

Repackaging exemptions under National Health Insurance in Ghana: how can access to care for the poor be improved?

Emmanuel Kanchebe Derbile^{1*} and Sjaak van der Geest²

¹Department of Planning and Management, Faculty of Planning and Land Management, University for Development Studies, Wa, Ghana and ²Medical Anthropology Unit, University of Amsterdam, Amsterdam, The Netherlands

*Corresponding author. Department of Planning and Management, Faculty of Planning and Land Management, University for Development Studies, P. O. Box 520, Wa Campus, Wa, Upper West Region, Ghana. Tel: +233 24 4516896. E-mail: derbile_uds@hotmail.com

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For the past 10 years the Ghana Government has been trying to replace the old user fee system with an overall health insurance scheme, but one problem of the old system continues to bedevil the new policy: exemption of the poor. This paper presents data from empirical fieldwork and also puts forward an opinion. It discusses how past experiences of user fee exemptions for the poor can inform exemptions under the new 'National Health Insurance Scheme' (NHIS) as a means to ensuring equity in health care. Drawing on a study of exemptions in the three regions of northern Ghana, and utilizing both qualitative and quantitative methods and data, the findings show that exemptions were applied in favour of under-fives, antenatal care, the aged and public servants to the disadvantage of the poor. As a result, the poor had very little access to exemptions. Exemptions therefore failed to address equity concerns in health care, the very reason for which they were introduced. Thus, although the paper acknowledges that provision for the enrolment of the poor into the NHIS is a step in the right direction, it underscores that effective enrolment will be essential for attaining the equity goal of the policy. Informed by past experiences that undermined the equity goal of exemptions, three policy recommendations are put forward for improving exemptions for the poor under the NHIS. These are: (1) effective community education for enhancing premium paying enrolments into the NHIS alongside education on exemptions for the poor; (2) reviewing and clarifying policy guidelines for guiding local-level identification of the poor based on communities' own understanding of poverty; and (3) providing the requisite resources to enable the Department of Social Welfare to discharge its core mandate of identifying the poor for exemptions.

Keywords National health insurance, exemptions, poor, user fees, Ghana

KEY MESSAGES

- Difficulties in identifying the poor and administrative inefficiencies account for inequity in the application of exemptions in the Ghanaian National Health Insurance Scheme (NHIS).
- While the NHIS makes provision for exemption of the poor, effective enrolment is essential for addressing systemic problems that affect exemptions for the poor.
- Informed by experiences of exemptions in the user fee era, additional measures needed to improve exemptions for the poor under the NHIS include effective community education, clarifying and contextualizing guidelines on identification of the poor, and sufficiently resourcing the Department of Social Welfare to enable identification of the poor.

Introduction

Following the introduction of cost sharing as part of health sector reforms in Ghana, user fee exemptions were introduced for vulnerable groups as part of an overall effort to address equity in public health care delivery. Since parliamentary enactment of the Hospital Fees Act 1971 introducing user charges (Shaw and Griffin 1995; Coleman 1997), exemptions have been part of Ghana's health care system and have changed in various forms through successive governments. However, the history of exemptions dates back to the 1960s under Nkrumah's Socialist Government that sought to provide free health care to the populace after independence under a regime of insignificant fees (Senah 1989). As part of health sector financing reforms, the Government of Ghana passed the National Health Insurance Law in 2003, which integrated the existing District Mutual Health Insurance Schemes with new ones set up in districts that did not already have them to form the National Health Insurance Scheme (NHIS). This gave rise to a new era of exemptions in which the poor and vulnerable were to be enrolled in the NHIS free of charge, thus replacing the user-fee exemption regime. This policy shift was not preceded by adequate conceptualization of how to deal with exemptions for vulnerable groups or the poor under the NHIS. Due to this inadequacy, there was a risk that the poor would be excluded from voluntary social insurance (Kunfaa 1996; Arhinful 2003). Thus, the shift in policy to an 'insurance-based system of exemptions' gives rise to outstanding questions on how to address equity concerns that the former exemption regime failed to adequately deal with.

This paper discusses how exemptions for the poor can be effectively applied under the NHIS drawing on lessons from the preceding user fees exemptions regime (cash and carry period) in Ghana. The paper is organized in five parts. In the first part, we describe the evolution of health insurance in Ghana. In the second, we examine the transition from a user fee exemptions era to an insurance-based exemption era. In part three, we discuss problems arising from the application of exemptions for the poor in the cash and carry period, drawing on an empirical study. Based on the past exemption experiences, we then discuss policy recommendations for improving the execution of exemptions for the poor under the NHIS, before finally concluding in part five.

Methodology

The paper draws on an empirical study on exemptions in 2006 involving 18 communities across the three regions of northern Ghana comprising Upper West Region (UWR), Upper East Region (UER) and Northern Region (NR). Study communities were selected through a combination of stratified and simple random sampling techniques. Stratification took into account the need to have a balance in the sample between communities providing different levels of health care services at the regional level. Three levels were considered: hospital services, health centre services and services of community clinics. Simple random sampling was then applied for the selection of study communities from each stratum and this resulted in a sample that included three urban hospital communities, six health

centre communities, five clinic communities and four non-health-facility communities.

