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Pitfalls of Universal Health Coverage Systems: Evidence from West Africa

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Abstract
The importance of establishing universal health coverage policies for facilitating health care access and utilisation in developing countries is recognised in the literature. However, previous studies focus primarily on the fiscal challenges associated with the implementation of universal health coverage schemes, particularly in sub-Saharan Africa. In the wake of the inclusion of universal health coverage as one of the key targets of the United Nation's Sustainable Development Goal 3, many African countries are preparing to implement some form of national health insurance system. We seek to contribute to the literature by discussing the experiences of Ghana's National Health Insurance Scheme and, more briefly, the health insurance initiatives of Senegal and Burkina Faso. Our purpose is to show that implementation of universal health coverage is challenging, but possible, if associated blind spots are managed.

Introduction

There have been incessant calls for governments in sub-Saharan Africa to implement universal health coverage schemes. The inclusion of universal health coverage as one of the targets of the recently launched Sustainable Development Goal (SDG) 3 has been welcomed as a positive step, and a demonstration of the commitment of the international community to realise the vision of a world where every country provides affordable health care for its citizens (United Nations [UN] 2016). Universal health coverage is believed to decrease extreme poverty and drive economic growth, and is gaining critical mass worldwide, with over 300 economists recently endorsing the concept (CMAJ 2012; Obiechefu 2012; Spaan et al 2012; UN 2016). The push for African countries to move towards universal health coverage stems from the reality that the region is unable to deal with epidemics (such as Ebola and cholera outbreaks), and is behind the rest of the world in areas such as family planning, immunisation and sanitation, regarded as basic health services (Obiechefu 2012; UNICEF 2012). This is compounded by the fact that Africa accounts for almost 25% of the world's disease burden, but has inadequate medical resources (3% of the world's doctors), and lacks workable private-sector solutions to health care financing (Obiechefu 2012).

Against this backdrop, health economists acknowledge universal health coverage schemes as a solution to health care financing for Africa. Universal health coverage is a policy that provides a form of national health insurance for all or the majority of the citizenry (CMAJ 2012). As universal health coverage is capital-intensive, many governments lack the political will to implement it. The governments of Ghana, Senegal and Burkina Faso have implemented respective policies through user fees, exempting vulnerable population groups, including but not limited to children under five, pregnant women and indigents. A major implementation challenge is the reliance on premiums paid by civil servants to fund the scheme, as typically, non-government workers cannot

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afford health insurance (excepting, of course, the very wealthy in the private sector). Throughout West Africa, civil servants account for almost 15% of employees, premiums from this group are inadequate to fund the health insurance schemes (CMAJ 2012; Obiechefu 2012; Spaan et al 2012).

The unpredictability of international aid has made this an unreliable source of health care financing in Africa. According to *Obiechefu (2012),* donor-funding accounts for just 25% of health care financing in one-third of African nations, with 60% of health expenses paid for out-of-pocket. *Obiechefu* (2012) further argues that while user fees are a source of revenue for West African governments, they are largely unpopular because of their tendency to drive people into poverty and overburden poor families. As a result, in the mid-1990s, the World Health Assembly recommended against African countries adopting universal health coverage in the form of national health insurance schemes (CMAJ 2012; Kusi *et al* 2015; Spaan *et al* 2012).

Current discussion on the challenges African governments face in implementing universal health coverage policies focuses principally on the lack of funds; this paper, however, argues that issues relating to universal health coverage in Africa go beyond fiscal considerations. Our discussion is centred on three West African countries (Ghana, Senegal and Burkina Faso) that have implemented health insurance schemes; however, the lessons learned are important not just for the countries in question, but for all countries encouraged by the SDGs to implement universal health coverage. In this regard, we seek to echo the views of Obiechefu (2012, p. 1) that a '"one-size-fits-all" approach to achieving universal health coverage must be avoided and that each country must determine which strategies and reforms best meet their needs.'

