A Framework Policy Analysis of National Health Insurance Policymaking in Sub-Saharan Africa

Amy Roll

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Jeff Lane

Aaron Katz

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University of Washington

Abstract

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Amy Roll

Chair of the Supervisory Committee:

Jeff Lane

Department of Global Health

A large proportion of the world's low- and middle-income population reside in sub-Saharan Africa where out-of-pocket payment systems have made healthcare inaccessible and unaffordable in many places. Universal health coverage (UHC) means that all people have access to high-quality health services and are protected against financial-risk while using those health services. Financing approaches to UHC include varieties of health insurance and tax-funded systems. National Health Insurance (NHI) is one such financing mechanism established by a national government with the goal of covering all or almost all citizens of the country. This descriptive, qualitative study used policy sources from four countries, Ghana, Kenya, Zambia, and South Africa, that are implementing or transitioning to an NHI scheme. The research goal was to understand how the introduction of an NHI scheme might affect national health policy making and to use the results to inform South Africa and other countries in sub-Saharan Africa

that are introducing NHI. A conceptual framework of 16 NHI policy domains was developed. Data were extracted from policy sources and indexed according to the different policy domains. Results revealed that following passage of legislation, NHI bodies were making policy decisions in order to operationalize and manage implementation of the NHI. We found variation in the four countries in terms of the types of policies developed and the decision-making authority around those policies. A key finding was that that Ministries of Health retained decision-making power over the NHIs through regulations and appointment of board members. However, NHIs were often delegated policymaking authority in key areas including financing mechanisms, provider payments, member payments, benefit schemes, accreditation, and relationships with private health insurance schemes. This study helps fill an important gap in research concerning policymaking responsibility in a health system after an NHI is adopted. Lessons from the focus countries can inform the transition to an NHI scheme including introduction of policies and delegation of decision-making authority in countries in sub-Saharan Africa considering NHI as a UHC financing mechanism.

Introduction

In 2005 the World Health Assembly adopted a resolution that urged member states to ensure that health financing systems included a method for prepayment to pool funding and share risk. The resolution was an effort to achieve universal health coverage (UHC) through population and service coverage and financial risk protection (1). In 2012 the United Nations General Assembly unanimously adopted the UHC resolution and, in 2015, 192 United Nations member states adopted UHC as a key Sustainable Development Goal (2, 3).

A large proportion of the world's low- and middle-income (LMIC) population reside in sub-Saharan Africa where out-of-pocket payment systems have made healthcare inaccessible and unaffordable for much of the population (4, 5). Services that may require out-of-pocket payments include inpatient care bed charges, consultation fees with the healthcare providers or payments for medicines (6). National health insurance (NHI) is one possible mechanism for raising and pooling funds to improve access to healthcare across populations while minimizing financial hardship due to health expenditures (7, 8). In this study, we conducted a policy analysis of four countries in sub-Saharan Africa that have transitioned or are in the process of transitioning to an NHI. The insurance scheme background, structure, and current stage are described below for Ghana, Kenya, Zambia, and South Africa.

Ghana

Ghana operated an out-of-pocket payment model for health care at the point of service delivery called "Cash and Carry". This system created financial hardship and discouraged the use of health services in the country where an estimated 80% of residents were not able to afford or access healthcare (4, 9). In 2003, the parliament of Ghana passed the National Health Insurance

Act (Act 650) that made it compulsory for every person living in Ghana to belong to a health insurance scheme, either public or private. Act 650 was replaced by Act 852 in 2012 to consolidate the National Health Insurance Scheme (NHIS) by shifting from decentralized district health scheme to an NHI Authority, remove administrative bottlenecks, and make more effective governance schemes (10, 11).

Ghana's NHIS is a mix of a social-type health insurance scheme and private mutual private commercial health insurance schemes (9, 10). The NHIS is financed through member contributions, the NHI Levy, social security contributions, donations, and investment income (9, 10). Indigent people, children (≤18 years old), and maternity care are exempt from contributions. Funds are pooled to pay for the benefit package and reduce financial hardship. All service providers accredited by the NHIS are required to offer the minimum benefit package. NHI Act 852 the NHIS is described as an "autonomous" body established by an Act of parliament governed by a Board appointed by the Minister of Health. The NHI Authority oversees operations and management (10).

The NHIS law mandates that all citizens register as members of the NHIS regardless if they are on a government or private health insurance scheme. However, NHIS membership has declined from a high of 40% in 2015 to 35.3% of the population in 2017. The NHIS plans to insure more healthy people to address threats to sustainability and to review the benefit package to emphasize primary care services (12).