The study led to an unpublished final research report (Derbile *et al.* 2007), from which this paper draws for empirical data and analysis. The study employed both qualitative and quantitative methods for data collection and analysis. The qualitative methods included focus group discussions and in-depth interviews while the quantitative method involved a survey. These two methods were complemented by review of secondary data and literature.

In each study community, opinion leaders, both men and women, were purposively sampled for separate focus group discussions. The male discussants, six on average per session, were drawn from the council of elders of chiefs because we assumed their role in governance made them knowledgeable about public health care services. Similarly, female discussants, seven on average per session, were drawn from leaderships of women's groups existing in the communities because their leadership roles also presumably made them knowledgeable about same subject. For the survey, 538 randomly sampled household heads and spouses were interviewed with the aid of an interview schedule across all study communities. Systematic random sampling was applied. At the institutional level, 32 health workers, including health administrators (9), medical doctors (4), medical assistants (4), nurses (9) and pharmacists/ or dispensing technicians (5) were sampled for in-depth interviews at facility levels. These were sampled purposively because they were knowledgeable about the subject of exemptions given the roles they play in executing exemptions at the institutional level. In addition, official files and documentation on exemptions were reviewed from health facilities.

All these methods were further complemented by a review of literature on policy issues and also the problems that confronted exemptions in the user-fee era. Although this paper contributes to understanding the same, it takes the discourse further, contributing to how experiences, empirical to this study, can better inform policy for improving the implementation of exemptions for the poor under national health insurance.

Health insurance in Ghana

Health insurance in Ghana is still going through its 'evolutionary' stage following earlier district pilot schemes undertaken by both government and non-governmental organizations in the 1990s. Non-governmental organizations generally played the pioneering role in piloting health insurance in Ghana. The Nkoranza Community Health Insurance Scheme, a provider-based scheme started in 1992, and the West Gonja District Health Insurance Scheme, set up in 1995, are examples of such pioneering schemes. Aside from these, there were NHIS pilot schemes in four districts of the Eastern Region. These include the Suhum Kraboa Coaltar, New Juaben, Birim South and Kwahu South districts (Arhinful 2003). Following these initial efforts, the Parliament of Ghana passed a National Health Insurance Bill on 26 August 2003 to commence a nationwide implementation of District Health Insurance Schemes (DHIS) (Badasu 2004). Since the enactment of the National Health Insurance Act in 2003 (Act 650), efforts at health insurance

have shifted from DHIS towards harmonizing all district schemes into a national health insurance policy framework, the NHIS. Although the NHIS is still in its early stages, many challenges are adversely affecting its implementation. Problems include the high cost of medical care placing a financial burden on the scheme.

Another problem is poor voluntary enlistments, especially in rural Ghana. For instance, the NHIS subscription rate is 38% in rural Asante-Akim North district (Sarpong *et al.* 2010). According to Kunfaa (1996), enlistment modalities at the early stages of health insurance in Ghana did not adequately address how a majority of the people in the informal sector and rural population in particular should be enlisted. The issue of poor enrolment in Ghana's NHIS remains unresolved. Recent research about health insurance enrolment in the Central and Eastern Regions in southern Ghana (Aryeetey *et al.* 2010; Jehu-Appiah *et al.* 2010; Jehu-Appiah *et al.* 2011a; Jehu-Appiah *et al.* 2011b; Kotoh, n.d.) highlight the complexity of the obstacles to enrolment of poor people. At the time of writing this article, the minimal cost of enrolment—per person, per year—was the equivalent of US\$10 plus US\$1.5 for registration. The percentage of households that were actually enrolled varied from 11% to 57% across districts in the two regions. The average was 30%. The reason for such wide variation in enrolment figures is not entirely clear; it is probably mostly related to the quality of local health care and the attitude of nurses and doctors. One of the three most common reasons for non-enrolment mentioned by respondents in recent research was 'No money', which according to the researcher was probably 'a convenient excuse to escape from being accused of irresponsible behaviour' (Kotoh, n.d.). Most respondents who complained of lack of money could probably afford the payment of US\$11.5, which is the approximate equivalent of half a piece of women's cloth. Which people in the community are really unable to pay the amount is difficult to say.

Pervasive poverty is a factor that presumably affects the ability to pay premiums in northern Ghana. In the northern half of the country comprising the UER, UWR and NR, 68% of the population live in poverty compared with the national average of 28.5%, so the northern–southern divide seems more important than the rural–urban divide in the analysis of national poverty (Coulombe and Wodon 2007). Thus, equity in access to health care is still far from being addressed singularly through the NHIS. Exemptions can make up for equity-related limitations of the NHIS and are justifiably important under NHIS in Ghana. In Nigeria, there is similar advocacy for subsidies and exemptions to improve health care for the poorest under community-based health insurance schemes (CBHIs) (Onwujekwe *et al.* 2010).

