

Instructions for authors, subscriptions and further details:

<http://rimcis.hipatiapress.com>

Sustaining Ghana's National Health Insurance Scheme Through Preventive Healthcare Strategies and Legislation

Samuel Adu-Gyamfi¹, Aminu Dramani¹

1) Kwame Nkrumah University of Science and Technology, Ghana

Date of publication: March 30th, 2017

Edition period: March 2017 – July 2017

To cite this article: Adu-Gyamfi, S., & Dramani, A. (2017). Sustaining Ghana's National Health Insurance Scheme Through Preventive Healthcare Strategies and Legislation. *International and Multidisciplinary Journal of Social Sciences*, 6(1), 47-69. doi: 10.17583/rimcis.2017.2149

To link this article: <http://doi.org/10.17583/rimcis.2017.2149>

PLEASE SCROLL DOWN FOR ARTICLE

The terms and conditions of use are related to the Open Journal System and to [Creative Commons Attribution License \(CC-BY\)](#).

Sustaining Ghana's National Health Insurance Scheme Through Preventive Healthcare Strategies and Legislation

Samuel Adu-Gyamfi
*Kwame Nkrumah University
of Science and Technology*

Aminou Dramani
*Kwame Nkrumah University
of Science and Technology*

Abstract

This article focuses primarily on secondary literature to highlight some of the key issues that has affected the effectiveness and the efficiency of the National Health Insurance in Ghana. The article proposes the need to use legislation and additional preventive healthcare strategies to lessen or reduce the pressure that comes upon the National Health Insurance Authority. Finally, it postulates that the people of a community, their institution, that is health institutions and Para-health institutions that ensure public safety, environmental protection, and sanitation among others are enjoined to reduce the occurrence of disease and injury or harm. This could ensure a healthy work force and a healthy population that has the tendency or proclivity to increase productivity and lessen disease burden with its associated harm and cost on the state, especially in countries where social insurance is practiced.

Keywords: National Health Insurance (NHIS), preventive health, laws, health

Manteniendo el Esquema de Aseguranzas Nacionales de Salud a través de la Legislación y de Estrategias Preventivas de Salud

Samuel Adu-Gyamfi
*Kwame Nkrumah University
of Science and Technology*

Aminou Dramani
*Kwame Nkrumah University
of Science and Technology*

Resumen

Este artículo se centra en primer lugar en literatura secundaria para subrayar algunos de los temas clave que han afectado la efectividad y la eficiencia de la Seguridad Nacional de Salud de Ghana. El artículo propone la necesidad de utilizar la legislación y estrategias de salud preventivas adicionales para rebajar o reducir la presión que se cierne sobre la Autoridad de la Seguridad Nacional de Salud. Finalmente, postula que los miembros de una comunidad, sus instituciones de salud e instituciones de para-salud que aseguran la seguridad pública, la protección medioambiental, y la sanidad entre otras cosas; estén orientados a reducir las enfermedades, accidentes y males. Esto podrá asegurar una fuerza de trabajo y una población saludable proclive a aumentar la productividad y reducir la cantidad de enfermedades con sus males y costes estatales asociados, especialmente en países donde se practica la seguridad social.

Palabras clave: Aseguranza Nacional de Salud (ANS), salud preventiva, leyes, salud

Health as defined by the World Health Organization is a state of complete physical mental and social well-being and not merely the absence of disease or infirmity (WHO, 1948). Prepayments and risk pooling through social health insurance has been advocated by international development organizations. Social health insurance is seen as a mechanism that helps mobilize resources for health, pool risk, and provide more access to health care services for the poor. Hence Ghana implemented the National Health Insurance Scheme (NHIS) to help promote access to health care services for Ghanaians (Saltman, Busse & Figueras, 2004).

Writing in 1987, Epp argued that health ceases to be measured strictly in terms of illness and death. It has evolved to include what has become a state in which individuals and communities strive to achieve, maintain or regain, and not something that comes about as a result of treating and curing illnesses and injuries. It should also include basic and dynamic force in our daily lives, influenced by our circumstances, beliefs, culture including social, economic and physical environments (Epp, 1987).

Everybody at some time in life, and often on many occasions, will need some kind of medical attention and treatment. When medical care is required, ideally the patient should be able to concentrate on getting better, rather than wondering whether he/she could pay for all the bills. In some countries, such as the United Kingdom or Canada, health care coverage is provided by the state and is seen as every citizen's right –it is classed along with public education, the police, fire-fighters, street lighting, and public road networks, as a part of a public service for the nation.

In other countries, such as the USA, health insurance coverage is seen somewhat differently –with the exception of some groups, such as elderly and/or disabled people, veterans and some others, it is the individual's responsibility to be insured. More recently, the Obama Administration has introduced laws making it mandatory for everybody to have health insurance, and there are penalties for those who fail to have a policy of some kind. Significantly, Stuckler and Basu (2013) have argued that when governments invest more in social welfare programs —housing support, unemployment programs, old-age pensions, and healthcare—

health improves and this is not merely a correlation, but a cause- and- effect relationship seen across the world (Stuckler & Basu, 2013).

