WIEGO
Women in Informal Employment Globalizing and Organizing

WIEGO Policy Brief (Social Protection) Nº 9 September 2012

The Ghana National Health Insurance Scheme: Assessing Access by Informal Workers

Laura Alfers[1]

Most of the workers in the developing world are informal workers, and most informal workers are poor. Attempts to mitigate poverty in the developing world therefore need to focus on informal workers. Over 90 percent of Ghana's workers work informally. Informal work is not homogenous and can include a variety of work statuses. The majority of informal workers in Ghana are self-employed, own-account workers[2], rather than waged employees. Very few of them have ever had access to national social security or healthcare schemes.

In 2003 the Ghanaian government for the first time introduced a National Health Insurance Scheme (NHIS). This is an innovative and large scale attempt to extend social protection to, among others, informal workers. It may hold important policy lessons for other countries where the informal economy is large and growing, and where informal workers are excluded from formal social protection.

Several studies have focused on the impact of the NHIS on poor people, but few have specifically focused on its impact on informal workers. Although the problems poor people may face in accessing the NHIS may be similar in many respects to the problems informal workers face, there is a difference between focusing on the problems encountered by 'poor people,' and focusing on the problems faced by 'workers,' who may encounter specific barriers to access related to the nature and context of their work.

This case study concentrates on female informal workers in particular and has three main objectives: to describe the background, structure, implementation and context of the NHIS in Ghana, to assess the barriers faced, particularly by female informal workers in terms of accessing the scheme and to determine how much participation these workers have had in the development of the

In 2003 the Ghanaian government introduced a National Health Insurance Scheme – an innovative and large scale attempt to extend social protection to informal workers. It may hold important policy lessons for other countries where the informal economy is large and growing, and where informal workers are excluded from formal social protection.

[1] Laura Alfers has worked on WIEGO's Social Protection Programme since 2009, focusing on the access of informal workers to health schemes, as well as occupational health and safety. She is currently registered for a PhD at the School of the Built Environment and Development Studies, University of KwaZulu-Natal, Durban, South Africa. Email: laura.alfers@wiego.org

[2] Own account workers are self-employed workers who do not employ any regular employees.

scheme. It is based on a desktop review of existing literature on the NHIS, as well as a small, qualitative study conducted in Ghana in 2009 and 2010 with traders, chop bar operators (who run informal eating houses), and *Kayayei* (headload porters, usually migrants from the rural northern areas of Ghana), and also semi-structured interviews with several key informants.

The Ghanaian NHIS was developed in consultation with a wide range of stakeholders, including the the Ghana Trades Union Congress (GTUC) who represented both formal and informal labour. It is an interesting fusion of Social Health Insurance (SHI) and Community Based Health Insurance (CBHI) models. The basic structure is described as a "hub-spokes" system. The hub, which is essentially based on the SHI model of pooled public tax resources, is the National Health Insurance Fund (NHIF) which is administered by the National Health Insurance Authority (NHIA). The sources of funding for the hub are varied, but come mainly from an extra VAT levy of 2.5 percent imposed on almost all goods in Ghana. The spokes are made up of a country wide network of CBHI schemes known as District Wide Mutual Health Insurance (DWMHI) schemes which are monitored, subsidized and re-insured by the hub.

This model was chosen because it was considered unrealistic, in a country with such high levels of informal employment, to implement a statutory SHI scheme, which would rely on deductions from employee wages. CBHI schemes are non-profit schemes based on voluntary membership, low premiums, and flexible payment schedules (Coheur *et al.*, 2007). These schemes are better suited, in theory, to contexts in which informal employment and poverty are high. However, CBHI schemes usually encounter problems of financial sustainability – high drop-out rates, small risk pools, and low premiums all contribute to this problem (Coheur *et al.*, 2007). They also tend to work best in small community settings, and it has proved difficult to scale them up to facilitate national coverage (Atim *et al.*, 2009). By combining a network of CBHI schemes with a centralized authority and source of funds (the SHI component) to ensure nationwide coverage and to guarantee the financial sustainability of the schemes, the NHIS is an attempt to adapt aspects of these health financing models to fit the particular socio-economic situation of Ghana. Figures on the scheme's coverage supplied in June 2010 by the NHIA – showing that 66 percent of the population are registered with the NHIS – suggest that this strategy has been successful.

Small, qualitative studies conducted in Ghana in 2009 and 2010 with traders, chop bar operators (who run informal eating houses), and Kayayei (headload porters) helped inform this assessment.