Kenya

Kenya's National Hospital Insurance Fund (NHIF) was established in 1966 as a department of the MOH to provide insurance for formal-sector employees. In 1998, the NHIF Act turned the

NHIF into a state corporation, introduced mandatory insurance for workers, expanded the health benefit package, and extended health insurance to health centres and lower level facilities (13). In 2005 the government of Kenya attempted to enact the National Social Insurance Act that would repeal the NHIF, however this was met with resistance and not pursued further. In 2015, the NHIF Act was amended to revise premiums upwards, expand the benefit package, and to provide special benefit packages such as maternity care, ambulance services, and chronic care (14).

The NHIF is financed through member contributions and revenues collected by the government through taxes and donor funding (15). The NHIF offers outpatient and inpatient coverage and population-specific packages such as maternity care, oncology, and the SUPAcover for low-income individuals. The NHIF contracts with public and private healthcare facilities and purchases services on behalf of enrolled members through capitation rates (13). The NHIF strategic plan describes the NHIF as a "State parastatal" governed by a Board appointed by the President and managed by NHIF staff who oversee operations (14).

In 2018, NHIF was the main insurer in Kenya covering 16% of the population (14). A key objective of Kenya's Vision 2030 development programs is to develop an equitable financing mechanism that will create a national health insurance scheme to promote equity in health care financing and allow the health system to focus on prevention, research, and policy (16).

Zambia

In 2017, Zambia's the National Health Strategic Plan 2017-2021 outlined plans to establish a social health insurance scheme (17). Parliament passed the National Health Insurance Act in

2018, the purpose of which was to provide reliable health system financing and universal access to health services (18).

The NHI requires contributions from all eligible citizens in addition to outside sources of funding and fees for services. Financial contributions will be pooled to provide more equitable health financing, and exemptions will be made for poor people. The NHI will accredit and approve health service providers, and providers will negotiate a schedule of fees for payment. The NHI is described in the NHI Act as an "autonomous" body established through an act of parliament that reports to the Minister of Health. A Board, appointed by the Minister, oversees implementation and provides strategic and policy direction, and the NHI is managed by the NHI Management Authority (NHIMA) (18).

The NHI is currently in the transition process to establish and rollout the scheme. The Board was inaugurated in 2019, however, the NHIMA, benefit package, role of private health insurance schemes, and levels of contributions have yet to be determined (19).

South Africa

In 2009 a South African Ministerial Advisory Committee on National Health Insurance was established and tasked with providing the Minister of Health and National Department of Health (NDOH) with recommendations for health systems reforms and transition to the NHI (20). The goal is to ensure access to quality health care services by eliminating the current tiered system where those with the greatest need have the least access to health care and the poorest health outcomes (21).

The proposed NHI will require contributions from all South Africans even if an individual opts to stay on a private medical insurance scheme. Public financing will raise revenue through

general tax allocations, and contributions will be pooled to reduce financial hardship. The NHI Fund will purchase health services from NHI accredited private and public service providers to ensure free services at the point of care. The benefits will be based on a primary health care approach and will fund an essential set of tests, medicines, and services. The NHI fund will be publicly administered and established through legislation and is described as an "autonomous" public entity in the National Health Insurance policy paper (21). The Minister of Health will recommend Board members and appoint Ministerial committees. The NHI Fund will be overseen by a Chief Executive Officer, and the Board will govern the fund and report to the Minister of Health (21).

The government of South Africa has a three-phase approach to transition to a social health insurance scheme. Phase one began in 2012 and focused on health system strengthening initiatives. Phase two is underway, and the objectives are to adopt the NHI legislation and establish the NHI Fund. The third phase will begin in 2021 and will continue health system strengthening, introduce NHI-specific taxes, and consider contracting with private providers to cover gaps in service provision (22, 23).

Table 1. Characteristics of NHI Schemes

Country	Year of adoption	% Enrolled	Implementation Stage	System	Financing Mechanisms	Management
Ghana	2003	35.5% in 2017 (12)	NHIS has been implemented for 16 years. In 2012 the NHIS underwent significant reforms and Act 650 was replaced with Act 852.	Mixed public health and private health insurance schemes. Requires mandatory enrollment of the population on a scheme.	Member and social security contribution, NHI Levy, taxes, donations, and investments.	NHI Authority is overseen by a Board appointed by the President. The Board reports to the MOH and Parliament.

