Health Financing

Financing health care in Ghana
W. Kwadwo Asenso-Okyere

Attempts to recover some government health care expenses through user charges have produced less revenue than hoped. National health insurance offers an attractive alternative, but needs to include features which check cost escalation. Community involvement and traditional medicine can also help to reduce costs.

Improvements in health status depend to a large extent on lifestyles and the quality of the health care system. Compared with other African countries Ghana has made considerable progress: it has increased life expectancy from 47 years in 1970 to 58 in 1988 and reduced the crude death rate from 17 per 1000 in the late 1960s to 13 per 1000 in 1989 (1). Nevertheless, the health status of the population still remains rather poor, as evidenced by high infant and maternal mortality, high prevalence of preventable infectious and parasitic diseases, and poor nutritional standards. There is also considerable inequality of health status between urban and rural areas and the different regions of the country. For instance, disaggregated data show that life expectancy was 13 years lower in the rural areas than it was in the urban areas. Infant mortality was 63 per 1000 live births in urban areas and 234 per 1000 in some rural areas (1).

Government health services

The Ministry of Health is the largest provider of health services in Ghana, owning 63% of the hospitals and 70% of all hospital beds in the country. Although many countries carrying out structural adjustment programmes have cut their social sector budgets to reduce government expenditure and budget deficits, the expenditure of the Ministry of Health grew by 12% in real terms from 1986 to 1990 when the country’s structural adjustment effort was at its peak. However, this growth in expenditure resulted in only a 2.3% real per capita increase because of the population growth rate of over 3% per annum.

Apart from inadequate budgetary support to the health sector, there is great inequality between urban and rural areas in access to health care. Analysis of allocations within the health sector indicates that increased proportions of the budget have been used to strengthen the predominantly urban curative health care systems where only 30% of the population live. The primary health care programme, which mostly benefits the rural people, normally receives about 20% of the government’s health budget.

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When the government realized that it could not bear the whole cost of public health care without compromising on quality, it introduced cost-sharing measures for the use of its facilities. The Hospital Fees Regulation, which came into force in July 1985, used the following criteria to specify prices:

- service level (health post, health centre, etc.);
- treatment location (urban or rural);
- age (child or adult);
- service (curative or preventive, type of disease, type of procedure).

In terms of service level and location, user fees are set in descending order, starting with teaching hospitals, continuing through regional hospitals, district hospitals and urban health centres, and ending with rural health centres and health posts. Children pay fees ranging from 50% to 67% of adult fees depending on the service level and location. Non-Ghanaians pay fees which range from 133% to 267% of those paid by Ghanaians. Patients suffering from certain diseases have to pay the charges for drugs but are exempt from other fees. In general, antenatal and postnatal medical services are free and health-service personnel are exempt from paying fees, except for special amenities. Immunization against any disease is free but there is a charge for vaccination certificates for international travel.

The legislation of 1985 allows full-cost pricing of drugs and pharmaceuticals, which makes it the most comprehensive cost recovery legislation in West Africa (2).

It has been pointed out that even without allowing for the administrative cost of collecting the charges, most developing countries in Africa are able to raise only about 5% of their health care operating costs from user charges (3). In Ghana the Ministry of Health had hoped to raise at least 15% of its total recurrent expenditures through user charges but in the event it raised on average less than 10% (see table).

As one might expect, the effect of price on demand for health services is higher for low-income groups than for high-income groups. A study made in Côte d'Ivoire in 1988 showed that responsiveness to price in the use of clinic and hospital services was from three to six times as great in the lowest income quartile as it was in the highest (4). These results indicate that user fees substantially reduced the use of health services by the poor. Studies in Ghana and elsewhere have found that attendance at health facilities dropped immediately after user fees were introduced (5, 6). Although attendance picked up in urban facilities later, attendance at rural facilities did not return to its previous level (5).

### Cost recovery of Ministry of Health

<table>
<thead>
<tr>
<th>Year</th>
<th>Recurrent budget</th>
<th>User fee receipts</th>
<th>Revenue as percentage of recurrent budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985</td>
<td>3765</td>
<td>194</td>
<td>5.2</td>
</tr>
<tr>
<td>1986</td>
<td>6497</td>
<td>520</td>
<td>8.0</td>
</tr>
<tr>
<td>1987</td>
<td>6856</td>
<td>851</td>
<td>12.4</td>
</tr>
<tr>
<td>1988</td>
<td>9833</td>
<td>977</td>
<td>9.9</td>
</tr>
<tr>
<td>1989</td>
<td>15833</td>
<td>1160</td>
<td>7.3</td>
</tr>
<tr>
<td>1990</td>
<td>20242</td>
<td>1140</td>
<td>5.6</td>
</tr>
</tbody>
</table>

Source: Ministry of Health, Accra.

a Between 1985 and 1990 the rate for US$ 1 changed from approximately 50 to 325 cedi.
Other health care providers

Other providers of health care services in Ghana are private orthodox medical practitioners, missions, herbalists and fetish priests.