Community-based health insurance and mandatory health insurance for either the entire population or a segment of it seem to be gaining ground in sub-Saharan Africa. Ghana’s scheme is one of very few attempts by a sub-Saharan African country to implement a national-level, universal health insurance program (Kirigia, Preker, Carrin & Mwikisa, 2006). Healthcare financing through social health insurance or tax-funded schemes has become a very important tool in achieving universal financial protection for healthcare in most developing countries such as Ghana. Contributions to these schemes are usually based on one’s means, and as such these systems provide relatively fairer means of financing healthcare, which is particularly good for the poor (Gajate-Garrido & Owusua, 2013).

The National Health Insurance Authority (NHIA) was established under the National Health Insurance Act 2003, Act 650, (now replaced by a new law, Act 852) as a body corporate, with perpetual succession, an Official Seal, that may sue and be sued in its own name. The NHIA was commissioned “to secure the implementation of a national health insurance policy that ensures access to basic healthcare services to all residents” (National Health Insurance Act, Act 650, 2003). The object of the Authority is to secure the implementation of a national health insurance policy that ensures access to basic healthcare services to all residents. The Authority, among others ensure equity in health care coverage, access by the poor to healthcare services, protection of the poor and vulnerable against financial risk, manage the National Health Insurance Fund, receive, process and pay claims for services rendered by healthcare providers, undertake programmes that further the sustainability of the National Health Insurance Scheme (NHIS) and generally oversees and reports on NHIS operations. Adu-Gyamfi, Brenya and Amoah (2015) argue that people access the facilities rampantly even when they have gone for treatment and it is not time for them to go for review. They also allude to the multiple inflation of cost by health or medical facilities. Dalinjong and Laar (2012) argue that high attendance and perceived service abuse by the insured had led to an increased workload for providers. Providers experience long working hours with little or no break times. However, providers were not motivated enough

by the NHIS and government to compensate for the heavy workload experienced (Dalinjong and Laar, 2012). This to an extent increases the burden on the National Health Insurance Authority.

The importance of Social Health Insurance (SHI) has been by different studies, the argument that Social Health Insurance alone is ultimate in dealing with the challenge of healthcare has been directly and by inference contested. Writing on social health insurance for developing nations, Shaw (2007) argued that SHI should not be seen as a magic bullet that will solve all the woes of healthcare financing and provision in developing countries including Ghana. This suggests that other elements or ingredients are essential in spicing the “financing Pudding” offered by SHI.

Although some studies have been done on the NHIS, none of them has focused on how preventive healthcare legislation can help ease the heavy financial demand which is collapsing the scheme. The major cause for concern in Ghana’s quest for answers about health delivery in the country is not even the much talked about administrative, managerial, training, exploitative and profiteering schemes of service providers to the National Health Insurance scheme often at the blind side of patients and other areas of the sector. Rather, this paper seeks to focus on the preventive care provisions with some comparative analysis or general outlook from the globe. Of great importance to the discourse is for us to find out the importance of public health laws on communicable diseases, non-communicable diseases, the position of the World Health Organization on communicable and non-communicable diseases as well as the position of Ghana Health Service on Public Health Laws.

The paper is divided into three sections. Following this introduction, background information on the NHIS is presented, including a brief review of previous studies of this scheme as well as evidence that the scheme is in financial crisis. The final section explains why preventive healthcare law and strategy is necessary and recommends what should be included in such a law.

Ghana’s National Health Insurance Scheme

Health care financing in Ghana began with a tax sponsored system that provided free public health care services to all after independence. As this system gradually became financially unmanageable especially with the economic challenges in the 1970s, low user fees were established for hospital services to deal with unnecessary access, and to also locally recover some costs and generate provider performance incentives. Continued regressions in government spending on health through the 1970s and 1980s led to shortages of medicines and supplies and worsening quality of care. Following adoption of structural adjustment reforms in 1983, the Rawlings administration elevated and extended user fees for public health care services in a system that became known as “cash and carry.” The user fee system improved operating revenues for some facilities, but it was poorly regulated, inconsistently implemented, and found to have worsened access to care for the poor (Blanchet, Fink & Osei-Akoto, 2012).

Starting from the early 1990s, Ghana began to seek other ways of financing health care, including NGO introduced community-based health insurance schemes (CBHIS). While popular among members and international donors at the time, the schemes were only targeted to specific areas, failed to address key social insurance issues, and were not sustained by general government revenue to allow them to satisfy for the poor. Most prominently, with CBHIS covering only about 1% of the population with limited benefit packages, the system of user fees continued the principal means of paying for health care. The highly unpopular out of pocket cost for medical care also referred to in Ghana as “cash and carry” system became an outstanding political issue and the main opposition party, the New Patriotic Party (NPP), called for its abolishment in its manifestos and campaign promises. This might have helped the NPP win the 2000 presidential and parliamentary elections (Blanchet, Fink & Osei-Akoto, 2012).

Ghana’s National Health Insurance Scheme (NHIS) was introduced in 2003 to replace the fee for service system. It was created by the National Health Insurance Act of August 2003. The NHIS is financed from four main sources: a value-added tax on goods and services, an earmarked portion of social security taxes from formal sector workers, individual premiums, and

miscellaneous other funds from investment returns, Parliament, or donors. The 2.5% tax on goods and services, called the National Health Insurance Levy (NHIL), is by far the largest source, comprising about 70% of revenues. Social security taxes account for an additional 23%, premiums for about 5%, and other funds for the remaining 2% (Yankah, 2009; Adu-Gyamfi, 2015).