Kenya	1998	16% in 2014 (14)	Health insurance implemented since 1966 but NHIF has been a "State parastatal" body for 21 years. NHIF Act was amended in 2014.	NHIF provides public health insurance. Private health insurers compete with the NHIF.	Member contribution, taxes, and donations.	NHIF staff is overseen by a Board appointed by the President. The Board reports to the MOH.
Zambia	2018	N/A	The NHI Act was adopted in 2018 and the scheme is currently in the transition stage and has not yet been operationalized.	Social health insurance for the whole population that requires mandatory enrollment.	Mandatory contributions and fee for service.	NHI Management Authority is overseen by MOH appointed Board. Board reports to the MOH.
South Africa	Not adopted	N/A	The NHI has been piloted in 11 sites. The legislation is in draft form but not yet adopted.	Social health insurance for the whole population that requires mandatory enrollment. Private health insurers will provide complementary services.	Mandatory contribution, taxes.	The NHI Fund CEO is overseen by a Board. The Board is appointed by Parliament. Board reports to the NDOH and Parliament.

Generally, studies have focused on implementation of health insurance schemes such as the variations in health seeking behavior and policymaker attitudes towards implementation. Few have looked at the policymaking role of NHIs and how this may impact the transition stage (24, 25). This analysis adds to the literature on health financing in low- and middle-income countries by identifying and describing the policy making responsibilities of the NHIs in four different countries using policy documents. Lessons from these countries can inform the transition to an

NHI scheme including introduction of policies and delegation of decision-making authority in South Africa and in sub-Saharan Africa more broadly.

Methods

Research design

The thesis entails a descriptive, qualitative policy analysis, including a review of policy source documents and a literature review, of four sub-Saharan African countries. The goal of the analysis was to identify the policy domains for national health insurance schemes in sub-Saharan African countries to inform the transition process and potential policymaking role of the NHI in South Africa and other countries considering NHIs.

Country and policy selection

The country selection process was guided by a set of key inclusion criteria to identify countries that could provide insight on policymaking scopes and capabilities of NHI schemes. Countries whose health insurance schemes more closely align with the one proposed in South Africa were prioritized to strengthen the utility of the analysis for the South African National Department of Health. The inclusion criteria included if the scope of health insurance was national, NHI legislation had been adopted, policy data are available online, and the country is an LMIC in sub-Saharan Africa. The criteria are described in Table 2. The target countries selected for analysis were Ghana, Kenya, Zambia, and South Africa.

Table 2. Country Selection Criteria

Criteria	Definition for inclusion
Scope of health insurance	Countries with a health insurance scheme operated by the government with national coverage.
NHI Legislation Adopted	Countries have signed national health insurance legislation into law.
Data are available	The availability of policy documents and legislation that are in English. Priority will be given to countries that have published documents online.
LMIC in sub-Saharan Africa	The geographic scope is limited to sub-Saharan Africa where political systems, health systems, and health needs are most likely to align with South Africa.

A broad approach was taken to identify policies. Policies were defined as documented governmental courses of action that were adopted or under consideration by one of the target countries. Sources reviewed include legislation, signed policy documents, guidelines, strategies, annual reports, web pages, notices, and news articles.

The inclusion criteria for policies were:

- The policy related to the operation of the National Health Insurance Scheme.
- A copy of the actual policy document existed or sufficient evidence to describe to which policy domain the policy belongs.
- The policies was adopted within the last 25 years.

The exclusion criteria was:

- Draft versions of policies prior to adoption with no changes to the final adopted version.

Search strategy

First, a review of the literature was conducted in seven electronic databases (Pubmed, CINAHL, Embase, Global Health Database, PAIS, and WHO Global Index Medicus) of publications in English without limitations on the publication date. The search strategy terms are listed in Table

3. The documents from the literature review were used to identify policy documents through the creation of search terms and citation chaining. Searches were then conducted on the websites of the South Africa National Department of Health, South Africa Parliament, Ghana Ministry of Health, Ghana National Health Insurance Scheme, Ghana Parliament, Kenya Ministry of Health, Kenya National Hospital Insurance Fund, Kenya Parliament, Zambia Ministry of Health, Zambia Parliament and International Labour Organization database of national labour, social security and related human rights legislation for historical policy documents. The inclusion and exclusion criteria were applied to each of the policy documents throughout the search.

