Achieving universal health coverage in Ghana: A matter of feasibility or Political Will?

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Good health is indispensable to human welfare and to sustained economic and social development. The best way to finance health care has long been a confusing area for policy-makers resulting in different policy options being debated for decades. Recently, government announced its decision to implement a one-time premium health insurance policy as a means of making health services accessible to all and citizenry in the country. This article aims to contribute to the health-financing debate and particularly argues that free healthcare policy is feasible in Ghana but will only require a political will to achieve this noble dream.

Is NHIS really covering the poor?

The NHIS undoubtedly provides a comprehensive package of services and for members of the scheme evidence suggests that access and quality of services have improved. Nevertheless, some research reports by civil society organisations (e.g. ISODEC, the Alliance for Reproductive Health Rights and the Essential Services Platform with support from Oxfam) recently noted that the yearly subscription of the scheme has been a barrier towards poor people's access to healthcare services in Ghana. For many people, the health insurance system is acting as a costly and inefficient barrier to claiming the health care they have already paid for (through VAT). The NHIS as currently constructed cannot therefore achieve Universal Coverage for health care in Ghana. The only way forward is to move towards the stage where healthcare really becomes free for people at the point of use or to strike away annual subscription fees and allow people to enjoy the service for their entire lives once they join—what the Government termed one-time premium.

How much will free health cost?

There is limited home-grown data currently available on comprehensive costing estimate of universal and equitable health coverage in Ghana. Some initial actuarial studies done for the one-time premium policy suggests that about GHC 1.7b (or $1b) will be needed by 2018 to make it a reality. This figure is a little bit lower with the WHO recommended figure of spending at least US$60 per capita per year by 2015-- which is about twice of the current per capita expenditure of $28 (as at 2008) to achieve universal coverage and the Millennium Development Goals. This 2015 figure includes the cost of expanding the health system so that they can deliver some specified mix of interventions. This figure thus serves as a guide, in the interim, of the investments required to make free healthcare possible in Ghana.

Financing free healthcare in Ghana: Who will pay and is it sustainable?

It will be of interest to mention that vast majority of NHIS revenues, approximately 70% in 2008, came directly from the NHIS-VAT levy, which is entirely unconnected to the NHIS membership rate. A free healthcare policy will therefore consider closing the 30% gap. This makes the path to free healthcare or for a start, the one-time NHIS premium relatively simple – at least on paper. Principally, financing the universal coverage of health can be achieved through innovative sources of domestic revenues to the government, potential efficiency savings within the health sector and quality aid.

The Ghana Revenue Authority has consistently exceeded its revenue target for the past half decade or so. This needs to be commended but whether the target is adequate or not, that is not the subject for this discussion. Encouragingly, there are several other (untapped) options for raising new domestic resources from to support a free healthcare policy without necessarily increasing the income tax rates and without much opposition from the citizenry and corporate bodies. The so-called “sin taxes” are just one of them. A 2010 WHO report shows that by raising tobacco taxes by 50%, low-income countries like Ghana could together generate new funds for health to the tune of about $1.4 billion each year. The report further argues that raising taxes on alcohol or alcoholic beverages to 40% of the retail price could have an even bigger impact—with tax revenues potentially tripling in some countries. Even a 1% levy on other harmful products, such as sugary drinks, the booming fried rice markets and other foods high in transfats would further raise substantial funds. The good thing about “sin taxes” is that they raise money while also protecting health. This is an important source we can look up to finance a free healthcare policy in Ghana. Even if only a portion of the proceeds are allocated to health, a substantial step would be made in closing the 30% funding gap required at the moment to strike away NHIS annual subscriptions.

