 2008). A small additional amount of NHI financing (estimated at 5% or less) comes from annual non-formal sector premiums, non-SSNIT contributors pay out of pocket and the registration fee paid by all subscribers. VAT in theory is not as progressive as an income tax. However, as designed and implemented in the Ghanaian context with a wide range of exemptions on basic consumption goods, the poor are less affected by the tax, and it is quite progressive (Shield 2010; Prichard & Bentum 2009). Enrolment in NHI nationwide has increased with holders of valid insurance ID cards rising from 6% of the population in 2005, to 20% in 2006 and 42% in 2007 (Boateng 2008). Along with its success, there have also been administrative and management challenges such as delays in issue of ID cards. There have also been repeated instances of accumulated unpaid provider bills with the 2008 external review of the health sector estimating that nationwide, about GH¢49 000 000.00 (US$ 49 000 000.00), equal to 3–4 months of Internally Generated Funds (IGF) was owed providers (MOH 2009). Research findings also show that the poorer income quintiles are enrolling less (Asante & Aikins 2007). Within Ghana, NHI remains a major topic of national concern to civil society, the media, politicians and bureaucrats. Internationally, organizations active in Ghana have also taken a keen interest. The World Bank, in particular, appears to be increasingly promoting Ghana's NHI as successful World Bank supported reforms that are a model for other LMIC, in a way that is sometimes perceived as rather prescriptive.

In December 2008, the government that introduced NHI lost the elections to the opposition. One of the 2008 election campaign promises of the government that took over power in January 2009 was to replace the non-SSNIT non-formal sector annual contributions with a 'one-time premium' as a way of rapidly attaining universal coverage. This effectively translates into a promise to move the country closer to a purely tax financed system. There has been some public, health sector bureaucratic as well as political debate in Ghana as to whether this election promise is feasible for immediate implementation. Recently, Oxfam publically weighed into the debate in support of the immediate implementation of the 'one-time premium' promise with its online publication (Oxfam 2010) labelled as part of efforts 'to promote discussion and evidence-based debate on health care financing and delivery in poor countries'. The Oxfam publication also suggests that the World Bank has been trying to discourage government from implementing the promise. The World Bank has not publically commented on the issue. Despite the fact that over the last few years it has actively championed and promoted the Ghana NHI reforms for other LMIC with a sometimes prescriptive tendency, it is not accurate to imply as the Oxfam publication does that Ghana's NHI has been heavily financed by World Bank loans and largely shaped by its technical advice. At the beginning of the reform process, some development agencies active in Ghana, of which the IMF and World Bank were part, were sceptical and not engaged. It was Ghanaians that crafted and championed the policy and program. The Ghana National Health Insurance Scheme (NHIS) is essentially a home grown system (Agyepong & Adjei 2008). The World Bank became involved with loans, grants and technical advice after the reform had been initiated and appeared to be succeeding.

It is a pity that out of its struggle to resolve its challenging problems, Ghana seems to have become to some extent the latest ideological battleground for international organizations that, no matter how well meaning are sometimes more focused on the theory of the particular ideological leaning of their organization than on how theory will work out within the actual low income country context, actors and processes that will be involved in the translation of theory and ideology into implementation. Such debates tend to conceptualize truth in simple black

and white. Truth is sometimes a complicated full colour picture.

On the ideological battlefield, arguments and debates can be consumed by whether the glass is 'half full' or 'half empty' – when paradoxically there are elements of truth in both perspectives. Worse still, it may not even matter whether the glass is described as half full or half empty. The more pressing question might be whether the fluid in the glass is water and can quench thirst or the thirsty should look elsewhere. There are good things and not so good things about Ghana's NHIS from which much can be learned. However, in our opinion, neither Ghana's NHIS nor any other reform or, worse still, untested ideas should be pushed prescriptively for others. Rather countries should be encouraged to critically learn from each other, but to develop what will work for them within their context.

In the paper by Oxfam, Ghana is urged to rapidly implement the election promise of a 'one-time premium' because it is progressive. But is the solution to Ghana's challenges as simple as that? Ghana has an estimated GNI per capita (Atlas method) of US$ 630 (World Bank 2010); per capita health expenditure of approximately US$ 23; and infrastructure and human resource shortages with one doctor to 13 500 and one nurse to 1350 people (MOH 2009). The increased utilization that has accompanied the rapidly rising insurance coverage over the last few years with no corresponding increase in infrastructure, human resource, equipment tools and supplies is increasingly stretching the limited health sector infrastructure, human and other resources to their limits (SEND Ghana 2010). Any way towards universal health coverage and financial protection for its citizens needs to raise new money to replace current out of pocket payments and also expand service access and quality. Without further funding to guarantee the infrastructure, tools, equipment, supplies and human resource needs of all residents of Ghana and to improve management and administrative capacity of the NHI as well as the health sector in general, it is not clear that simply removing annual premiums will guarantee universal coverage.