Table 3. Search Strategy

Databases Searched	**Search Terms**
Pubmed	#1: ((Ghana AND National Health Insurance Scheme) AND (Polic* OR Translat*)) OR ("National Health Programs/organization and administration"[Mesh] AND "Ghana"[Mesh] AND national health insurance AND (translat* OR polic* OR reform OR health financing)) #2: ((Kenya AND "National Hospital Insurance Fund") AND (translat* OR polic*)) OR ("National Health Programs/organization and administration"[Mesh] AND "Kenya"[Mesh] AND national hospital insurance AND (translat* OR polic* OR reform OR health financing)) #3: (Zambia and National Health Insurance Scheme) OR ("National Health Programs/organization and administration"[Mesh] AND "Zambia"[Mesh] AND national health insurance) AND (translat* OR polic* OR reform OR health financing))
CINAHL	#1: (Ghana AND National Health Insurance Scheme) OR ((Ghana AND National Health Insurance Scheme) AND (translat* OR polic* OR reform OR health financing)) #2: (Kenya AND National Hospital Insurance Fund) OR ((Kenya AND National Hospital Insurance Fund) AND (translat* OR polic* OR reform OR health financing)) #3: (Zambia AND national health insurance) OR (Zambia AND national health insurance AND (translat* OR polic* OR reform OR health financing))

Embase	#1: (Ghana AND National Health Insurance Scheme) OR (Ghana AND National Health Insurance Scheme AND (translat* OR polic* OR reform OR health financing)) #2: (Kenya AND National Hospital Insurance Fund) OR ((Kenya AND National Hospital Insurance Fund) AND (translat* OR polic* OR reform OR health financing)) #3: (Zambia AND national health insurance) OR (Zambia AND national health insurance AND (translat* OR polic* OR reform OR health financing))
GH Database	#1: (Ghana AND National Health Insurance Scheme) OR (Ghana AND National Health Insurance Scheme AND (translat* OR polic* OR reform OR health financing)) #2: (Kenya AND National Hospital Insurance Fund) OR ((Kenya AND National Hospital Insurance Fund) AND (translat* OR polic* OR reform OR health financing)) #3: (Zambia AND national health insurance) OR (Zambia AND national health insurance AND (translat* OR polic* OR reform OR health financing))
PAIS	Ghana AND National Health Insurance Scheme Kenya AND National Hospital Insurance Fund Zambia AND National Health Insurance
WHO GIM	Ghana AND National Health Insurance Scheme Kenya AND National Hospital Insurance Fund Zambia AND National Health Insurance

Data extraction and analysis

Data extraction and analysis was guided by a conceptual framework of NHI characteristics and the policymaking power of national health insurance schemes (Table 4). This framework was informed by the World Health Organization (WHO) key design features in developing social health insurance systems, WHO Health System Framework, WHO Regional Essential Public Health Functions, Ministry of Health enabling legislation, and peer reviewed studies related to policy, governance, and national health insurance scheme analyses (7, 24, 26-32). While no

single framework exists to analyze policymaking roles of health institutions, the assumption underlying the framework was that certain NHI characteristics and Ministry of Health policy domains are associated with policymaking responsibilities of a functional NHI.

A qualitative analysis of policy documents was conducted using Atlas.ti software. The framework was developed using pre-existing theoretical constructs deductively, and then was revised using an inductive approach as additional themes emerged from the data. This method allowed the large amount of textual data extracted from policy documents and legislation to be organized in a systematic and structured way. The data were coded according to the framework constructs and policy domains found in Table 4.

Table 4. Policy Domain Framework

Policy Domain	Definition
Method of financing	Policies that define the types of financing mechanisms available to the NHI to implement, e.g., taxes, grants, donations, enrollee premiums, co-insurance, deductibles, etc.
Payments to providers	Policies that define how the scheme pays providers, e.g., reimbursements, capitation, fee-for-service, diagnostic groups, etc.
Member payments	Policies that define how participants pay for NHI services, e.g., premiums and co-payments.
Benefit scheme	Policies that define available benefits in a scheme and decision-making around those benefits including medicines, health technologies, and services.
Coverage	Policies that define who can and cannot be covered by the NHI, including special interests groups.
Equitable access	Policies that promote equitable access to necessary health services along economic, geographic, and ethnic lines. Policies that define the type of health services available (e.g., improved transportation) at low cost or free of charge for populations and sub-populations.
Decision-making authority	Policies that define organization, responsibilities, and accountability of an NHI governing body.
Investment decisions	Mobilize funding for service delivery through government (ministries and parliament) and international partners and allocate resources to health care delivery agencies. Ensure that financial resources are mobilized for uninterrupted access to quality health services country wide.

Human resources for health	Policies and frameworks for the management of human resources for health, policies for staff employment within the NHI, and guidelines, training, and maintenance of standards for human resources.
Public health regulation	Policies that define norms and standards on health matters and/or provide a framework for the regulation of health service delivery, including provider credentialing (licensure, certification, accreditation, recognition designation, and certificates) for health services from practitioners, health facilities, and health care providers; quality assurance in health services; and security of health information.
Relationship with providers	Policies or powers that define the role of the NHI or MOH in creating relationships with health providers not including contracts and credentialing or payment mechanisms.
Adjudication and appeals process	Policies that define the system for providers and participants to appeal decisions of the NHI.
National health goals and priorities	Overall health policy goals for the country.
Primary Healthcare	Policies related to the promotion of primary healthcare and preventative services.
Collaboration and coordination	Policies created in collaboration and coordination with other arms of the government (national and sub-national), regional and international bodies, and stakeholders.
Health promotion and wellness	Policies that promote health and healthy lifestyles including public health campaigns and health education.

