Social Science & Medicine 186 (2017) 10–19

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Equitable access to health insurance for socially excluded children? The case of the National Health Insurance Scheme (NHIS) in Ghana

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ARTICLE INFO

Article history:
Received 7 June 2016
Received in revised form
1 March 2017
Accepted 6 May 2017
Available online 10 May 2017

Keywords:
Universal health coverage
National Health Insurance Scheme
Social exclusion
Ghana
Children
Enrolment

ABSTRACT

To help reduce child mortality and reach universal health coverage, Ghana extended free membership of the National Health Insurance Scheme (NHIS) to children (under-18s) in 2008. However, despite the introduction of premium waivers, a substantial proportion of children remain uninsured. Thus far, few studies have explored why enrolment of children in NHIS may remain low, despite the absence of significant financial barriers to membership. In this paper we therefore look beyond economic explanations of access to health insurance to explore additional wider determinants of enrolment in the NHIS. In particular, we investigate whether social exclusion, as measured through a sociocultural, political and economic lens, can explain poor enrolment rates of children. Data were collected from a cross-sectional survey of 4050 representative households conducted in Ghana in 2012. Household indices were created to measure sociocultural, political and economic exclusion, and logistic regressions were conducted to study determinants of enrolment at the individual and household levels. Our results indicate that socioculturally, economically and politically excluded children are less likely to enrol in the NHIS. Furthermore, households excluded in all dimensions were more likely to be non-enrolled or partially-enrolled (i.e. not all children enrolled within the household) than fully-enrolled. These results suggest that equity in access for socially excluded children has not yet been achieved. Efforts should be taken to improve coverage by removing the remaining small, annually renewable registration fee, implementing and publicising the new clause that de-links premium waivers from parental membership, establishing additional scheme administrative offices in remote areas, holding regular registration sessions in schools and conducting outreach sessions and providing registration support to female guardians of children. Ensuring equitable access to NHIS will contribute substantially to improving child health and reducing child mortality in Ghana.

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1. Introduction

Reaching universal health coverage (UHC) has become a primary goal of health systems globally to ensure that all people have access to quality health services in times of need and are protected from the financial hardships of health care costs (WHO, 2005; WHO, 2013). Many low-and middle-income countries (LMIC) have made significant efforts to reach this goal in recent decades through implementation of a variety of ambitious pre-payment Social Health Protection (SHP) schemes that aim to reduce reliance on regressive out-of-pocket payments. Ghana has emerged as a pioneer of these health financing reforms in Sub-Saharan Africa, becoming the first country in the region to implement a National Health Insurance Scheme (NHIS) (Rajkotia and Frick, 2012). Passed into law in 2003 through the National Health Insurance Act (Act 650), the NHIS aims to promote equitable access to health care for all by abolishing the previous ‘cash and carry’ user fee system that posed significant financial barriers to access for poor and vulnerable groups (Mensah et al., 2010; Witter and Garshong, 2009). To

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http://dx.doi.org/10.1016/j.socscimed.2017.05.023
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help expand coverage, premium payments are kept low, with the scheme largely financed through government funds and value added taxes (VAT) (NHIA, 2012). In addition, a number of premium exemptions are offered to specific groups, including children under-18 years of age. However, despite significant efforts to achieve universal population coverage, membership remains low with just 38% of the population being active members (i.e. in possession of an up-to-date NHIS card) in 2013 (NHIA, 2012). Furthermore, coverage remains unequitable, with the poor, women and rural inhabitants consistently shown to be disproportionately uninsured (Akazili et al., 2014; Atinga et al., 2015; Jehu-appiah et al., 2011; Kusi et al., 2015a).

Previous studies have identified a number of causes of low overall enrolment in NHIS, including unaffordability of premiums, perceived poor quality of health care, perceptions of an inadequate benefit package due to some drugs and treatment for certain conditions not being covered, lack of trust in NHIS officials and a complicated enrolment process (Akazili et al., 2014; Atinga et al., 2015; Dixon et al., 2013; Jehu-appiah et al., 2011, Kusi et al., 2015a; Sarpong et al., 2010). What remains less clear is why enrolment in NHIS continues to be unequitable, despite considerable efforts to enrol poor and vulnerable groups through targeted removal of financial barriers. In order to fully understand these inequities it is thus important to look beyond purely economic explanations to also consider how factors in the wider social, cultural and political environment may shape access to NHIS.