As a departure from a 'normal' insurance system, increased membership does not bring increased income from premia in the NHIS in Ghana. According to the CEO in 2008, about 90–95% of the income comes from Social Security and National Insurance Trust (SSNIT) and the Value Added Tax (VAT) levy, so that the bulk of its income will grow with national income rather than membership numbers (Witter and Garshong 2009). Additional sources of funds for the NHIS include: 2.5% National Health Insurance Levy on VAT; 2.5% of public sector workers pension contributions to the SSNIT; premium and

registration fees largely from the informal sector; and interest on funds from investments and other sources. In 2008 for instance, 69.5% of the income of the NHIS came from the health insurance levy. The remaining sources contributed to NHIS income as follows: SSNIT 23.2%; insurance premium 5.1%; and investment income 2.2% (Results for Development Institute, n.d.).

From user fee exemptions to insurance-based exemptions

User fee exemptions have been part of various packages for promoting equity in Ghana's health delivery system since the 1960s. Four distinctive eras of exemptions are discernible. The first concession on exemptions was an almost free health care policy granted to the major part of the populace in 1962 under Nkrumah's socialist government (Senah 1989). The second era of exemptions came into being after the overthrow of Nkrumah's government in 1966. Under 1971 Legislative Instrument (LI) 701, the Busia government exempted clients who attended rural health centres and posts from the payment of user fees.

The third era of exemptions was introduced by the Provisional National Defence Council (PNDC) government in 1985. Under LI 1313 of the 1985 Hospital Fees Regulation, the government made two categories of exemptions. The first was disease category: patients suffering from leprosy or tuberculosis and other special diseases were exempted from the payment of all fees. The client category of this exemption package provided free medical care for antenatal and post-natal services, health service personnel and trainees, and treatment at child welfare clinics. In a presidential address in 1997 the Government of Ghana in a renewed effort extended the exemption policy as stated in LI 1313 to include antenatal care, those aged 70 years and above, and children under 5 years (Government of Ghana 1999). Later, the exemption of the poor was included. Guidelines and budgets were prepared and issued to public health institutions in October 1997 for implementation of the policy (*ibid.*). Thus, exemptions in the third era occurred during the user-fee or cash-and-carry period until 2003 when the NHIS was instituted as the new policy framework for health financing in Ghana. This set the agenda for the fourth era of exemptions, an era characterized by a migration of exemptions from the user fee era to the NHIS era.

We shall now turn our attention to discussing the problems of exemptions for the poor drawing on empirical findings from our study on the past user fee period, the third era.

Problems arising from implementing exemptions for the poor in the past

The study revealed a wide range of problems that affected implementation of exemptions in the user fee era. These include low awareness of exemptions, particularly exemptions for the poor; difficulty in identifying the poor; extremely low exemptions and expenditures for the poor compared with other categories of exemptions; abuse by health workers; and

shortage of drugs, but also perceptions of poor quality drugs associated with exemptions.

Although exemptions at public health institutions had been implemented for some time, the study revealed low public awareness of exemptions for the poor vs high awareness of other exemption categories. From the survey on exemptions, 61% of respondents did not know about exemptions for the poor, while a higher percentage knew about antenatal exemptions (84%), under-fives exemptions (79%) and exemptions for the aged (62%). From the 39% who did know about exemptions for the poor, a majority did not know the modalities for accessing exemptions.

Similar limited public awareness of specific categories of exemptions has been observed by others (Garshong *et al.* 2002; Aikins and Arhinful 2005). In the Volta Region for instance, people generally lacked knowledge or did not believe that exemptions were granted at health facilities (Nyonator *et al.* 1994). No patient interviewed at the Volta regional hospital in Ho knew of exemptions for the poor (Ten Asbroek 1992). The causes of lack of public awareness are hardly addressed in the literature, however. Imbalances in knowledge about the specific categories of exemptions may be partly due to institutional factors and the nature of public education on exemptions. Since the initial education on exemptions, there seems to have been a lack of critical evaluation of knowledge on exemptions, and hence, waning interest among service providers to pursue public education further. Secondly, impressive demands for under-fives and antenatal exemptions placed a heavy financial burden on the health care system and probably served as a disincentive for further exemptions education.

The findings also reveal that service providers faced difficulties in identifying the poor for exemptions. While the guidelines for identifying under-fives, the aged and antenatal exemptions were straightforward and easy to deal with, those for identifying the poor lacked clarity for operational purposes. The guidelines stipulated that any person who claimed he or she could not pay for health care and who in the opinion of the clinician spoke the truth should be granted exemption (Government of Ghana 1999). Although clinicians were allowed by the guidelines to identify poor clients, the task of identifying the poor was vested in social workers affiliated to the Department of Social Welfare. Social workers were expected to reach such decisions after social and economic assessments of the individuals in question. However, most health facilities with responsibilities for exemptions either had no social workers or at best one (in the case of a hospital). Nyonator *et al.* (1994) found that health facilities in the Volta Region of Ghana also lacked social workers to support identification of the poor. The low staff and logistical capacity of the Department of Social Welfare at the district level meant that no support in determining poverty status was forthcoming to health service providers. Hence, health service institutions were generally less inclined to grant exemptions for the poor. Only in cases where it was easy for service providers to identify the 'poor', did they grant exemptions, for instance to orphans, mentally retarded patients and in some cases prisoners. These cases did not have significant statistical relevance but their occurrence revealed that where the characteristics of the poor were easily verifiable, service providers granted exemption.