Data extraction and analysis were guided by a framework analysis—a highly structured and deductive approach to analyzing qualitative data—following five stages of analysis described by Pope, et al. (33, 34). First, the data were read through to familiarize the researcher with the content. Second, the framework was developed to identify common policy domains related to NHI to guide data organization. Third, the data were indexed with the framework policy domains (Table 4) in Atlas.ti software. Fourth, data were charted into the matrix. This involved summarizing the data by each policy domain code from all documents reviewed. Fifth, the charts were used to define concepts and to map associations between the policy domains and the countries being analyzed. Policies that have been adopted or considered and their characteristics were described and common features were analyzed. The findings were synthesized into

considerations for the National Department of Health, South Africa and for other countries considering adopting a national health insurance scheme.

Limitations

Study results will be specific to the context of NHI in sub-Saharan Africa with a focus on implementation of an NHI scheme in South Africa. The selection of countries is limited by geography to sub-Saharan Africa. Although the themes may be applicable to other NHI policies in developing countries, the results may not be applicable in their specific settings. Further, the policy analysis is limited to countries with adopted NHI policies that are available in English. This limits the potential amount of data that may be available for analysis. The policy analysis itself relies on document analysis and may not be able to capture all the contextual knowledge of the policymaking process in the selected countries. In some cases we only had the policy name and not the underlying policy itself and we were only able to include the information if the policy title or summary was sufficient to determine which policy domains would be covered by that policy. Stakeholders were not interviewed in each country, and this limits the type of information that can be used to analyze the policymaking process.

Results

Domains underpinning policymaking in National Health Insurance Schemes

This section synthesizes the study findings related to the policy areas (called domains) that are relevant to implementing an NHI. We did not identify any existing framework to analyze policymaking in National Health Insurance, therefore, we created a new framework that was informed by the WHO key design features in developing social health insurance systems, WHO Health System Framework, WHO Regional Essential Public Health Functions, Ministry of

Health enabling legislation, and peer reviewed studies related to policy, governance, and national health insurance scheme analyses (7, 24, 26-32). The analysis of policy documents was structured under 16 policy domains and example policies for each domain are summarized in Table 5.

Table 5. Example policies by policy domain

Policy Domain	Example Policies
Method of financing	The policies that described NHI financing, including taxes and contributions, were often in the enabling legislation. National health financing policies and strategies were identified in Ghana and Kenya.
Payment to providers	All four countries have policies describing how accredited providers will be paid. In Ghana the enabling legislation describes three methods: DRGs, fee-for-service, and capitation. In South Africa the draft legislation outlines a pre-payment policy where pooled funds will be used to pay providers so that members pay no fees at the point-of-service.
Member payments	Each country has a policy requiring member contributions. In Zambia and South Africa these are mandatory contributions from the population. Policies that discuss member payments include a proposed one time premium payment policy in Ghana. In Kenya, the scheme-specific handbooks provide member payment information including cost and frequency.
Benefit Scheme	Benefit scheme design and selection policies are common throughout the four countries. In South Africa, Ghana, and Kenya the country-specific essential medicines lists are used in some capacity in determining medicines that will be covered by the schemes. In Kenya there are several different types of schemes and some of them have specific benefits.
Coverage	Ghana, Kenya, and South Africa have adopted or are considering adopting coverage policies for special populations, including a policy for maternal health care exemptions. In Zambia, the MOH determines the process and procedures for enrollment and removal of members.
Equitable Access	Equitable access is a foundational feature in all four analysis countries. Access policies include financial and physical access and were often aligned with benefit and coverage policies to increase access to services and people. For example, adoption of legislation in Ghana was in part to ensure universal access to a benefit package of health care services. Benefit schemes in Kenya include a provision to cover emergency transportation and will increase access to emergency services.
Decision-making Authority	The majority of policies relate to management, operation, and administration of the NHI schemes. For example, the NHIA (Ghana) and NHIMA (Zambia) are accountable to create guidelines and manuals that ensure compliance with the NHI Act.