Oxfam suggests the reform can be performed by increased tax revenue, which is a good suggestion if given its current economic situation Ghana can immediately raise adequate taxes to guarantee services are equitably available across Ghana and of sufficient quality. If Ghana is in the position to raise enough revenue for a health system that attains universal coverage through tax funding, we would actually go further and suggest that there should not be a premium of any sort, one-time or annually. A realistic one-time premium contribution is likely to be beyond the reach of the poorest. An unrealistic one leaves the potential financing gap problem unaddressed. The question is, practically, where is the money to come from? Future projected oil revenue following Ghana's recent oil find will help in the long term, but will that make up the deficit in the short to medium term? Given the already mentioned fact that VAT as implemented in Ghana has been documented to be reasonably progressive, further raising VAT from the current 15% would also provide more tax revenue. It is not clear, however, how politically acceptable this will be in a country, where there are already consumer complaints and discontent over 'too high prices'. In calling for the immediate and urgent implementation of the one-time premium promise, it is not clear that Oxfam has taken a critical look at Ghana's immediate economic situation and tax-generating ability in relation to its needs. We tend to agree with OXFAM that purely tax-based financing is a good way of attaining universal financial protection for citizens, but only if a country can afford it. Advocates of the one-time payment justify it with the fact that the non-SSNIT contributors' premiums form only 5% of the NHIF. It can be easily done away with. However, even though small, it needs to be replaced given Ghana's current health financing challenges. Under the one-time premium proposal, SSNIT contributors' classical social health insurance premiums taken from pension contributions of workers and that form 20–25% of the NHIF would continue. So far, organized labour has not raised any objection to this. However, this deduction was a major bone of contention between organized labour and government in 2003 when the current NHI bill was first laid before parliament. Government had to repeatedly promise that the deductions would not affect pension benefits that were already perceived as too low (Agyepong & Adjei 2008; Wahab 2008). Ghana tried a purely tax funded health system immediately after independence. It was abandoned not because anyone thought the idea was bad in and of itself but because the Government of Ghana could not mobilize enough tax revenue to pay the bills. Will history repeat itself if she once more rushes into a system without carefully addressing issues of the ability to pay?

Oxfam also proposes that extensive exemptions should be put in place to protect the poor. The Ghana health care system has had extensive exemptions since user fees were first introduced. There have been user fee exemptions for the 'indigent', children under five, pregnant women, the elderly, selected diseases, etc. They have all failed to work properly for reasons that are a story in themselves (Bosu *et al.* 2004; Garshong *et al.* 2001; MOH 2006; Witter & Adjei 2007; Witter *et al.* 2007; Agyepong & Nagai 2007). Exemptions have not only failed in implementation in Ghana but also in several other low income countries where they have been tried (Kivumbi & Kintu 2002;

Mubyazi 2004; Bitran & Giedion 2002). Because of built in exemptions, over 50% of those on the NHIS, mainly children under 18, the elderly, indigent and pregnant women, are non-paying. If the circumstances that caused the failure of past and present exemptions to work still exist, what is new about 'extensive exemptions'?

Oxfam is right – all the data from Ghana shows the higher income quintiles are enrolling disproportionately more than the lower in the NHIS (Ansah *et al.* 2009; Asante & Aikins 2007). However the issues are complex and will not be solved by waiving the fees only. Apart from the ability of the poor to pay, there are also problems of the access of the poor – geographic as well as socio-cultural; and the quality of service available (SHIELD Information Sheet 2010). They are related to the critical fact that the health system is heavily under-funded, short of human resources, infrastructure, tools, equipment and supplies. Any financing arrangements that do not provide more funding to expand access and quality in an equitable manner are likely to continue to struggle with the complex problems that exclude the poor. A free item of extremely poor quality and limited supply can be as bad as not having the item.

Ghana's health financing problems, like that of many other low income countries cannot be solved by confusing ideological and politically motivated suggestions for resolution with practically effective solutions. There is some wooliness about the how and the practicability of implementation of ideas to solve these problems. And yet, implementation is the rock on which many brilliant ideas and theories have foundered and continue to founder. We cannot afford to be woolly. No matter how theoretically sound a recommendation is in abstract – it is fairly useless if it is not practically feasible in the context where the problem needs to be solved. Under different contextual circumstances, such as better economic growth and a stronger economy, a broader tax base with capacity to adequately mobilize income taxes and a bigger tax pool from which to finance the health sector as well as better health sector administrative and organizational capacity, infrastructure, human and other resources; the tax funded system concept behind the "one time premium" idea could be immediately implemented. In abstract it is not a bad idea per see as way of attaining universal coverage. In the context of the current reality of Ghana, its time has probably not yet come. It needs to be carefully worked towards rather than immediately implemented.

In conclusion we want to make an appeal for problem solving approaches involving informed debate as to optimal ways forward to solve Ghana and other low income country health financing woes that are open minded about possible options rather than vested in particular positions. If they are serious about helping low income countries, we would appeal to would be international benefactors to stop prescribing ideological positions and work with countries to find workable solutions appropriate to the context and circumstances. Or, of course it may be that they come up for other interests and hidden agendas where the targeted country is merely a battlefield for ideological battles."

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