At a lower level of care, taking the Kassena-Nankana East Health Centre as an example, orphans from the Sirigu Orphanage were on record as having been granted exemptions as poor people, one of the rare cases in which such exemptions were granted at that level.

In cases where inpatients absconded from wards without settling bills, some service providers 'reclassified' them as exemptions for the poor for easy recovery of costs. According to Nyonator *et al.* (1994), facility managers in the Volta Region also granted exemptions for the poor simply to waive bad debts. This corroborates findings that identification of the poor and aged in exemptions has been challenging to service providers in the country (Nyonator and Kutzin 1999; Garshong *et al.* 2002). They indicate that unclear guidelines, varied institutional interpretation of the policy, lack of documentation or comprehensive database systems on potential clients and lack of adequate social workers aggravated administrative difficulties for granting exemptions to the poor.

Results also showed that exemptions for the poor were very low relative to exemptions for under-fives, the aged, antenatal clients and even health personnel and civil servants in terms of numbers. For instance, annual exemption records at the St. Joseph's District Hospital, Jirapa, from 2001 to 2004 showed that, while antenatal and under-fives exemptions ranged from 24% to 53%, the aged from 23% to 29%, those for the poor ranged from 0.4% to 1%. Figure 1 shows a comparative analysis of exemptions between the poor and the aged, health personnel and civil servants.

From the analysis, exemptions have generally been skewed in favour even of public servants to the disadvantage of the poor. While annual exemption records for the poor ranged from 80 to 107 cases between 2001 and 2004, those for health personnel ranged from 1126 to 1571 cases between 2001 and 2003. Thus, exemptions for the poor were rare. In 1992, 3 out of 5192 admitted patients in the Ho Regional Hospital benefited from exemptions for the poor, although some patients had difficulty or were unable to pay fees leading to lack of full treatment (Ten Asbroek 1992). Some facility managers saw exemptions as income loss that threatened the viability of the revolving fund for drugs.

As a corollary, the wide disparities in numbers of exemptions between the poor and other categories of exemptions are also reflected in the cost of exemptions. The comparative analysis of total costs of exemptions for St. Joseph's Hospital, Jirapa, for the four categories of exemptions show that expenditure (costs) of exemptions for the poor was extremely low compared with other exemptions (Figure 2).

The occurrence of such disparities in an area of endemic poverty raises intriguing questions and corroborates the assertion that the poor had extremely limited access to exemptions (cf., Adams *et al.* 2002). Service providers attribute imbalances in exemptions funding to administrative challenges they face in identifying the poor. For instance, poverty alleviation funds were allocated through District Assemblies to District Health Management Teams for funding exemptions for the poor. However, in some cases, such allocations were paid back to government because of the lack of administrative capacity to utilize the funds before the financial year ended. Health administrators suggested that while government had shifted

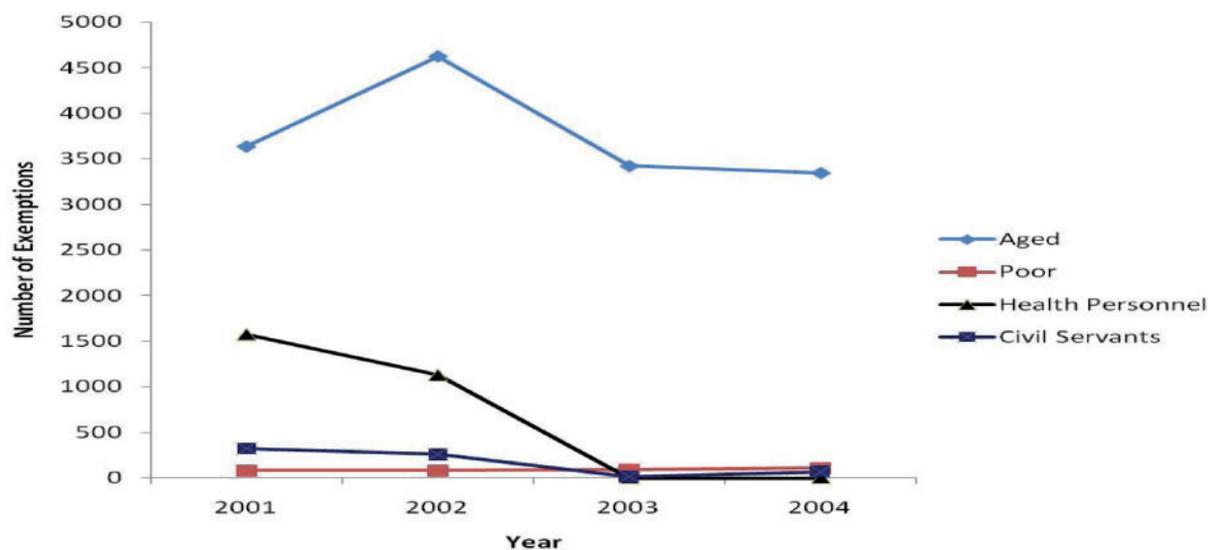


Figure 1 Comparison of exemptions at St. Joseph's Hospital, Jirapa, Ghana, 2001–2004