Investment decisions	Most policies in this category looked at the development of a budget and investment decisions. In Ghana and Zambia the NHI authorities are responsible for creating the budget. In Zambia the NHIMA may invest money with approval from the MOH. In South Africa the NDOH with the Minister of Finance is responsible for the budget creation.
Human resources for health	Ghana and Kenya created policies on hiring and appointing staff. Ghana and South Africa are both considering policies on HRH training and development.
Public health regulation	All four countries grants authority to the NHI schemes to accredit service providers. The NHIS in Ghana was responsible for frameworks, operational procedures, accreditation and credentialing policies. In South Africa, the Minister can create regulations on the relationships between the fund and health care providers. In Zambia the Minister prescribes reporting requirements.
Relationship with providers	South Africa's draft legislation allows regulations on relationships with providers and private medical schemes that are not specific to credentialing and accreditation.
Adjudication	In Ghana, the NHI is responsible for creating guidelines for submission of claims and the PHIS guidelines from the NHIS also have information on the adjudication policy.
National health goals and priorities	We did not find any evidence that the NHIs are dictating national health goals and priorities. In all four countries there was evidence that the creation of the NHIs contributed to national health financing goals. In Kenya the KHSSP defined the scope of health and health related services and was used to inform the design of the benefit package.
Primary healthcare	In Kenya, the NHIF schemes for civil servants and the national police encourage primary healthcare through the provision of annual health check-ups that include a specific list of tests and benefits to be included. In South Africa the NDOH is considering guidelines to improve the management of primary healthcare facilities as part of the NHI rollout.
Collaboration	In South Africa, the draft legislation grants the NHI Fund authority to work with other government departments when necessary to achieve the object of the Act. In Ghana and Kenya the NHIs have collaborated with other government agencies to create finance, access, and benefit policies. These include an ambulance service policy in Kenya and financing of indigents in Ghana.
Promotion	Ghana and Kenya were the two countries with promotion policies. The purpose of these policies were to educate and communicate the purpose of the NHI scheme. Ghana and Kenya are both considering communication strategies to use in public education.

Description of the policies and their domains

Ghana

We identified 24 sources referencing policies from Ghana that met our inclusion criteria, including the NHI Acts 650 and 852, guidelines, policies, annual reports, strategies, and NHIS website pages. These 24 sources reference 71 policy decisions that either had been adopted (n=38) or policies referenced in NHI source documents but status of which was unclear (n=33). We identified policies under all 16 policy domains (Table 6). The majority of policies (n=30) adopted or considered in Ghana related to financing mechanisms, member payments, and provider payments. The two NHI laws describe in detail the types of financing mechanisms implemented including the NHI Levy, social security tax, member contributions, and three types of provider payment mechanisms: diagnostic-related groupings (DRGs), fee-for-service, and capitation (10, 35). We found evidence that the capitation policy was considered but not adopted due to implementation issues and that DRGs and fee-for-service were adopted after passage of the legislation (11, 36, 37).

We identified 19 public health regulation policies. The legislation granted authority to the NHI to accredit private and public service providers and to contract with private health insurance schemes, and each year the NHIS is responsible for sharing a list of accredited providers in the Gazette (10, 35, 38). We identified 14 benefit scheme policies, which were often associated with the equitable access or coverage policies. The benefit package was designed to increase access to health services for 95% of diseases in Ghana, including treatment for infectious diseases such as malaria and HIV symptomatic treatment, cancer treatment, oral care, maternal care, and prescription medicines (39). We identified one policy relating to national goals and primary

health care, the Ghana Health Financing Strategy, that proposed national goals for the health sector and proposed creation of the Preventive and Primary Health Services Strategy (40).

Kenya

We identified 19 sources referencing policies from Kenya that fit our inclusion criteria, including the NHIF Act 9 of 1998 and the 2014 Amendment, guidelines, national policies, strategies, annual reports, and NHIF website pages. The sources reference 32 policies that had been adopted (n=23) or policies referenced in NHI source documents but status of which was unclear (n=9). We identified policies associated with 15 domains; no provider relationship policies were identified (Table 6). The majority of policies we identified were associated with the benefit scheme domain (n=16). All benefit scheme policies show evidence of adoption and include benefit package guidelines and handbooks for the civil servants scheme and the National Police Service and Kenya Prisoners Service Scheme (41, 42). The benefit package is divided into outpatient, inpatient, and specialized care and includes lab tests, medicines, surgical services, and drug rehabilitation. Annual medical check-ups to examine cholesterol and perform pap smears, among other preventive services, are included the NHIF benefits (43).