The NHIS (including all DMHISs) has a single benefit package that is set by Legislative Instrument 1809 and described by the NHIA as covering “95% of disease conditions” that afflict Ghanaians (National Health Insurance Regulations, LI 1809, 2004). The NHIS covers outpatient services, including diagnostic testing and operations such as hernia repair; most in-patient services, including specialist care, most surgeries, and hospital accommodation (general ward); oral health treatments; all maternity care services, including Caesarean deliveries; emergency care; and, finally, all drugs on the centrally-established NHIA Medicines List.

Finally, one of the objectives of the NHIS is to be able to provide funds to health care providers in bulk for planning purposes to ensure efficient and effective delivery of healthcare service, thus, solving the problem of inability of patients to pay for the cost of healthcare (Akosua Akortsu & Aseweh, 2011).

The Position of the Literature

If properly managed, the NHIS comes along with increased access to health care and general improvement in health of the people (Adu-Gyamfi et al., 2015). According to Dalinjong and Laar NHIS has made access to health care services very easy. This was due to the fact that one is not required to pay for services at the point of consumption (Dalinjong & Laar, 2012). By the end of 2011, the total number of accredited health facilities was 3,344, in contrast to 1,672 in 2008. Outpatient utilization of healthcare services increased more than fortyfold, from 0.6 million in 2005 and 16.9 million in 2010 to 25.5 million in 2011. Also, Dalinjong and Laar have confirmed the utilization of health care services have increased under the NHIS. For instance, both baseline and end line studies on the NHIS saw an increase in

utilization of health care services from 37% in 2004 to 70% in 2008 in Ghana. Similarly, the Ministry of Health (Ghana) reported that the use of outpatient and inpatient services under the NHIS almost doubled between 2005 and September 2007 (Dalinjong & Laar, 2012). Finally, inpatient utilization increased more than thirtyfold from 28,906 in 2005 to 973,524 in 2009, and then it rose further to 1,451,596 in 2011 (NHIA, 2011). According to Asuming (2013) the insurance coverage has led to reduced out-of-pocket payments among individuals with prior positive expenses and also to improved health outcomes (fewer days of illness suffered). According to the 2008 Citizens’ Assessment (NDPC, 2009), being an NHIS cardholder improves the chances of seeing high-quality health professionals (doctors and medical assistants versus consult drugstores and traditional providers). Similarly, being registered in the DMHIS increases the probability of seeking higher quality maternal healthcare as well as the likelihood that parents take their children to health facilities more often for both curative and preventive care (Gajate-Garrido & Ahiadeke, 2013). NHIS members have a higher probability of obtaining prescriptions, visiting clinics, and seeking formal healthcare when sick (Blanchet, Fink & Osei-Akoto, 2012). The 2008 Citizens’ Assessment (NDPC, 2009) indicates that the number of days of school or work lost due to illness is highest among those who have not registered (4.8 days) compared with days lost by the insured population (3.6 days). Finally, pregnant women who participate in the scheme enjoy reduced incidence of birth complications and are more likely to receive prenatal care, to deliver at a hospital, and to be attended by a trained health professional during birth (Mensah, Oppong & Schmidt, 2009).

Financial Challenges of the NHIS and Implications

Unfortunately, the NHIS is bedevilled with challenges including the inability to pay claims for services rendered by healthcare providers. Gajate-Garrido and Owusua (2013) identified delayed reimbursement of claims as an issue in several regions, especially in the Ashanti, Brong Ahafo, and Western regions. Akosua Akortsu and Patience Aseweh also identified that the NHIS is not a reliable source of financing, although the policy is a good one. In their research most of the respondents lamented that there are delays in the

payment of reimbursements. They explained that reimbursements from the use of the scheme are supposed to take a maximum of four weeks. However, payments for services rendered to subscribers could take as long as twelve months. It was found that the delays tend to affect the ability of the Hospital to pay suppliers of drugs and also impede the smooth running of the Hospital (Akosua Akortsu & Aseweh, 2011). The Executive Director of Health Insurance Service Providers Association of Ghana (HISPAG), Frank Richard Torblue, disclosed that the NHIA owed the service providers GH¢213 million which is for a four-month claim out of the seven months (Daily Guide, 2016). The Chairman of the Public Accounts Committee (PAC) of Parliament asked the Health Minister to lobby cabinet to release enough money for the running of the National Health Insurance Scheme (NHIS) because the scheme is choked with huge debt which is crippling its operations. The minister admitted that the NHIA owes several health service providers accredited to the scheme in arrears of between six and eight months, and that the funding sources cannot match the growing number of people getting registered into the health insurance scheme (Daily Guide, 2016).

Anecdotal evidence suggests that there exists over-utilization and health shopping among health facilities by the insured, an evidence of moral hazard and a negative effect on the quality of healthcare being delivered as a result of the increasing utilization. The perceived low quality of service received from healthcare providers were attributed to unavailability of drugs and long waiting times. The seemingly unavailability of drugs was in part attributed to delays in submission of claims by health facilities and reimbursement by the scheme, which put financial burden on the facilities considering the fact that most of them now earn more than 80% of their revenue from insurance (Gobah & Zhang, 2011).