The private orthodox medical practitioners, which include doctors, midwives and nurses, usually operate their clinics in the urban areas. Their practices are oriented towards curative and obstetric care. Charges are on a full cost recovery basis, so users pay for all the services they receive at these facilities. Apart from entry, which is restricted through licensing, the market operates freely, and user charges vary from facility to facility, depending on such factors as the location, clientele, the amenities available, goodwill and the reputation of the practitioner. Since there is no regulation of charges, user fees at private medical facilities tend to be beyond the means of the ordinary Ghanaian, especially where service differentiation or scarcity makes monopolistic pricing possible. In short, most private facilities are run as businesses, without reference to the ability of many potential users to pay the charges. Thus they tend to locate in urban areas where there are people with higher incomes.

The mission hospitals and clinics charge user fees to cover recurrent expenditures and they pass on the full cost of drugs to users. Since the quality of service is high, users are willing to pay for it. The poor who cannot pay the fees are exempted. Exemption can pose identification problems but since the missions operate mostly in the rural areas where people know each other it is usually not too difficult for a social worker to recognize the needy.

Despite the efforts of the orthodox health care system, traditional practitioners play a major role in the provision of health care, especially in the rural areas. These traditional practitioners use herbs or fetishes or both to cure diseases. Apart from unavailability of orthodox facilities in many rural areas, one of the factors that lead people to use traditional practitioners is the belief that some diseases are caused supernaturally and can only be cured by mystical powers which are thought to be possessed by the traditional practitioners, especially the fetish priests.

The cost of treatment at herbal facilities or fetish shrines varies considerably. It may depend on the patient’s apparent access to money, how well he or she is known, the supposed cause of the disease (supernatural or natural) and the length of time needed for treatment. There is usually an initial access fee, which may be fixed, or a token gift.

Traditional health care can be expensive. In the course of treatment the sick can be asked to provide eggs, fowl or sheep to be used in performing rituals to find the cause of illness or a treatment. Nevertheless, a patient is not normally refused access to a traditional facility on the grounds of inability to pay. When necessary, credit arrangements are made or the treatment is given free of charge.

The Hospital Fees Regulation legislation has not been adequate to provide the funds needed to improve and expand the health care services in Ghana. More effective ways of supplementing government efforts at a time of budget rationalization should be devised to save the health sector from further deterioration.
Insurance

Insurance is a way of financing health services by spreading the risk evenly among policy-holders. A national health insurance scheme was proposed for Ghana in 1985 after a prefeasibility study was completed by a commission set up by the government. The proposal has not yet been implemented because of problems involved in organizing and managing the scheme. It was to be managed by a privately run central agency, the National Insurance Company, which would receive premiums at a flat rate for children and adults and rural and urban dwellers, and contract out ambulatory and hospital services to both public and private providers. The insured and three dependants would receive free services from designated providers. The company would pay private providers through a fee-for-service system for ambulatory care and itemized billing for hospital care.

It was proposed that the initial coverage for the insurance scheme should be limited to identifiable groups. Potential insurable groups include the 200,000–300,000 private cocoa farmers registered with the Ghana Cocoa Board, the 2 million employees in the formal labour markets registered with the Social Security and National Insurance Trust and the country’s almost 200,000 civil servants.

The scheme was designed so that the policy-holders themselves did not contribute to it. The government was to pay for civil servants, the Ghana Cocoa Board for the registered cocoa farmers, and employers for their employees.

It has been noted that individuals covered by insurance took fewer precautions to prevent illness and that those who became ill used more resources for treatment than they would have if they had to bear the full cost them-selves (7). The scheme as designed would also lead to cost escalation, especially in the private sector, since it would create an incentive for hospitals to take in more patients and provide more services per patient in order to make money (6). It has been found that itemized billing encourages health care providers to use the most profitable technologies (8). It can be concluded that under such an insurance scheme neither the users nor the providers are concerned about costs since “the insurance company is paying”. Therefore, to reduce cost escalation a way should be found to share the costs of insurance between the insurer and the insured. Deductions and co-payments beyond a certain claim level tend to be effective in this respect. It is only when the consumer is contributing that unnecessary tests and lengthy hospital stays are likely to be questioned to reduce provider-induced demand.