Informal workers who were interviewed for this study had generally welcomed the idea of the NHIS as an alternative to the previous system, which was based on out-of-pocket cash payments at the point of service. Participants who were members of the NHIS clearly felt that it had increased the quality of their lives. Particularly noteworthy was the mention by several women that they had used the NHIS to have regular blood pressure checks. In 2008 the Government extended free care to all pregnant women, regardless of their NHIS status, and this has also been warmly welcomed.

However, there were a number of barriers to access which meant that the majority of informal workers interviewed in this study (32 out of 40) were not NHIS members. The main barriers were:

1. The cost of premiums: Although all Ghanaians contribute to the NHIF through the VAT levy, they are only able to access the scheme's benefits once they have paid a once-off registration fee and an annual premium. The premium levels are set between GH¢7.2 ($5)[3] and GH¢48 ($32), depending on income, and district schemes are meant to judge on a case-by-case basis what premium

[3] The exchange rate is approximately 1.44GH¢ to the US$1

people qualify for. Evidence suggests that many urban schemes have now set their minimum premiums well above GH¢7.2 – numbers mentioned range from GH¢15 ($10) to GH¢25 ($17). This is far out of reach for many of the poorest workers, particularly rural migrants such as the *Kayayei* who on average earn just over $1 a day.

2. Registration fees for children: In 2008 the Government declared that all children under the age of 18 would have free NHIS membership. In reality, however, a registration fee of GH¢2 per child is charged by the district schemes. This can add up to a significant amount for women with many children, who tend to be among the poorest.

3. Poor administration in the District schemes: Many of the better off workers interviewed had at one point tried to join the scheme, or had tried to renew membership, but had failed because of poor administration at the district level. Some workers had paid premiums, but had not received membership cards; others had tried to renew their cards, only to find that the offices had moved. A number complained that their work commitments meant that they did not have time to follow up further with the schemes, and so they had given up.

4. Lack of detailed information on the NHIS: Leaders of the worker associations felt that the NHIS had not made enough effort to spread detailed information about the scheme in the market areas in which a significant number of Ghana's informal workers work. Many *Kayayei* women, for example, do not know that they qualify for free pre- and post-natal treatment at health facilities. There is no easily available information on whether premium payments can be made in instalments, and many traders were unaware that they may be able to qualify for lower premiums depending on their earnings.

***Kayayei* spoke of their inability to access the NHIS because of the inflated premiums charged in urban areas at a health policy dialogue organized by WIEGO. Evidence suggests that many urban schemes have set their minimum premiums well above the proscribed minimum of GH¢ 7.2.**

5. Long waiting periods for NHIS members at healthcare facilities: NHIS card holders are reportedly being made to wait for treatment in favour of cash paying patients at health facilities. This appears to be a consequence of overcrowding at the facilities and the late payment for health services by the NHIS. Again, for most informal workers, time is very literally money.

6. Out of pocket payments for medication: Many of the workers interviewed felt that there was little point

Although registration drives are held fairly regularly, chaotic administration in the district schemes means that many people struggle to access the benefits.

in joining the NHIS, because they said that the drugs covered by the NHIS are often inadequate, and members still have to pay extra for medication.

Apoya and Marriott (2011) have recently argued that, despite its intention of increasing equity in healthcare provision, the NHIS is a deeply unfair system. The authors give evidence that coverage figures have been grossly inflated by the NHIA, and point out that the scheme results in poorer people subsidizing healthcare for those who are richer. While everyone must pay the NHIS VAT levy, only those who can afford to pay premiums are able to access the service. Apoya and Marriott (2011) argue that instead of spending money on a chaotic, over complicated, inefficient NHIA, a far more equitable approach would be to use the funds to bolster the health system and to institute non-insurance based universal healthcare. It should be noted here that Thailand is one country where a low cost health insurance scheme was later converted into a free universal healthcare system.

Whatever health financing route the Ghanaian government ultimately decides to take, it is important for now that the scheme begin to address some of the specific barriers to access that informal workers face. Some of these barriers are related to the wider functioning of the healthcare system and of the scheme itself, and may not be simple to solve. This study has identified some areas, however, where focused action could be taken in a relatively straightforward manner.