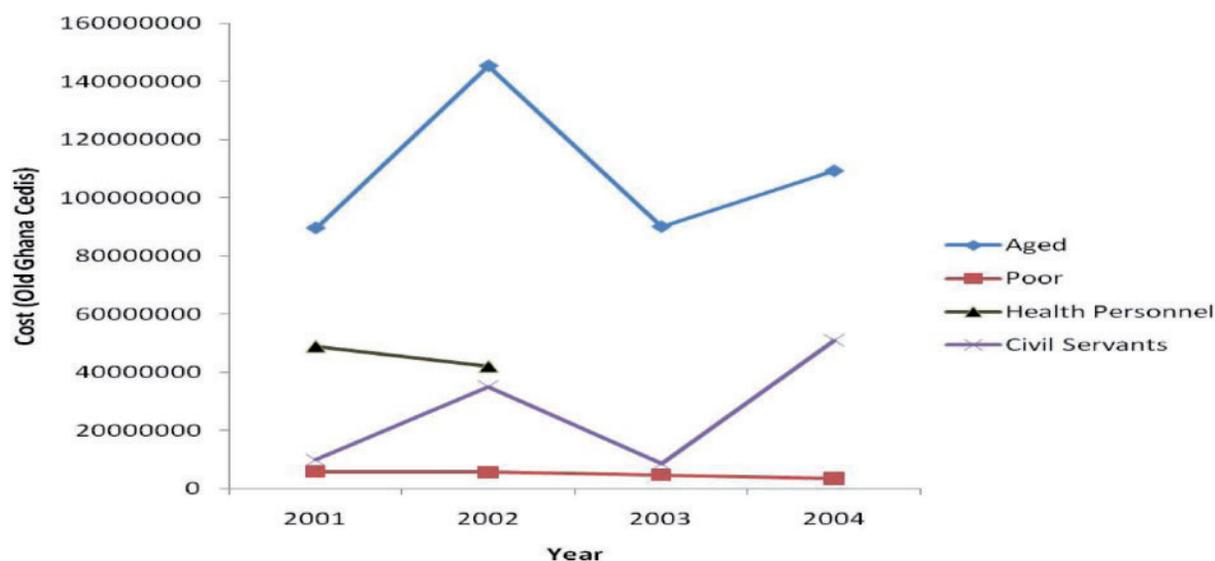


Figure 2 Cost of exemptions for St. Joseph's Hospital, Jirapa, Ghana, 2001–2004

the burden of granting exemptions to them, this had not been backed by the requisite administrative capacity for identifying the poor or by efficiency in national resource allocation. Public spending was neither equitable nor efficient because it subsidized those that had greater ability to pay and those who paid more for health services (Government of Ghana 1999). McIntyre (2003) shows that the three most deprived regions (Northern, Upper East and Upper West) received less exemption reimbursement funds per poor person than the national average, while four of the least deprived regions (Greater Accra, Western, Volta and Ashanti) received considerably more than the national average per poor person. Thus, according to Kotoh (n.d.), politicians made unrealistic campaign promises about exemptions for the poor when it was virtually impossible to provide free health insurance to the

almost one-third of Ghana's population which, according to the Ghana Statistical Service (2007), live below the poverty line.

Furthermore, communities held the view that health personnel abused exemptible clients, particularly the poor, when they sought health care at the facility levels. Focus group discussants generally agreed that service providers were unfriendly, disrespectful, shouted at clients and made embarrassing remarks about them. This behaviour accordingly made them feel uncomfortable and unwelcome at health facilities. Such perceptions were widespread among communities, and whether true or untrue, they adversely affected exemptions for the poor. While many health workers agreed that some of them were rude to their clients, others held different views about this. First, some believed that incidences of rude behaviour by health personnel were isolated cases. Secondly, to others exemptions

gave rise to abuses by some clients, such as unnecessary re-attendance, and efforts to curb these behaviours were interpreted by clients as unfriendly attitudes. Given the divergent views, the best interpretation is probably that there is a clash of two different ‘cultures’ with varying orientations involving ‘rural service consumers’ on one hand and ‘elitist health personnel’ on the other hand.