The non-payment of claims by the NHIA has led to card bearing members of the scheme being denied services as the service providers refuse to render any more service until their money is refunded to them. Such a situation affects the health seeking behaviour of the population. It comes with negative tendencies on the health of the entire nation resulting in low productivity, high cost of living and emergence of social

and economic delinquencies. It worsens access to basic healthcare for the poor. It may also mean reintroduction of charging of fees. There is overwhelming evidence that suggests that user fees constitute a strong barrier to the utilization of health care services, as well as preventing adherence to long term treatment among poor and vulnerable groups (James, (James, Hanson, McPake, Balabanova, Gwatkin, Hopwood & Preker, 2006; Palmer, 2004).

The delay in payment had made providers resort to the issuance of prescription forms for insured clients to buy drugs out of the facilities. Another consequence of the delay in reimbursement was the fact that it had made some providers prefer clients who would make Out of Pocket Payments (OOP) for services to those with the NHIS cards. These OOP payments from the uninsured assist providers to run the facilities while they wait for the main payments from the NHIS. In addition, providers were handicapped in the payment of their casual employees. For example, cleaners and security men whose names were not on government’s payroll are usually paid from internally generated funds mobilized by the facilities (Dalinjong & Laar, 2012).

Discussion

This section focuses on the essence of the law in ensuring prevention of diseases and also to reduce the fiscal burden diseases impose on health care financing. The question asked is why is law important in the sustenance of Ghana’s health insurance? There are other important themes that are discussed to supplement the issues on law.

Why is Law Important

Of all the professions with which health workers must deal with, law is undoubtedly the most pervasive. Law does not only constitute the structural framework of the whole of our organized society including our multitude of governments, but it provides those rules or norms of conduct to which society expects adherence and the means of compelling adherence when that is necessary. Every governmental agency is created and its authority defined

by law, and every administrative regulation and every expenditure of public funds must be authorized by law. Practitioners are licensed and institutions chartered and their authority fixed by law. Health agencies, public and private, and practicing members of the health professions, because of the critical importance to the public of what they do, are held to a high measure of accountability, of which the law is and must be the final arbiter (Willcox, 1964).

The law is in some sense the master and in some sense the servant of the health professions, whether in the traditional realms of public health or in the private practice of these professions. If it is the master in defining what may legally be done and how, it should be the servant in its readiness to adapt, at the behest of other disciplines, to the changing needs of the times. If it is the servant in enforcing those rules of conduct which the health professions have found necessary to the protection of the public, it is the master in setting bounds beyond which the rules may not impinge on the rights of individuals. We live in an age when man is challenged as never before by the need to adjust his social institutions including, conspicuously, the law to keep pace with his ever broadening mastery over nature (Willcox, 1964).

The majority of conditions leading to out-patient attendance at clinics in Ghana are malaria, diarrhoea, upper respiratory tract infection, skin disease, accidents, hypertension, eye infection, pregnancy-related conditions, among others. In fact, the poor environmental conditions in which Ghanaians live, work and go to school has a major impact on their wellbeing. The poor air, water and soil quality in the country is mainly due to improper disposal of waste, emission of dangerous gases from industries and vehicles, and smoke from burning of waste and bush fires. Despite this situation, the measures for controlling these problems have not been effective. Access to potable water, for instance, is a problem. Less than half of the population in the country has access to potable water (NHP, 2007) leaving the rest to obtain water from streams and rivers, which are often contaminated with organic and inorganic substances from household and industrial pollutants. Even where portable water is available, beliefs and social misconceptions leave such a facility unused.

Most of these diseases are preventable if appropriate legal, environmental and lifestyle measures are taken. Over 90% of these diseases and conditions could easily be prevented (NHP, 2007). However, instead of developing and promoting preventive health lifestyles through good nutrition, regular physical exercise, recreation, rest and personal hygiene, safe food, housing and roads to the benefit of its people, health programmes and projects in the country have focused on curative care (Adu-Gyamfi et al., 2013). The over concentration on curative health largely contributes to the large number of card bearing members reporting at the hospitals and other health facilities daily. This has direct financial implication to the National Health Insurance Scheme (NHIS) as a social intervention programme that seeks to increase access to basic quality health care. Poor service delivery by health care providers under the NHIS is an act that defeats the purpose for which the scheme was established.

While this paper does not intend to overlook the critical nature of the other sources of challenges facing the scheme, it recommends the promulgation of laws or amendment of existing ones to promote preventive healthcare. Such laws may promote good health among the populace and thereby reduce the volume of claims from the scheme. New laws (or amendments) to enhance the work of sanitation inspectors (commonly known as ‘*saman saman or tankase fo*’) can, at least, help to ensure clean environment in our immediate surroundings and thereby improve personal hygiene. Health and Sanitation are vital components of human health and development. Improved sanitation according to medical scientists reduces diseases such as cholera, diarrhoea, worm infestation, pneumonia, malaria and typhoid, among others and death in millions of people.

Also, all radio and television stations should be mandated to design and promote preventive health awareness campaign programmes. Such programmes could take the form of drama, documentary or even advertisements. This could come as part of their corporate social responsibility. Remember, radio gets results. Significantly, the question is if people do not get sick would they go to hospitals in the first instance? By less people going to the hospitals financial burden on the NHIS will reduce and that in essence has the tendency or the proclivity to ensure a smooth running of the NHIS.