These include:

1. Regulation of urban premium levels: Anecdotal evidence suggests that the minimum premiums in urban areas are set well above GH¢7.2 because urban areas are considered to be wealthier than rural areas. It is not always easy to draw a clear geographical line between the rural and the urban in Ghana. Also, there are significant populations of very poor, rural migrant workers, such as the *Kayayei*, living and working in cities like Accra. Ideally for workers as poor as the *Kayayei*, there should be some form of premium exemption. Failing this, there should be regulations which force urban district schemes to at least offer the lowest premium (GH¢7.2) to such workers.

2. Better dissemination of information in informal workplaces: Awareness of the NHIS amongst Ghanaians is high – no one interviewed in the research was unaware of the scheme's existence. However, there is a differ-

ence between a general awareness about the scheme's existence, and the wide availability of accurate information on the details of the scheme. The market areas could be strategic places to provide this kind of information. The market women themselves suggested that health booths could be installed in the markets to act as information points. They could also be used as a central space in which to conduct targeted, detailed education campaigns for market workers and customers alike. Using worker organizations to spread accurate information about the scheme may also be a good idea.

3. Better representation of informal workers at all levels of the NHIS: The NHI Act makes provision for a representative of organized labour to sit on the National Health Insurance Council (NHIC). This position has been filled, since the inception of the scheme, by the Secretary-General of the Ghana Trades Union Congress (GTUC). As the GTUC represents both formal and informal workers, informal workers are technically represented on the governing body of the scheme. However, the interests of formal and informal labour are not always the same, and may often clash. This means that, whatever good intentions are present, it is likely to be very difficult for one individual to truly represent the interests of both groups. In this case, it is important that provision is made for an additional representative of informal organized labour to sit on the NHIC.

It is also important that representatives of informal workers be included in the governing bodies of the district schemes. All levels of the NHIS need to keep in touch with what is happening on the ground, and including representatives of informal labour in these bodies is a necessary part of doing that, especially considering the central role these workers play in Ghanaian social and economic life.

This registration drive was organized in collaboration with a Membership Based Organization of *Kayayei*. The NHIS should work more closely with organizations of informal workers, and informal workers should be better represented in the scheme's governance.

References

Atim, C., Fleisher, L., Hatt, L., Masau, S. and Arur, A. 2009. Universal Access to Quality Health Services: Improve Maternal, Neonatal and Child Health. Paper presented at the Fourth Session of the African Union Conference of Ministers of Health, Addis Ababa, Ethiopia, 4-8 May 2009

Apoya, P. and Marriott, A. 2011. 'Achieving a Shared Goal: Free Universal Health Care in Ghana.' [Online]. Retrieved 24 June 2011, from www.oxfam.org.

Coheur, A., Jacquier, C., Schmitt-Diabate, V. and Schremmer, J. 2007. 'Linkages between statutory social security schemes and community-based social protection mechanisms: A promising new approach'. *Technical Report 09.* Geneva: International Social Security Association.

Acknowledgements:
Photographs by Dorcas Ansah, Laura Alfers, and Marty Chen.

Layout by Anna Gaylard of Develop Design.

In addition the author wishes to thank Francie Lund who supervised this project, as well as the Ghana Trades Union Congress, the StreetNet Ghana Alliance, and the Kayayei of Komkomba Market who participated in the research. Thanks also to research assistants Dorcas Ansah, Hamza Bukari and Clement Adamba.

This research was made possible through the support of the Swedish International Development Agency (SIDA), and the Dutch MDG3 Fund.

Policy briefs 9, 10 and 11 are derived from a suite of three case studies which were presented at the Rockefeller Foundation funded WIEGO/HomeNet Thailand Health Policy Dialogue held in Bangkok in January 2012.

WIEGO POLICY BRIEFS offer information on policies and organizational practices that affect the informal economy. This series supports advocacy processes and disseminates better practices and ideas, contributing to a worker- and livelihood-centered approach to development.

THE SOCIAL PROTECTION PROGRAMME OF WIEGO aims to investigate and highlight the risks faced by the working poor in the informal economy, and particularly the risks faced by women workers. It aims to identify, document and promote innovative approaches to providing social protection to informal workers, and ultimately to promote a new approach to social protection that integrates informal workers into social insurance schemes as well as social assistance.

ABOUT WIEGO: Women in Informal Employment: Globalizing and Organizing is a global research-policy-action network that seeks to improve the status of the working poor, especially women, in the informal economy. WIEGO draws its membership from membership-based organizations of informal workers, researchers and statisticians working on the informal economy. For more information see www.wiego.org.