This clash of cultures gave rise to what Andersen (2004) describes as differential treatment of patients. From a study of interactions between patients and health workers in the Bolgatanga Hospital, Ghana, Andersen concluded that health workers divided patients into elite and ‘villagers’. The elite were the educated whom health workers identified themselves with. The ‘villagers’ were the low-educated and those less enlightened about urban life. Health workers generally favoured those patients who were educated, rich and influential, and paid less attention to poor, uneducated patients, who were considered as having low social status. Thus, differential treatment referred to the way that hospital staff distinguished between those patients they favoured and provided with good care, and patients they neglected and looked down upon (Andersen 2004). The wide gap between exemptions for the poor and civil servants at St. Joseph’s Hospital, Jirapa (Figure 1) reflects a similar pattern of favouritism. On a broader scale, differential treatment of patients is a barrier to equity in health care in Africa (Andersen 2004).

Finally, the results also showed that shortage of drugs and perceptions of inferior drugs associated with exemptions adversely affected implementation of the policy. Since a chunk of the exemption resources at facility levels went to support other categories of exemptions, cumbersome and delayed government reimbursements generally affected the availability of drugs at dispensaries. This affected exemptions for the poor as well. For instance, costs of exemptions for health personnel and their dependants accounted for de-capitalization of the revolving drug fund in the Volta Region of Ghana (Nyanator *et al.* 1994). The evidence from our study revealed that partial and non-fee exemptions for exemptible drugs were common among eligible clients due to non-availability of drugs at dispensaries. In many instances, clients eligible for exemption paid for exemptible drugs from private shops due to the shortage of drugs. From the survey, 33% of clients who were granted exemptions as poor people indeed paid for drugs either from dispensaries or private drug shops because of drug shortages at public health facilities. A discussant highlighted the non-availability of drugs at public health institutions during a focus group discussion:

“I worked as a public servant until I retired at age 60, 14 years ago. I am now 73 years old but I am not keen about seeking health care under exemptions. If you go to the health centre or hospital hoping to enjoy exemption, the health workers ask you to go and buy drugs from the chemical shops. So which is better? To go and buy drugs from the chemical shop right away yourself or to go to the health centre to be told to buy drugs from the chemical shop? I always buy my drugs right away from the chemical seller.”

Nyanator and Kutzin (1999) report similar experiences in which clients eligible for exemptions paid fees for health care in

the Volta Region. According to Garshong *et al.* (2002), almost half the clients interviewed in a national study who were eligible for exemption had in fact paid for the services. The study also revealed that community perceptions strongly associated poor quality drugs with exemptions. This issue is also captured in the contribution of a discussant during focus group discussions:

“I think health workers deceive us about this policy of exemptions. They tell us these exemptions are operational but when you visit the health centre and seek exemption, the drugs that you receive are only paracetamol and quinine. Why is this always the case? Are these the only drugs available at the health centre? Drugs that are more effective are not offered under exemption simply because their costs are higher than the ones they easily dish out under exemption.”

Although the implementation of exemptions improved access to health care, the empirical discussions clearly show that numerous challenges undermined smooth implementation of the policy. These issues as discussed corroborate the wide range of literature that asserts that exemptions did not function effectively due to problems of implementation (Government of Ghana 1999; Nyanator and Kutzin 1999; Garshong *et al.* 2002; Aikins and Arhinful 2005). Drawing on the literature, a synthesis of the issues that affected exemptions in the user fee era since 1999 included: a lack of common understanding of the policy itself; broad targeting and associated inequities; lack of adequate funding; and administrative challenges (Box 1). These factors adversely affected the implementation of exemptions and undermined the equity goal of the policy. The poor were the most affected by problems of implementation.

From the empirical results and discussions, many factors affected the implementation of exemptions in the user fee era, thus undermining the equity goal of the policy. One of the key findings was that exemptions were applied in favour of other categories of exemptions to the disadvantage of exemptions for the poor. In the next section, we discuss how experiences from the past exemption era as discussed can inform policy for improving exemptions in the fourth era, the NHIS era.

Improving exemptions for the poor under the NHIS

The Government of Ghana has decided to continue with exemptions under the NHIS to address equity in health care. Under the NHIS, there are two exemptible groups. These include direct and indirect exemptions. The direct exemptions cover the aged and the poor. Exemptions for this group are funded from an exemption fund for the poor and vulnerable. The indirect exemptions cover children under 18 years old, who are covered by the insurance of their parents (Aikins and Arhinful 2005).

In general, it is clearly justifiable that the poor be enrolled into the NHIS as an equity measure, but effective enrolment will be essential for addressing some of the systemic problems that affected exemptions in the past. According to Witter and Garshong (2009: 5), enrolment of the poor under the NHIS fell from 4% of the population in 2005 to 1% in 2008; this is clearly