Ghana's National Health Insurance Scheme

Ghana established a National Health Insurance Scheme (NHIS) in 2004 to replace the existing out-of-pocket payment system (Agyepong & Adjei 2008; Arhinful 2003; Sodzi-Tetteh *et al* 2012). A National Health Insurance Act (Act 650) of 2003 was passed to make way for the creation of a National Health Insurance Authority (NHIA), mandated to oversee the implementation of the new NHIS. The purpose of Ghana's NHIS was to enable Ghanaians to access basic health care services. Act 650 was reviewed and replaced with Act 852 in 2012, which made it mandatory for every resident in Ghana to belong to the scheme (Blanchet, Fink, & Osei-Akoto 2012).

Ghana's NHIS has five funding streams, including a 2.5% tax on particular goods and services from the Value Added Tax, called the National Health Insurance Levy (NHIL). The NHIL is the largest source of funding for the scheme, contributing 60% of the total (Kusi *et al* 2015). The NHIS is also funded by a 2.5% per month contribution from formal sector workers through the Social Security and National Insurance Trust (SSNIT). Other sources of funding include profits obtained from National Health Insurance Fund investments, premiums paid by informal-sector workers and an annual government allocation from the consolidated fund to the NHIA (Adusei-Asante & Doh 2016; Sodzi-Tetteh 2012).

The NHIS includes those exempt from payments and those who pay premiums. As explained elsewhere (Adusei-Asante & Doh 2016; Adusei-Asante & Georgiou 2017), the

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exempt group consists of public sector employees and self-employed/private employees who voluntarily contribute to the SSNIT. Children under 18, indigents, some people with disabilities (without any productive ability) and persons with intellectual disability also fall in the exempt group. Other groups in the exempt group are retirees with social security benefits and people aged above 70. All government sector employees (18–69 years) who are not part of one of the above-listed groups pay premiums (NHIA 2013).

Payment of yearly premiums is a graduated scheme, ranging between GHC7.2 (US$1.9) and GHC48.0 (US$12.6), depending on the socio-economic group an individual belongs to, determined by the NHIS district offices. The NHIS covers 95% of the disease burden in Ghana, excluding cancers (except breast and cervical cancers), HIV retroviral drugs, dialysis for chronic renal failure, hormone and organ replacement therapy and some non-communicable diseases (NHIA 2013). The NHIS is an important social protection policy, with 10,256,862 subscribers as at 2014, representing approximately 40% of the current population of Ghana, and an outpatient utilisation rate of 29,637,189 (Adusei-Asante & Doh 2016; Jehu-Appiah 2015).

Recognised globally as a promising model for social protection in health, Ghana's NHIS has made a significant impact in terms of: (1) improving health-seeking behaviours and utilisation of health care (Adusei-Asante & Doh 2016; Blanchet, Fink, & Osei-Akoto 2012; Fenny *et al* 2016; Gobah & Liang 2011; Jehu-Appiah 2015; Kuuire *et al* 2015; Teye *et al* 2015); (2) increasing utilisation of antenatal care (Brugiavini & Pace 2016; Kotoh 2013); (3) reducing maternal mortality (Dzakpasu *et al* 2012; Sofo & Thompson 2015). However, various scholars (including the authors) have followed the NHIS keenly, gleaning valuable lessons that may prove helpful for other countries seeking to implement universal health coverage systems. These insights are presented below.

The NHIS has led to high utilisation of hospital-based health care, and has consistently exceeded the projected budget allocation. According to NHIA (2013), claims for outpatient services increased from 580,000 cases in 2005 to 23.9 million in 2012, a growth of more than 400%. Similarly, inpatient services increased from 29,000 cases in 2005 to 1.4 million in 2012. Overall, claims increased from GHC7.6 million in 2005 to GHC616 million in 2012 (Adusei-Asante & Doh 2016; NHIA 2013). Jehu-Appiah (2015) cited the high claim payment as one of the key factors mitigating against the sustainability of the NHIS, arguing that allocated funds are unable to meet the emerging claims liabilities and sustain efficiency-gain initiatives—the total approved allocation (NHIL/SSNIT) for 2015 was GHC1,185.67 million, while GHC280 million was spent in respect of all expenditure for 2015.[1] Providers agitating for higher tariffs over and above this projection compound this challenge (Jehu-Appiah 2015). A further challenge relates to claims arrears and anticipated funding gaps. According to Jehu-Appiah (2015), claims arrears for 2014 totalled GHC360.4 million (as opposed to GHC85 million), while the projected funding gap for 2015 was GHC364.80 million (as opposed to $86 million). This has led the NHIA to pilot a new system called the capitation system, based on the Ghana Diagnostic Related Groupings' ideas regarding how to curb the financial challenges facing the NHIS.