Special population groups may apply to different benefit schemes that improve access and coverage. For example the SUPAcover offers lower monthly insurance contributions for low-income individuals to increase coverage and access to healthcare (44). We identified 16 public health regulations policies, including the NHIF Act which grants the NHIF Board authority to accredit hospitals, as well as two policies under consideration: guidelines on service provision quality and contract management (13, 14, 45). We identified 5 financing mechanisms policies, two of which were national-level policies: Kenya Health Policy and Kenya Health Sector

Strategic and Investment Plan (KHSSP) (15). These policies describe reforms to NHIF financing to achieve strategic and national level health goals.

Zambia

We identified two sources describing policies in Zambia that met our inclusion criteria, the proposed National Health Insurance Bill from 2017 and the adopted National Health Insurance Act from 2018. The two versions of the bill were deemed similar enough that the 2018 NHI Act was used in this analysis. We found reference to 15 policies and processes in 11 policy domains (Table 6). We identified 4 decision-making authority policies and processes, including the National Health Insurance Management Authority's (NHIMA) role to create guidelines and processes for NHI management and to ensure compliance with the Act and any affiliated guidelines, policies, processes, and manuals (18). We identified 4 financing mechanism policies and processes, which include member rates of contribution and a uniform national standard schedule of fees and charges for NHI services. We identified 3 public health regulation policies and processes that include the NHI's power to accredit providers and the MOH's role in prescribing provider reporting requirements (18).

South Africa

We identified three sources describing policies in South Africa that met our inclusion criteria, the draft NHI legislation (2018), the NHI Green Paper (2011), and the NHI White Paper (2017) (20, 21, 46). We identified 36 policies and processes in 13 policy domains (Table 6). We identified 11 policies in the benefit scheme domain, including guidelines for lab tests and an essential medicines and services list. We found 6 provider payment policies in the draft legislation outlining payment mechanisms including, mandatory pre-payment, DRGs, and capped case-

based fee payment mechanisms (23, 46). Capped case-based fees will use a cost-based tariff schedule and volume contracts based on the needs of the population and will use a capitation-based reimbursement model (23). We identified 5 public health regulation policies including the MOH's power to create regulations on the relationships between the NHI fund and providers. We found 2 primary healthcare policies—one is an NDOH initiative to establish a National Health Commission on preventing and managing diseases through multi-sectoral collaboration and guidelines for clinic committees to improve management and governance of primary healthcare services offered by the NHI (21).

Table 6. Number of policies by country and domain

Policy Domain	Number of Policies			
	Ghana	Kenya	Zambia	South Africa
Method of financing	23	7	4	2
Payments to providers	12	3	2	6
Member payments	12	5	1	1
Benefit scheme	14	16	3	11
Coverage	11	10	1	1
Equitable access	9	13	2	1
Decision-making authority	9	6	4	3
Investment decisions	3	4	2	2
Human resources for health	7	3	1	5
Public health regulation	19	6	3	5
Relationship with providers	3	0	0	1
Adjudication and appeals process	5	2	1	1
National health goals and priorities	1	2	0	0
Primary Healthcare	1	2	0	2
Collaboration and coordination	5	3	0	1
Health promotion and wellness	3	3	0	0

Distribution of policymaking roles

Ghana

Policymaking for NHI is distributed across Ghana's President, Parliament, the MOH, and the NHIS. We identified 44 policies that were adopted or under consideration by the NHI Authority or Board, 9 policies by the Ministry of Health, 9 policies jointly adopted or considered by NHIS and MOH, 6 policies adopted by Parliament, and 2 policies by the office of the President. We found that the NHIS adopted or considered policies in 12 domains. The NHIS is responsible for some benefit scheme policies, including the NHIS medicines list adapted from the Ghana essential medicines list (EML), a tariff and benefits package operations manual that outlines financing of benefits, and the selection of benefits in collaboration with the MOH (10, 39, 47-49). The NHIS is responsible for creating operational and administrative policies such as a human resource policy and operation manuals for implementation, including claims processing and reimbursements (50). We found that the MOH adopted or considered policies in 9 policy domains. These include high-level national policies such as the Ghana Health Financing Strategy and Health Financing Policy, policies that define coverage including the exemptions policy and free maternal health service policy, and guidelines for adjudication of health service provider claims (10, 11, 48). Policy decisions that are neither the NHI or MOH are primarily finance policies including taxes and budget allocations to finance the NHIS.

Kenya

Policymaking for the NHIF in Kenya is distributed across Parliament, the MOH, and the NHIF. We identified 22 policies that were adopted or under consideration by the NHIF, 7 policies by the MOH, and 2 policies by Parliament, which were the NHI legislation and its amendment. We

found the NHIF policies covered 12 policy domains. The NHIF was responsible for adopting benefit scheme policies, including the creation of schemes for certain groups like mothers and civil servants, and for creating handbooks that provide benefit, coverage, and member payment information to scheme members (41-43, 51). The MOH was responsible for the creation of national level policies, including the essential health package, essential medicines list, and clinical guidelines that direct services available under the NHIF schemes (15, 43).