An important concept through which these wider determinants of access to SHP can be analysed is that of social exclusion. A relatively new concept in the field of health research, the social exclusion framework provides a holistic understanding of how unequal social interactions and organizational/institutional barriers hinder the effectiveness of equity-oriented interventions such as SHP (Mathieson et al., 2008). As explained by the WHO's Social Exclusion Knowledge Network (SEKN), exclusion consists of “dynamic, multidimensional processes driven by unequal power relationships interacting across four main dimensions – social, political, economic and cultural” (Popay et al., 2008). Social exclusion shapes deprivations, heightens inequalities, and restricts social, political and economic participation for marginalized individuals or groups (Babajanian and Hagen-Zanker, 2012; Popay et al., 2008). As further explained by SEKN, “these exclusionary processes create a continuum of inclusion/exclusion characterised by an unjust distribution of resources and unequal access to the capabilities and rights” which are required to access SHP (Popay et al., 2008).

However, despite being an important concept through which to analyse SHP, few studies have thus far assessed how social exclusion occurring in the broader environment may affect access to health financing arrangements in LMIC (Williams et al., 2014). In this study we respond to this evidence gap by investigating how the social, political, economic and cultural dimensions of social exclusion influence access to NHIS and may help explain persistently unequitable enrolment for excluded individuals. We focus specifically on children aged under-18, a group that are eligible for a premium waiver. We first analyse enrolment determinants for individual children and then investigate exclusion of children *within* the household. Assessing intra-household exclusion is important given that enrolment in NHIS is at the individual level; households may therefore choose to enrol some children preferentially over others, for instance preferring to enrol sons over daughters. We hypothesize that children vulnerable to exclusion in all dimensions will be less likely to enrol in NHIS.

As far as we are aware, this is the first study of equity of enrolment in NHIS for children using a social exclusion perspective. Using the social exclusion lens to assess equity in health financing schemes will generate an improved understanding of the wider determinants of health insurance enrolment for children and will help expand access among this group. Reaching universal coverage of children is critical as it will contribute significantly to reducing preventable infant and child mortality in Ghana. Furthermore, timely access to health interventions in early life will have important implications for improving future health and life outcomes (Blackwell et al., 2001; Marmot et al., 2008).

2. The NHIS

The NHIS has decentralised operations, with each district having its own insurance fund, financed from central-level resources. The primary source of funding is a 2.5% VAT levy, which contributes approximately 60% to total NHIS revenue (NHIA, 2012). Other primary sources of funding include investment income (17%), premium contributions from the Social Security and National Insurance Trust (SSNIT) pension scheme (16%) and premiums and registration fees from the remaining population (<5%) (NHIA, 2012). The scheme covers over 95% of disease conditions and includes inpatient, outpatient and emergency care, deliveries, dental care and essential drugs. Enrolment in the NHIS is at the individual level, with members required to register once to join the scheme and renew their NHIS card annually to remain active members. Registration and renewal is undertaken at a District Mutual Health Insurance Scheme (DHMIS) office or by a scheme agent. Premium payments for formal sector workers are automatically deducted from their SSNIT contributions, although renewal at a DHMIS is still required to become an active member. Other individuals aged 18–69 pay a premium contribution and registration fee which varies according to socioeconomic status and district (Kusi et al., 2015b; NHIA, 2012). To enhance enrolment of vulnerable groups, indigents identified through their community and pregnant women are exempt from paying premiums and registration fees, although proof of exemption status such as an antenatal card must be shown at a registration office. Older people aged over 70, SSNIT pensioners and children aged under 18 are exempt from paying premiums, but must pay an annual registration fee of approximately GhȻ4.0 (US$2.7) (Kusi et al., 2015a). Until 2012, children aged under 18 were only entitled to a premium waiver if at least one parent or guardian was a member of NHIS; this clause was abolished in 2010 for children under 5 and for all children in 2012, but is yet to be fully implemented (Kusi et al., 2015a). In 2013, an estimated 10.1 million people were NHIS members, corresponding to 38% of the Ghanaian population; children accounted for 46.5% of active members (NHIA, 2012).

3. Methodology

3.1. Study design and data

Data were collected from a cross-sectional household survey conducted in 2012 in five regions: Central, Eastern, Ashanti, Brong-Ahafo and Northern, that covered the three ecological zones of Ghana, coastal, forest and savannah. In each region, one district was selected for sampling in consultation with the Ghana Statistical Service (GSS). These districts are all relatively underdeveloped and were selected purposively to ensure a mix of urban and rural areas and to ensure that a random sample of households would elicit a significant sample of socially excluded individuals for our analysis. From each district, 27 nationally representative Enumeration Areas (EAs) were randomly selected by GSS. EAs contain a mix of urban and rural areas and are determined by the GSS based on the 2000 Ghana population and Housing census to ensure nationally representative surveys. Following MEASURE Demographic Health

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