Commenting on public health law and non-communicable diseases, Tanaka et al. (2014) drew our attention to the background of diseases and public health. Law, imposition of statutory duty on a range of bodies to reduce health inequalities, legislation to bring about a renewed focus on the prevention of ill health as well as the legislation to encourage community action around health protection and improvement. She argued that by 2008, nearly two-thirds of all deaths- 36 million were caused by non-communicable diseases, cancers, diabetes, and chronic lung diseases. With the increasing number of global deaths arising out of non-communicable diseases, social insurance would have to focus on this. If that is the case, there should be modalities or laws to ensure effective, individual, organisational or institutional and proper community behaviour to reduce the number of people who suffer from these diseases and would have to depend on social insurance. Tanaka et al. argues that economic burden of NCDs is sizeable, with a 2011 projection of cost on world economy amounting to 47 trillion dollars over the next two decades which is approximately seventy-five percent of the 2010 global Gross Domestic product (GDP).

As put out by the WHO “Investing in prevention and better control of this broad group of disorders will reduce premature death and preventable morbidity and disability, improve the quality of life and well-being of people and societies, and help reduce the growing health inequalities they cause” (WHO, 2011). World Health Organisation 2011 Strategies for NCD Interventions include:

- Protecting people from tobacco smoke and banning smoking in public places.
- Enforcing bans on tobacco advertising, promoting and sponsorship.
- Raising taxes on tobacco
- Restricting access to retailed alcohol
- Enforcing bans on alcohol advertising
- Raising taxes on alcohol
- Reducing salt intake and salt content of food
- Replacing trans- fats in food with polyunsaturated fat

- Promoting public awareness about diet and physical activity, including through mass media.

Globally, Tanaka et al. (2014) has argued that between 1972 and 2006, as a result of a policy focused on healthy diet, exercise and the reduction of smoking, the world witnessed 85% decrease in annual mortality rate from coronary heart disease. Also by 2013, in New York, a five-year old health Department regulation banning trans- fats has reduced consumption of trans fats among fast-food customers from about 3 grams to 0.5 grams per purchase-which shows that local health regulations can significantly influence public consumption.

The Importance of Public Health Law

In 2007 the Nuffield Council on Bioethics presented a vision on the stewardship role of the state. They emphasized that governments have a duty to look after important needs of people individually and collectively. It was anticipated that goals of public health programmes would encompass reduction of risk, environmental protections, and protections for vulnerable populations, health promotions, enabling the populations to make healthy choices, access to medical services and a reduction of health inequalities.

Public health law is defined among others as “the study of the legal powers and duties of the state to assure the conditions for people to be healthy (example to identify, prevent and ameliorate risks to health in the population) and the limitations on the power of the state to constrain the autonomy, privacy, liberty or other legally protected interests of individuals for protection or promotion of community health”. Hoke and Swinburne also defined Public health law as a field that focuses legal practice, scholarship and advocacy on issues involving the government’s legal authorities and duties “to ensure the conditions for people to be healthy, and how to balance these authorities and duties with “individual rights to autonomy, privacy, liberty, property and other legally protected interests. The scope of public health law is broad. Public health law issues range from narrow questions of legal interpretation to complex matters involving public health policy, social justice and ethics (Hoke & Swinburne, n.d.).

Comparatively, in the United States, Federal and state laws prohibiting the production, sale, use or possession of synthetic drugs are an important element in the public health response but law enforcement officials face significant hurdles in pursuing criminal charges against those who sell synthetic drugs. Essentially, other scholars like Mariner (2009), Magnusson (2007), and Burris, Kawachi and Sarat (2002) argue among others that public health laws should focus on determining or serving as a mechanism for the health effects of social and physical environments. Callahan and Jennings (2002) have also argued toward this end that as the concern of health policymakers turn toward health outcomes, cost-effectiveness, and preventive measures throughout the life cycle (primary, secondary, and tertiary prevention), the field of public health is gaining increased public and legislative attention. They further argue among other things that Public health, especially the public health professional in many matters has the legal power especially the police power of the state behind it. As a result of that it can through use of law, compel citizens to behave in an approved healthy way especially through compulsory immunization of their children, restriction on smoking in public places, or by quarantining them to stop the spread of infectious disease (Callahan & Jennings, 2002).

However, researching on international law and global health, Fidler (1999) concluded by warning that neither law nor global health jurisprudence provides a panacea for the public health problems facing the planet. He argues among other things that law is ultimately an instrument in human affairs, not an end in itself and legal energy alone is not enough to establish footholds on the mountains of problems confronting humanity. This notwithstanding, Hodge (1998) argued that “there is perhaps no facet of governmental regulation more important to the public welfare than the maintenance of public health. The role of law is vital to the accomplishment of public health objectives. The field of public health owes its existence in large part to the role of government and the laws it enacts to control the factors which contribute to a healthier society. As a result, the field of public health law is coextensive with the dynamic field of public health: the goals of the latter necessarily become, at least in part, the objectives of the former”. In Africa and Ghana in

particular, the challenge of implementation of some of existing public health regulations stem from the lack of preparedness on the implementers of the law and the recipients to change from ingrained negative attitudes that public health laws are anticipated to engineer in the society to bring about good health and well-being.