Box 1 Issues arising from implementing exemptions

- Lack of common understanding among service providers about the exemption policy (who is exempted and for which specific services), thus leading to different interpretation of the policy and variation in institutional data-keeping.
- Waning political commitment to funding and cumbersome government system of refund which often leads to long waits by service providers for reimbursement of exemption costs and in some cases under-refunds.
- A growing number of health facilities were no longer providing fee exemptions at some points in time, except in special circumstances owing to funding problems.
- Exemptions were skewed in favour of under-fives, pregnant women and the elderly to the detriment of the poor.
- Service providers have demonstrated more interest in sustaining services than in providing exemptions.
- Limited public awareness about specific categories of exemptions; even for those who know, fear of confrontation with service providers is a disincentive for insisting on right to exemptions.
- Difficulties in identifying the poor and aged-based identifications relative to identification of pregnant women. The difficulty in determining ages relating to illiterate beneficiaries.
- Exemptions were not linked to geographical targeting of the core poor nor categories of exemptions at the regional and district levels.
- Stigmatization potentially served as a deterrent to exemptions by the poor.
- Fear of high cost of treatment combined with low awareness of exemption among sections of the population that potentially deterred access to exemptions.
- Clients by-passed the referral system, therefore, the 'gate-keeping' roles of clinics and health centres, and went straight to tertiary facilities in order to enjoy exemptions.
- Wide and overstretched exemptions package against too little resources for implementation.

low given that an estimated 28% live under the poverty line, according to 2006 Ghana Living Standard Survey. Under the NHIS, premiums for the poor are paid from the exemption fund for the poor and vulnerable. Effective enrolment will address the following issues.

Equity can be achieved if enrolment of the core poor is effective because voluntary health insurance is not an absolute solution to care for the very poor in society. Thus, some exemption mechanisms are necessary to protect the poor under voluntary insurance schemes (Arhinful 2003). By providing coverage for the poor and insurance identity cards, they will have the right to health care under the NHIS like other insured persons without their identity known to service providers. This will protect their social prestige and at the same time boost their confidence to seek health care. It will also minimize what Ten Asbroek (1992) observed as negative attitudes of service providers towards patient inability to pay for care and moral pressure to pay for services.

Enrolling the core poor into the NHIS will also eliminate the additional burden of identifying the poor by health personnel and allow them to focus on their mandate of health care. Aside, the 'on the spot' determination of eligibility for exemptions by health personnel is inadequate. According to Nyonator *et al.* (1994), 95% of heads of facilities determined inability to pay on the spot during consultations. Although a necessary step, this alone is not adequate for verifiable assessments. Moreover, the method is prone to abuse by service providers and consumers alike.

It will also eliminate the conflict of interest between poor people and health workers in the application of exemptions. This should further eliminate bias against the poor even if differential treatment of clients persists in public health care. However, not all problems that affected exemptions in the past can be addressed through effective enrolment alone. Several

other factors will be required for improving exemptions for the poor. Even effective enrolment as discussed will depend on some other factors. It is in this context that the cardinal question as explored in this paper is relevant: thus, how can experiences of exemptions under the user fee era be carried over for improving exemptions for the poor under the NHIS?

First, effective community education on the need for enrolment in the NHIS alongside exemptions for the poor is important and will require genuine community participation. As we have seen, a problem that confronted exemptions in the past was the lack of knowledge about exemptions for the poor. Thus, effective community participation in public education on the NHIS itself will be essential for the success of exemptions. As discussed, a major challenge confronting the NHIS is low enrolment across the country. Lack of money is interpreted as a 'convenient reason' for not enrolling (Kotoh, n.d.). An examination of premium rates and life styles of people suggests that a greater part of the population could probably afford the required premiums. The problem seems to be a lack of 'acceptance' of the concept of health insurance, leading to a lack of priority among the population. Thus, the success of exemption for the poor will depend on the success of the NHIS itself. Hence, public education is vital and should focus on the dual objective of promoting awareness on need for enrolment into the NHIS and exemptions for the poor. Genuinely working through indigenous institutions could yield enormous support from chiefs and their councils of elders, providing enough traditional political clout to engender acceptability of the NHIS, encourage general enrolment at community levels and also provide effective education on exemptions for the poor. Women's groups exist in virtually every community, playing proactive roles in community development. Engaging women's groups in community-based outreach education on the NHIS and exemptions could make public education more effective. In

northern Ghana, one way in which women groups have been effective in public education is through composing songs in the local languages for publicity on the issues, and these songs go far and quickly too. This potential should be explored for the sustainability of the NHIS and exemptions for the poor. Overall, these strategies will engender acceptability and encourage wider premium paying enrolments in the NHIS. This should help generate resources for funding health care for all, including funding exemptions for the poor.

Secondly, the policy guidelines for identifying the poor should be reviewed, clarified and made more detailed for operational purposes. The Department of Social Welfare (DSW) can play a leading role in this policy review process with the effective participation of beneficiary communities. The participation of communities will be crucial in identifying the core poor of every community at the district level. A starting point is to incorporate views of communities own understanding of poverty. Such input can help develop a set of possible indicators for identifying the poor for enrolment into the NHIS. However, such indicators will have to be 'localized' based on varying socio-economic conditions of different parts of the country. At the national level, providing more detailed policy guidelines for guiding the development of local indicators for identifying the poor will be a better solution than attempting to provide a 'national' definition of a poor person. Findings from our study showed that communities preferred to characterize the poor rather than give a working definition of a poor person (Box 2).