Secondly, substantial revenues can be obtained from the financial and banking sectors to support this all-important policy—which until now have not really gained much attention. The foreign exchange market easily comes to mind in this direction. A **daily** turnover of the FOREX market is estimated to be approximately $38m. This gives an annual figure of $13.680b. A currency transaction levy of just 1 % on this volume of trade could yield about US$ 136.8 million per year—and hence provide a substantial amount of money to finance the scheme. Each year not less than $150 million are bagged as profit by the commercial banks and insurance companies of the country. Will it be morally wrong to impose some additional charges (aside profit tax) to the financial sector to ensure that they make a fair contribution to society (as done to the mining sector)? Definitely No! Just a 2% tax will raise more than $3 million to support the course towards free health policy. Additionally, a tiny tax of as little as 1 % applied to financial transactions such as shares, bonds, currency and their derivatives could raise tens or even hundreds of millions revenue to meet the cost of the one-time NHIS premium policy. In 2009 alone—which was one of the most difficult years for the GSE due to the global financial crisis, volume and value of shares traded was 97million shares worth GH¢74.19million. A small tax on these financial transactions will generate substantial resources for government.

Another possible source of funds worth considering in this regard is the telecommunication sector. The National Communication Authority reported in September, 2011 that there were more than 19 million telecommunication subscribers in Ghana. If each subscriber is made to pay at least GHC 2 a year to finance the scheme, is it not GHC 38 million which is being generated? Even at the moment that some tax are being levied to support the NYEP, call rates is as low as GHC 0.03 (i.e. 3p) for some networks. I am therefore not sure paying GHC2 annually as tax will be greeted with much opposition by both subscribers and the companies in question considering the motivating force behind the tax. Other options for raising additional revenues to finance universal care or the one-time NHIS premium policy include taxation of property and rental income and reversing the free zone status of some

existing forestry firms. A research report by ISODEC suggests that taxation of property and rental income could raise revenues worth an estimated 1-2% of GDP. A target of 1.5% of GDP (2009 levels) could contribute GHc 345 million additional revenues annually. Also, reversing the free zone status of existing forestry firms would raise 0.5% GDP in additional revenue (About $78million). It has also been argued by the Tax Justice Network that revenue lost to the state since lowering royalty tax on mining is estimated at US$68 million per year or GHc 102 million. Some argue that marginally increasing corporation tax to 27.5% (still below the pre 2006 level) would yield about GHc 56 million annually(per 2009 total corporate income of GHc 1.2 billion in 2009) to finance the one-time NHIS premium policy.

Aside the proposed taxes, a number of cost-savings could also be made from inefficiencies, cost-escalation, corruption and abuses in the health sector. The Independent Health Sector Review for 2009 for instance found that the price of some major medicines is about 300% higher than international reference prices. In a research report jointly published by the ISODEC, the Alliance for Reproductive Health Rights and the Essential Services Platform with support from Oxfam, it was found that at least savings worth about 36% of total government health expenditure in 2008 (an equivalence of US$10 per capita) could be made on the inefficiencies and cost escalation in the health system. The report concluded that nearly GHC 374 million could be generated annually to support the financing of the universal healthcare policy. In 2011 for instance, auditing of claims carried out by the NHIA saw GH¢471,215 and GH¢755,582 being recovered from services and medicines respectively (p. 25 of 2012 budget statement). Some of the strategies of achieving these cost-savings include regular clinical audit to reduce fraud and leakages; better negotiations with suppliers and reducing unnecessary cost escalation along the medicine supply chain and investing more in preventive rather than curative health. A well coordinated and quality aid will further increase the efficiency and revenues needed to finance the free healthcare policy.

Conclusion

If the introduction of 'Cash and Carry' health care was stage one, and the NHIS stage two, it is now time for stage three—to achieve universal health coverage where healthcare is free at the point of use. This article has argued that Ghana can afford a fully tax-financed health care system free at the point of delivery with no reliance on premium incomes. The sources identified above combined mean that Ghana could significantly increase its per capita expenditure for health to at about US$60 per capita by 2015 to deliver free healthcare to its citizenry. This figure assumes a minimum government investment in health of 15% of total revenues—in tandem with the Abuja commitment. This might however provoke some powerful resistance across many actors but with the right political will, free healthcare could be achieved through progressive and fairer taxation, cost-savings and good quality aid.