District Assemblies must create Sanitation Section. Where such sections already exist, they must be strengthened and made responsible for the maintenance of public health. The core duties of the section are primarily to ensure public cleansing, proper waste management, effective pest and disease control, supervision of food hygiene and undertaking fumigation services. This in essence would reduce the disease burden on the population which means that there would be little or minimal spending from the insurance kitty on health. Again, referring to colonial records on Ghana show those sanitary bye-laws prevented the spread of diseases like virulent diarrhoea and bubonic plague among others (Adu-Gyamfi, Adjei & Owusu-Ansah, 2013).

The implementation of existing laws on sanitation, city and urban planning, the ban on marijuana usage, the restrictions on the use of tobacco among others do not only have the tendency and proclivity to ensure public safety and well-being but also reduces the financial burden on healthcare financing. As already argued by Tanaka et al. (2014), law can be used to advance public health in a number of different ways. For example, for emphasis our attention is drawn to a 2011 report from the WHO Regional Office for Europe which sets out four major roles. They include the following: defining the objectives of public health and influencing its policy agenda; authorising and limiting public health action with respect to protection of individual rights, as appropriate; serving as a tool for prevention; and facilitating the planning and coordination of governmental and non-governmental health activities. We could also infer from same literature that there are essential areas to look out for in legislating to improve upon the health of society which also has the potential to reduce the pressure on National Health Insurance with Ghana not an exception. The areas include extending the requirement to use Health Impact Assessments; imposing a statutory duty on a range of bodies to reduce health inequalities; legislation to bring about a renewed focus on prevention of ill health; and

legislation to strengthen community action around health protection and health improvement (Tanaka et al., 2014).

Comparatively, Epp (1987) argued concerning the adult population in Canada that with regard to adults, the use of preventive measures could to a future 50% reduction in the incidence of lung cancer and heart. Concerning this, we include legislations that ensure that institutions concerned with health promotion and preventive healthcare are able continuously and persistently ensure that the population especially the adult population is able to act in a way or pursue causes that would ensure good health and well-being.

Preventive Healthcare

Again, Epp (1987) argued among other things that prevention involves identifying the factors which cause a condition and then reducing or eliminating them. He argued that within the nineteenth century, through the efforts of public health, the practice of prevention gained wider acceptance across the globe. Immunization and the chlorination of drinking water were prime examples of measures introduced to prevent and reduce the incidence of infectious disease.

Within the twentieth century, preventive efforts were extended into areas like individual lifestyle and behaviour. Comparatively, Epp (1987) argued that in Canada, the realization that smoking, alcohol consumption and high-fat diets were contributing to lung cancer, cirrhosis of the liver, cardiovascular disease and motor vehicle accidents, led the country to turn their attention to reducing risk behaviour and tried to change people's lifestyles. Closely linked to this is the element of health promotion. Epp (1987) refers to the WHO that "health promotion is the process of enabling people to increase control over, and to improve, their health". It "represents a mediating strategy between people and their environments, synthesizing personal choice and social responsibility in health to create a healthier future" (Epp, 1987). This health promotion should not be restricted only to the making of pamphlets and posters about health but it should include health education, training, research, legislation, policy coordination and community development (Epp, 1987). It is essential that

in any country including Ghana where such strategies are deployed, it should be able to reduce disease burden on the population in the country and further lessen the pressure it would put on the existing social or health insurance because of over patronage or hospital attendance due to ill health. The public health profession itself should have a lot of political power and governmental support including the necessary ethical considerations to allow for effective prosecution of the health agenda as expressed by Callahan and Jennings (2002). They argued that “Public health also has the distinction, along with a few others —such as city management, public administration, and law enforcement— of being a profession in which many practitioners are government employees and officials. It has an obligation both toward government, which controls it, and toward the public that it serves” (Callahan & Jennings, 2002).

Conclusion

Health delivery in Ghana is faced with such a complexity of problems that instead of improving and becoming sophisticated, it rather deteriorates by the day. There are so many thousands of patients who throng our hospitals, clinics, polyclinics and sometimes health centres everyday seeking health care. The numbers are overwhelming to an extent that it has made these facilities look like hopeless refugee holding centres. In all such cases, it is the poor and the vulnerable who are worst affected. To avoid any humanitarian disaster and ensure that Ghanaians are healthy, happy and hearty to work for the attainment of the goals of the country, drastic measures must be taken and swiftly. Preventive health legislation with effective enforcement mechanisms is the solution.

From what the literature has put out; whether on the question of public health law on communicable diseases, the position of the WHO on health laws, as well as the position of the Ghana Health Service suggest that prevention is better than cure. To a larger extent, the people of a community, their institution, that is health institutions and Para-health institutions that ensure public safety, environmental protection, and sanitation among others are enjoined to reduce the occurrence of disease, injury or harm. This would ensure a healthy work force and healthy population that has the tendency or

proclivity to increase productivity and reduce disease burden with its associated harm and cost on state, especially where social insurance is practiced.