[1] US$1 was approximately 4GHC in 2015.

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Increased utilisation of hospital-based health care exerts pressure on understaffed and underresourced medical facilities, particularly in rural areas. The NHIS brought about unprecedented, unanticipated patronage of hospital-based treatment, and the limited medical infrastructure in rural parts of the country have not been capable of accommodating the influx. The NHIS has exerted enormous pressure on health staff and facilities in deprived areas, resulting in patients spending long hours at the hospital, and raising concerns about the quality of health care received. There have been reports that stressed medical professionals have behaved unprofessionally towards clients, leading some NHIS clients to resolve not to seek medical assistance from hospitals (except in emergency cases), for fear of being maltreated for presenting with illnesses deemed "mild" by health professionals. Owing to distance and the lack of medical facilities and drugs in some localities, some rural dwellers, though enrolled in the NHIS, have self-treated, through drugstores, traditional medicines and faith healing (Adusei-Asante & Doh 2016; Adusei-Asante & Georgiou 2017; Aniah 2016; Dalinjong & Laar 2012).

Kusi *et al* (2015) found that the NHIS is a burden on households with low socio-economic status and large household size, and called for innovative measures to encourage the more financially able households to enrol, while abolishing the registration fee for children. Kusi *et al* (2015) also advocated for the need to price insurance according to socio-economic status of households, while addressing inimical non-financial factors to increase NHIS coverage (see also Addae-Korankye 2013). Results revealed that 66% of uninsured households and 70% of partially insured households have sufficient financial resources to fully insure. Enrolling all household members in the NHIS would constitute 5.9% of household non-food spending, or 2.0% of total expenditure; this figure is higher for households in the first (11.4%) and second (7.0%) socio-economic quintiles. All households who indicated being unable to afford to fully insure (29%) were in the two lower socio-economic quintiles and had large household sizes. The researchers revealed that non-financial factors, pertaining to qualities of the insurer and problems in the health system, affect potential membership in the NHIS.

Evidence of abuse of the NHIS has been noted. Some clients take advantage of the free policy to treat particular medical conditions and opt out immediately afterwards. We have noted several instances where this has happened, and have argued for a policy change in this regard, as its absence is negatively affecting NHIS financial viability (see Adusei-Asante, 2017; Adusei-Asante & Georgiou 2017; Kotoh 2013). Health care is a basic human need and should be viewed apolitically; however, Ghana's NHIS is heavily politicised, with various political parties using it to further their campaign agenda (Kotoh 2013). A change in government results in a change in the persons who make critical decisions on the scheme nationally. In one region, a group of people refused to join the NHIS on the grounds that the New Patriotic Party who introduced the NHIS would use the success of this health care policy as a political slogan. Politicisation of NHIS has been condemned, and politicians admonished to desist from using it for political gains, for the sake of the ordinary people who depend on it (Adusei-Asante & Doh 2016; Braimah, Rufai & Annin-Bonsu 2014; Kotoh 2013).

Other general challenges identified with the NHIS include: (1) subscribers being denied health care as a result of unpaid claims; (2) unauthorised/illegal co-payments; (3)

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increasing enrolment to achieve universal health coverage under the current financial constraint, sometimes for political expediencies; (4) agitation for expansion of the benefit package; (5) supply-side and demand-side moral hazard; (6) quality of care challenges; (7) high cost of medicines; (8) over 100% average increases in provider fees and charges (9) administrative barriers on renewal and transfer of membership; (10) gender-specific impacts (Abbey 2003; Adusei-Asante 2017; Dixon 2014; Doku, Alhassan, & Nketiah-Amponsah 2014; Jehu-Appiah 2015; Sodzi-Tettey *et al* 2012).