Community involvement

Health services can also be financed through community involvement, especially in the provision of physical infrastructure and disease control programmes. Communities must be made aware that the government cannot pay for all aspects of health care, especially when preventive measures are inadequate. Therefore there is a need for community-initiative programmes such as improvements in sanitation and provision of water. Ghana has done well in this respect, and many communities have provided social amenities for themselves through contributions levied by the Town Development Committees. A pro-
gramme was launched by the government with the support of the donor community to meet the needs of vulnerable groups during the structural adjustment process. It has encouraged communities to carry out development projects and provided funds to complete them. Many health posts and centres have been built as a result.

The involvement of the community in health care delivery has been the basis of the Ministry of Health’s Level A health care facilities programme. At this level the community is involved in providing both the infrastructure and the human resources needed to set up and run a clinic. The community pays the clinic attendant and forms a committee to manage a revolving fund for drugs. There are no consultation fees, but users meet the full cost of drugs supplied at the clinics. An efficient referral system links them with Level B facilities, which are looked after by trained paramedical staff who are paid by the government. For many rural people Level A facilities are the only contact with some sort of orthodox medicine.

The major advantage of involving the community in the provision of health care is that people recognize the value of facilities they have set up themselves. Very often, when development projects are planned and carried out without the involvement of the beneficiaries, they fail.

Nevertheless, since the incidence of poverty is very high in the rural areas, it may not be equitable to ask rural people to bear the major cost of health care when the relatively wealthy urban areas have their facilities provided for them by the government. Although good health contributes to higher household production and consumption, poor households should not be overburdened with financing health care as this reduces their ability to provide for other needs, such as food.

Traditional medicine

The important role traditional healers play in providing health care in Ghana, especially in the rural areas, has already been emphasized. However, the lack of standardization in traditional medicine is undesirable. Herbal preparations may differ from one practitioner to another and dosages are vague, which can lead to complications. Also, the unhygienic conditions in which preparations are made have often caused concern.

In order to reduce costs for the health sector and improve the services of traditional healers, traditional medicine can be integrated into the orthodox medical services. Ghana started doing this by establishing a Centre for Research into Plant Medicine in the early 1970s and introduced a practice whereby a team of doctors and traditional healers diagnosed diseases and prescribed medicine. The medicine could be a herbal preparation or a pharmaceutical drug. Unfortunately, however, when the few doctors who were interested in the practice left, the collaboration collapsed.

In a major step towards recognizing traditional medicine the Ministry of Health has established a unit in charge of herbal medicine. One of the preoccupations of the new unit has been to organize the traditional healers and register them with the various district health management teams, so that some training can be provided for them. To gain recognition in the health profession for the complementary role of traditional healers in the provision of health care, there are plans for consensus-building programmes among the orthodox practitioners, especially doctors.

Because of lack of modern midwifery facilities in the rural areas, many deliveries are attended by traditional birth attendants. In order to help reduce the high infant and maternal mortality rates, these birth attendants are orga-
organized and trained by the Ministry of Health. They are given courses in modern child delivery, hygiene, nutrition, family planning, perinatal care and child welfare. The Ministry plans to expand the training programme so that most of the existing traditional birth attendants can benefit from it.

Although the general health of Ghanaians as measured by average life expectancy has improved over the years, better nutrition and cost-effective disease control methods are still badly needed. As the demand for health services expands, expenditure increases and it therefore becomes imperative to find a variety of ways to finance the system to prevent it from breaking down. One approach is to ask the beneficiaries to bear some of the costs of health care so as to reduce the strain on the budget. The initiative of communities, especially in the provision of infrastructure, is very useful in complementing government efforts to finance the health sector. In searching for these non-traditional sources of funds, care must be taken not to overburden the poor, who may react by refusing to seek the health care they need. It should be possible to charge the rich more than the poor, so that part of their contribution could be used to fund health services in the rural areas. The missions have been implementing cost-sharing schemes successfully for a long time now, and the government has a lot to learn from them in this regard.

With the increasing cost of health care to both patients and governments, health insurance seems to be a viable option for financing health care and covering risks so that some level of social security is assured. However, Ghana’s proposal for national health insurance without co-payments and with fee-for-service reimbursements would tend to escalate the costs of health care. To control costs, a health insurance scheme must include limits beyond which expenses are borne by the insured. Also, to avoid monopoly, health insurance should be available from more than one company.

The traditional healers continue to play an important role in health care in Ghana. By recognizing this role and formally incorporating it into the country’s health care system, an important step forward can be taken in improving the quality of traditional medicine. This will reduce the demands on orthodox health care and thus further help to control the public sector health budget.

References