Gobah and Liang (2011) have reported that “there exists over-and health shopping among health facilities by the insured, an evidence moral hazard and a negative effect on the quality of healthcare being delivered as a result of the increasing utilization. The perceived low quality of service received from healthcare providers were attributed to unavailability of drugs and long waiting times.” This amply suggests among others that there is the need to look at preventive health care to deal with the frequent utilization of hospitals or health centres to reduce disease burden on the population which will reduce the cost or expenditure that burdens the National Health Insurance Authority. It is justifiable to note however, that it does not make economic sense to have oversubscription of health insurance but the funds do not complement the expenditure due to overutilization of the health facilities or hospitals. Legislation or laws that seek to at least deal with the conduct of members of society with regard to their own health and well-being would produce a healthy population that would visit the hospital fewer times in a given year or more. This in essence would add to the success of the health insurance.

It can therefore be surmised that the National Health Insurance in Ghana continues to be plagued by oversubscription and utilization of health centres. There are moral and legal arguments that have been raised to direct both patients and management of health facilities to help reduce the cost or expenditure in financing the health and well-being of individuals. However, in this paper we have argued that effective public health laws and other legislations that prevent the use of harmful drugs/herbs among others would improve the health and well-being of the population and further lessen hospital visits and the claims that are made by the medical facilities. This has the proclivity to reduce the pressure on the National Health Insurance Authority and ensure the sustenance of the National Health Insurance Scheme. It is envisaged that in this instance the centrality of law for the work of public health should

bring uncommon visibility to its actions and an uncommon need for public accountability (Callahan & Jennings, 2002).

References

- Adu-Gyamfi, S., Brenya, E., & Amoah, A. (2015). National Health Insurance Scheme of Ejisu-Juabeng and Matters Arising. *International Journal of Social Science Studies*, 3(5), 40-60. doi: [10.11114/ijsss.v3i5.962](https://doi.org/10.11114/ijsss.v3i5.962)
- Adu-Gyamfi, S., Brenya, E., & Adjei, G.N. (2015). National Health Insurance and Free Maternal Healthcare in Ghana: Responses from Women and Health Workers in Akropong. *Modern Research Studies: An International Journal of Humanities and Social Sciences*, 2(4), 696-737.
- Adu-Gyamfi, S., Osei-Wusu Adjei, P., & Owusu-Ansah, D. (2013). Preventive Healthcare Strategies Among the Asante People of the Early Twentieth Century Gold Coast: A Historical Narrative and Lessons for the Present Sanitation Challenge in Kumasi. *Journal of Studies in Social Sciences*, 5(2), 214-238.
- Akosua Akortsu, M., & Aseweh Abor, P. (2011). Financing Public healthcare institutions in Ghana. *Journal of Health Organization and Management*, 25(2), 128-141. doi: [10.1108/147772611111134383](https://doi.org/10.1108/147772611111134383)
- Asuming, P.O. (2013). Getting the Poor to Enroll in Health Insurance, and its effects on their health: Evidence from a Field Experiment in Ghana. *Job Market Paper – Columbia University*.
- Blanchet, N.J., Fink, G., & Osei-Akoto, I. (2012). The Effect of Ghana’s National Health Insurance Scheme on Healthcare Utilisation. *Ghana Medical Journal*, 46(2), 76–85.
- Burris, S., Kawachi, I., & Sarat, A. (2002). Integrating Law and Social Epidemiology. *Journal of Law Medicine and Ethics*, 30(4), 510-521. doi: [10.1111/j.1748-720X.2002.tb00422.x](https://doi.org/10.1111/j.1748-720X.2002.tb00422.x)
- Callahan, D., & Jennings, B. (2002). Ethics and Public Health: Forging a Strong Relationship. *American Journal of Public Health*, 92(2), 169-176. doi: [10.2105/AJPH.92.2.169](https://doi.org/10.2105/AJPH.92.2.169)

- Daily Guide (2016, January 26). Save NHIS From Collapse – PAC Tells Health Minister. *Daily Guide*. Retrieved from: <https://www.modernghana.com>
- Dalinjong, P.A., & Laar, A.S. (2012). The national health insurance scheme: perceptions and experiences of health care providers and clients in two districts of Ghana. *Health Economics Review*, 2(1), 2-13. doi: [10.1186/2191-1991-2-13](https://doi.org/10.1186/2191-1991-2-13)
- Epp, J. (1987). Achieving Health for all: A framework for Health Promotion. *Health Promotion*, 1(4), 419-428.
- Fidler, D.P. (1999). *International law and infectious diseases*. Oxford: Oxford University Press.
- Gajate-Garrido, G., & Owusua, R. (2013). The National Health Insurance Scheme in Ghana: Implementation Challenges and Proposed Solutions. *IFPRI Discussion Paper 01309*.
- Gajate-Garrido, G., & Ahiadeke, C. (2013). The Effect of Parents' Insurance Enrolment on Healthcare Utilization: Evidence from Ghana. *SSRN*. doi: [10.2139/ssrn.2158824](https://doi.org/10.2139/ssrn.2158824)
- Galbraith-Emami, S. (2013). *Public Health Law and Non-Communicable Diseases*. London: UK Health Forum.
- Galbraith-Emami, S., & Lobstein, T. (2013). The impact of initiatives to limit the advertising of food and beverage products to children: A systematic review. *Obesity Reviews*, 14(12), 960-974. doi: [10.1111/obr.12060](https://doi.org/10.1111/obr.12060)
- Gobah, F.K., & Zhang, L. (2011). The National Health Insurance Scheme in Ghana: Prospects and Challenges: A Cross-Sectional Evidence. *Global Journal of Health Science*, 3(2), 90-101. doi: [10.5539/gjhs.v3n2p90](https://doi.org/10.5539/gjhs.v3n2p90)
- Hodge, J.G. (1998). Role of New Federalism and Public Health Law. *The Journal of Law & Health*, 12(2), 309-357.
- Hoke, K., & Swinburne, R.M. (n.d.). *What is Public Health Law?* Retrieved from The American Public Health Association website: <https://www.apha.org/>
- James, C.D., Hanson, K., McPake, B., Balabanova, D., Gwatkin, D., Hopwood, I., Kirunga, C., Knippenberg, R., Meessen, B., Morris, S.S., Preker, A., Souteyr, Y., Tibouti, A., Villeneuve, P., & Xu, K.