Health Insurance in Senegal

Full-cost recovery has existed in Senegal's health care system since the 1980s, owing to government financial constraints (Carrin, Waelkens, & Criel 2005; Mladovsky & Ndiayeii 2015). Accordingly, access to quality health care services is an area of social concern, particularly among rural and peri-urban dwellers, due to the high incidence of poverty (Barnes *et al* 2016; Jütting 2004; Soors *et al* 2010). In the last three decades, efforts have been made at both national and community levels to find alternative solutions, leading to the introduction of various forms of health care support and insurance schemes. These schemes can be grouped under two broad categories—user-fee exemption for some segments of the population and some health conditions, and community-based health insurance (CBHI) schemes (*mutuelles de santé*), an innovative community initiative (Mladovsky & Bâ 2016; Witter *et al* 2010). The CBHI schemes date back to 1990, and aim to make health care affordable to the rural poor and the vulnerable. The user-fee exemption policy, though not the prime concern of this paper, is a governmental intervention launched in 2005 in response to hardships associated with out-of-pocket payments at the point of health care services (Carrin *et al* 2005; Jütting 2004; Mladovsky & Bâ 2016; Ouimet *et al* 2007).

Senegal has one of the most successful CBHI schemes in sub-Saharan Africa, with 139 such schemes operating in 2004 (Mladovsky & Ndiayeii 2015). Available records indicate that rural subscription to CBHI between 2000 to 2007 increased from 7.1 to 17.9% respectively with a 4% nationwide coverage (Odeyemi 2014; Soors *et al* 2010). Concurrently, out-of-pocket expenditure on private health care also reduced from 91.7% to 78.5% (Odeyemi 2014; Soors *et al* 2010). The CBHI schemes are not-for-profit and voluntary, owned and organised by members of the community, on the principles of redistribution of financial resources, empowerment, solidarity and risk sharing (Carrin *et al* 2005; Mladovsky & Ndiayeii 2015). Schemes are organised into mutual health organisations (MHOs), which determine the board members, convene regular meetings with members and look for hospitals in their respective communities that are willing and able to provide subsidised services to their members. The MHOs are thus responsible for the management of the schemes (Chankova, Sulzbach, & Diop 2008; Jütting 2004). Subscription is on both household and individual bases—each household pays a one-off registration fee, while individuals pay monthly premiums (Jütting 2004). The CBHI schemes have a significant impact on access to health care among the rural poor, with negotiated arrangements between MHO managers and partner hospitals providing subscribers with up to a 50% reduction in the cost of treatment (Chankova *et al* 2008; Jütting 2004).

Despite the merits of the CBHI schemes in Senegal, the system faces a number of inherent challenges. One is the lack of a legal or institutional framework (Odeyemi 2014;

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Soors *et al* 2010). Although CBHI started in 1990, a legal instrument was only established in 2003, was under revision until 2010, and still lacks the relevant implementation Act (Odeyemi 2014; Soors *et al* 2010). According to Odeyemi (2014) and Soors *et al* (2010), this legal vacuum has threatened enrolments, financial sustainability and solidarity of some schemes, due to a lack of control and administrative and implementation abuses. Odeyemi (2014) posits that some schemes value financial viability at the expense of social equity and solidarity, by refusing membership to potential subscribers identified as economically and medically vulnerable.

Further, private health insurance schemes have the tendency to create inequalities and result in low patronage among socially heterogeneous populations, due to differing abilities to pay premiums (Jütting 2004; Sekhri & Savedoff 2005). In addition to the participation cost, the CBHI schemes only provide partial relief to members; for example, in every treatment circle, members are required to make a 50% out-of-pocket payment. Thus, the schemes are unable to provide social protection for the vulnerable who are incapable of paying subscription and monthly premiums as well as up-front payments at service points (Chankova *et al* 2008; Jütting 2004; Sekhri & Savedoff 2005).