In a recent publication on identifying poor people in Ghana for exemption, *Aryeetey et al. (2010)* argue for Participatory Wealth Ranking (PWR), which identifies poor households on the basis of criteria defined by the community in focus group discussions. Another approach to the inclusion of poor people into health insurance goes a step further. The setting up of multilevel Problem Solving Groups in local communities aims to combine the views of the community with those of health workers and agents of the insurance scheme to arrive at a more complete understanding of poverty in the context of health insurance (*Kotoh n.d.*). Results on community perspectives present a range of possible issues that can inform new policy guidelines for identifying the poor. An inability to meet nutritional needs, limited and poor productive assets (land, poultry and livestock), a lack of opportunities for making social claims, childlessness, being aged and lacking support, being

physically challenged and having chronic illness were identified by communities as indicators of poverty. Thus, anyone who is experiencing one or more of these may be classified as a poor person at the community level. There is an additional lesson that can be learnt from these findings: poverty is not only about income, it is also social. The importance of family and having someone caring is illustrated as an important social dimension of poverty in the Volta Region of Ghana (*Ten Asbroek 1992*). Local authorities, churches, women's groups, in dialogue with health providers and health insurance agents, can play a central role in identifying the core poor in their communities if they are genuinely involved.

Further, the Department of Social Welfare (DSW) should be supported to carry out its responsibility of identifying the core poor of every community for exemptions at the district level. One of the problems of the past exemption regime was the limited capacity of the department. This made it difficult for the department to play its role of identifying the poor. For instance, funds allocated to District Health Management Teams for exempting the poor were not utilized in some cases at the district level. The lack of administrative capacity to identify the poor often accounted for this. Although the role of the DSW in exemptions is crucial, their services were not immediately available in every hospital in the Volta Region due to limited capacity (*Ten Asbroek 1992*). Providing the DSW with adequate office accommodation, logistics, qualified and adequate staff, transport and funding will enable it to provide the required administrative support for identifying the poor. As long as health care for the poor is a priority, some proportion of the exemptions fund for the poor and vulnerable should be allocated to the DSW. This should be an additional budget line for field operations aside from its usual budgetary allocation from the Ministry of Manpower, Youth and Employment. It will increase resources and administrative support for identifying, reviewing and managing information about the poor at district and sub-district levels. Such an institutionalized information management system, if updated periodically, will better support the implementation of exemptions for the poor under the NHIS. This runs contrary to discussions that District Health Committees be responsible for identifying the poor under the NHIS (*Badasu 2004*). Information about the poor will be better managed by the DSW than by committees which are very often ad hoc in

Box 2 Communities' characteristics of a poor person

- One who is unable to provide a square meal for him/herself.
- One who has no external support from relatives residing outside the community.
- One who has neither (single) livestock nor poultry.
- A childless man or woman who lacks opportunity to be supported by his/her child(ren).
- The aged who have children/distant relatives but do not receive remittances from them.
- The 'aged' who beg to survive because they lack people to support them.
- A small land size and marginal holder.
- One who is not resourceful enough to farm even if he/she has arable land.
- The physically challenged such as the blind and disabled who do not do self-sustaining jobs.
- A person suffering from a chronic disease that makes him/her unable to work.
- A paralysed person who is unable to work but with or without support from relations.

nature. However, the DSW should involve key stakeholders in developing a cost-effective system for identifying the poor in order not to induce efficiency losses through high cost. This is the reason effective and genuine community participation is important.

Conclusion

In this paper, we set out to discuss how exemption experiences in the user fee era in the 1990s and early 2000s can inform policy making for improving exemptions for the poor under the NHIS in Ghana.

The discussion showed that although exemptions were meant to improve access to health care for vulnerable groups, including children under five, the aged, antenatal care and particularly the poor, the manner in which exemptions were applied did not ensure equity in health care. Exemptions were generally applied in favour of other beneficiary clients to the disadvantage of the poor. The poor rarely benefited from exemptions and several factors accounted for this. These included low awareness on exemptions, particularly exemptions for the poor, and difficulty in identifying the poor arising from a lack of clear guidelines, institutional and resource capacity. These factors culminated into extremely low exemptions and expenditures for the poor compared with other categories of exemptions. In addition, shortage of drugs, perceptions of discriminatory behaviour against the poor by health workers and perceptions of poor quality drugs associated with exemptions all affected the implementation of exemptions in the user fee era. The study therefore concludes that although exemptions improved access to health care for the vulnerable, the equity goal of exemptions was largely unmet because the poor rarely benefited.

Drawing on these experiences, three policy recommendations are put forward for improving exemptions and health care for the poor under the NHIS. These include: more effective community education for enhancing premium-paying enrolments into the NHIS alongside education on exemptions for the poor; clarifying and contextualizing guidelines for identification of the poor to reflect communities' own understanding of poverty; and resourcing the DSW to discharge its mandate of identifying the poor for exemptions.

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Conflict of interest

None declared.

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