- (2006). To retain or remove user fees? *Applied Health Economics and Health Policy*, 5(3), 137-153. doi: [10.2165/00148365-200605030-00001](https://doi.org/10.2165/00148365-200605030-00001)
- Kirigia, J.M., Preker, A., Carrin, G., Mwikisa, C., & Diarra-Nama, A.J. (2006). An overview of health financing patterns and the way forward in the WHO African Region. *East African Medical Journal*, 83(9 Suppl), S1-S28. doi: [10.4314/eamj.v83i9.9492](https://doi.org/10.4314/eamj.v83i9.9492)
- Magnusson, R.S. (2009). Rethinking Global Health Challenges: Towards a Global Compact for Reducing the Burden of Chronic Disease. *Public Health*, 123(3), 265-274. doi: [10.1016/j.puhe.2008.12.023](https://doi.org/10.1016/j.puhe.2008.12.023)
- Mariner, W.K. (2009). Toward an Architecture of Health Law. *American Journal of Law and Medicine*, 35(1), 67-87. doi: [10.1177/009885880903500102](https://doi.org/10.1177/009885880903500102)
- Mensah, J., Oppong, J.R., & Schmidt, C.M. (2009). Ghana’s National Health Insurance Scheme in the Context of the Health MDGs: An Empirical Evaluation Using Propensity Score Matching. *Ruhr Economic Papers*, 157, 1-20. doi: [10.2139/ssrn.1532169](https://doi.org/10.2139/ssrn.1532169)
- Ministry of Health (2007). *National Health policy: Creating Wealth through Health*. Accra: Ministry of Health.
- National Development Planning Commission (NDPC) (2009). *2008 Citizens. Assessment of the National Health Insurance Scheme*. Accra: NDPC.
- National Health Insurance Act, Act 650. 2003.
- National Health Insurance Authority (NHIA) (2009). *Annual Report*. Accra: NHIA.
- National Health Insurance Authority (NHIA) (2011). *Annual Report*. Accra: NHIA.
- National Health Insurance Regulations, LI 1809. 2004.
- National Health Policy (NHP) (2007). *Ghana National Health Policy: Creating Wealth Through Health*. Accra: Ministry of Health.
- Palmer, N., Mueller, D.H., Gilson, L., Mills, A., & Haines, A. (2004). Health financing to promote access in low income settings—how much do we know? *Lancet*, 364(9442), 1365–1370. doi: [10.1016/S0140-6736\(04\)17195-X](https://doi.org/10.1016/S0140-6736(04)17195-X)

- Saltman, R., Busse, R., & Figueras, J. (2004). *17. Social health insurance systems in Western Europe*. European Observatory on Health Systems and Policies Series.
- Shaw, R.P. (2007). *Social health insurance for developing nations*. WBI Development Studies. Washington, DC: World Bank.
- Stuckler, D., & Basu, S. (2013). *The body economic: why austerity kills*. New York: Basic Books.
- Tanaka, S., Hawkes, S., Pegram, T., & Buse, K. (2014). *Non-communicable Diseases: Global epidemics; global determinants; global solutions? Towards a healthy role for transnational food, beverage and alcohol industries in the global governance of noncommunicable disease risk*. London: London's Global University.
- World Health Organization (WHO) (1948). Definition of Health. *WHO Constitution*. Geneva: World Health Organization.
- World Health Organization (WHO) (2011). *Scaling up action against noncommunicable diseases: how much will it cost?* Geneva: World Health Organization.
- Willcox, A.W. (1964). The Role of Law in Public Health. *Public Health Report*, 79(8), 647-653.
- Yankah, B. (2009). Financial sustainability of NHIS based on recent financial assessment of the scheme. *Health Summit*, November 16–20.

Samuel Adu-Gyamfi is Lecturer at the Department of History and Political Sciences at the Kwame Nkrumah University of Science and Technology, Ghana

Aminu Dramani is Lecturer at the Department of History and Political Sciences at the Kwame Nkrumah University of Science and Technology, Ghana

Contact address: History and Political Studies Department, Faculty of Social Sciences, Kwame Nkrumah University of Sciences and Technology, PMB, University Post Office, Kumasi, Ghana. Email: mcgyamfi@yahoo.com