Given the above challenges, Mladovsky & Mossialos (2015) and Ouimet *et al* (2007) advocate state participation and international support, to augment the efforts of the micro-schemes. They further argue for the incorporation of social science and political perspectives into CBHI policy design and implementation, in order to better understand and maximise equity and sustainability. Since 2007, complementary and mandatory schemes have been introduced, specifically targeting formal employees (Soors *et al* 2010). One such scheme is Assurance Maladie des Elèves, a scheme for school children (Soors *et al* 2010). Another complementary policy interventions, though not without implementation difficulties, are user-fee exemptions for childbirth, anti-retroviral drugs for HIV/AIDS and tuberculostatic drugs, and free medical care for people aged above 60 (Soors *et al* 2010).

Health Insurance in Burkina Faso

Like many developing countries, health service delivery has been a central issue in Burkina Faso, where it has been characterised by poor utilisation as a result of high costs and poor quality service (Dong *et al* 2004). In 1993, the Government of Burkina Faso introduced a user-fee system as a supplement to the existing government health services financed through the tax system; however, there has been a consistent decline in health service utilisation, as many people are not able to afford the cost-sharing arrangement (Mugisha *et al* 2002).

Burkina Faso has a very restricted formal health insurance system, which is largely exclusive to public sector employees, including the National Social Security Fund (*Caisse National de Sécurité Sociale*) and the National Social Security Fund for Retired State Employees (*Caisse de Retraite des Fonctionnaires*). Consequently, a large proportion of the population, especially rural dwellers, have been alienated from state-sponsored health insurance systems (Dong *et al* 2004). Since 2004, there have been attempts to improve health service utilisation among rural dwellers through the introduction of CBHI schemes in selected districts (Dong *et al* 2009). However, as observed by Su, Kouyaté and Flessa (2006), the introduction of CBHI led to increased

household health expenditures. Due to this, many households were unable to utilise health services to the fullest . Notwithstanding, Gnawali et al. (2009) and Parmar, De Allegri, Savadogo and Sauerborn (2014) suggested that the CBHI has made some positive strides in inducing health-seeking behaviour and fulfilling equity requirements, albeit greatly constrained by high costs. Overall, current health system financing in Burkina Faso is fragmented, preventing state-level subsidisation (Ridde *et al* 2013). However, the government's National Health Development Plan 2011–2020 seeks, among other things, to increase public financing of health services and develop strategies towards achieving universal health coverage. There are fundamental challenges involved with implementing the policy, including modalities of funding through taxation and weak government commitment towards universal health coverage (Agier *et al* 2016).

In addition, the Universal Health Insurance Law of Burkina Faso was adopted in September 2015 by the National Transition Council (Agier *et al* 2016; World Health Organization [WHO] 2015). This law created a conditional health insurance scheme, with household contributions to the scheme based on ability to pay. Other operational issues are expected to be established by government decree. The model is being trialled for three years, with challenges anticipated to arise regarding raising adequate revenue through taxation to subsidise health costs, expansion and upgrade of health facilities to accommodate the volume of health seekers and the extent to which the equity-based contribution system will be operationalised.

Conclusion

This paper provides insights into the challenges associated with the implementation of health insurance schemes, with reference to Ghana, Senegal and Burkina Faso. Aside from facilitating health care utilisation and improving health-seeking behaviours, the paper reiterates that universal health coverage schemes are capital-intensive—national insurance schemes can be counter-intuitive if implemented in a setting where human resources and infrastructure to support the policy are lacking. Further, despite efforts to improve affordability, some citizens cannot afford health insurance, requiring governments to devise innovative ways of catering for poorer citizens. Moreover, users of health insurance have a tendency to abuse loopholes if there is no enforceable institutional framework to counter this. The paper also notes that health insurance policies provide ample fodder for political game-playing. As the world readies itself to implement the SDGs, African countries planning to implement universal health coverage systems should look to Ghana and other countries that have successfully implemented such systems for inspiration, while they plan and carefully implement and monitor health insurance systems that cater for their particularised contexts, needs and human resource and fiscal capabilities, informed by relevant feasibility studies.

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