Zambia

Policymaking for the NHI in Zambia is distributed across Parliament, the MOH, and the NHIMA. The analysis identified 12 policies and processes that will be NHIMA responsibility, 2 policies that will be MOH responsibility, and 1 joint MOH and NHIMA policy. We found that the NHI will be responsible for determining benefit package design and implementation and a standard schedule of fees and charges for the services provided. The NHI is also responsible for management and implementation guidelines and manuals (18). Policies associated with coverage and public health regulation will be the responsibility of the MOH, specifically the procedures and conditions for NHI eligibility and prescribing reporting requirements for health care providers. The MOH and NHI will collaborate on contribution and payment mechanisms covering finance, member payment, and provider payment policy domains (18).

South Africa

The policymaking roles at this stage in South Africa's implementation are distributed across the NDOH, the NHI Board, NHI committees, NHI Fund CEO, Parliament, and in collaboration with other government agencies. The analysis identified 22 policies under consideration by the

NDOH, 6 policies by the NHI, 4 policies shared by NDOH and NHI, 2 policies by NDOH and other government agencies, and 1 policy adopted by Parliament. Nine of the 22 NDOH policies were associated with the benefit scheme, including schemes for specific populations and the appointment of a ministerial committee called the Benefit Advisory Committee (BAC), which has authority to create detailed treatment guidelines. The NDOH and NHI will design the benefit package together (46). The NHI is granted policymaking authority to establish rules and mechanisms for payment of health care providers as well as accrediting providers. The NHI may also establish operational, financial, and administrative policies and create committees (46). The NDOH suggested the adoption of the Office of Health Standards and Compliance to support regulation of health service providers, and Parliament created this office through the National Health Amendment Act of 2013 (20).

Common features and differences of NHI policy development roles that may support the transition and implementation of health insurance policies

Policymaking bodies in the NHI

Common across the focus countries were the creation of NHI Boards appointed by government bodies to oversee NHI management and operations. The legislative instruments in each country identify institutions that must be represented on the board and the length of a board appointment. Selection and appointment vary by country; in Ghana and Kenya the President appoints the chairman and representatives of the board, and in Zambia the institutions that make up the board nominate representatives for the Minister of Health to appoint (10, 13, 45, 46). In South Africa the Minister recommends Board members who will then be appointed by the Cabinet (46).

Each country describes a management body that operationalizes and implements the NHI schemes. In Ghana and Zambia, the NHIA and NHIMA, respectively, are granted powers to

create guidelines and policies and to ensure compliance with the Act (10, 18). In Kenya the NHIF Authority is mandated to advise on national policy and implement all policies relating to NHI (13, 45). The NHI Fund in South Africa will be administered by a CEO whose duties include fund administration, management and deployment of staff, and establishment of the investigating unit (46). In Ghana and South Africa, the Board is given the power to create committees, which can advise on policies (10, 46). In South Africa the Minister of Health may also create ministerial committees that can make policies (46). We did not find evidence that Kenya and Zambia had committees with additional policymaking power.

Relationship between MOHs and NHIs

In Ghana, Zambia, and South Africa historical documents indicate that the MOHs were considering the design and implementation of the NHI before passage of legislation (17, 20, 21, 52). In Kenya, the NHIF was a department of the MOH before becoming a separate "corporate body" with the passage of the NHIF Act in 1998 (15). A common feature is that the Minister of Health is granted regulatory powers in the enabling legislation. Each country's legislation contains language that allows for regulations to be made in support of any area of the NHI and the Minister of Health is granted the power to adopt these regulations.

In Ghana, Zambia, and South Africa the MOH and NHI collaborate to create the benefit package. In Kenya the MOH creates the benefit package and essential health services that the NHIF must include in the benefit package (43). The sources we reviewed indicate that the NHI takes more of a policy-making role in accrediting providers. For example, the NHIS in Ghana was responsible for creating the regulatory framework and operational procedures for accrediting and

credentialing (10, 38). In Kenya, the NHIF has taken the initiative to reform accreditation policy by reducing the number of steps to accredit service providers (14).

Policy areas that may have shifted from the MOH to the NHI

The NHI in itself is a financing mechanism for the health system. Based on the analysis, the finance mechanisms, provider payment, and member payments domains may indicate a shift from a role traditionally held by the MOH to the NHI in Ghana and Zambia. For example, we found evidence of the NHIS CEO advocated to the Ministry of Finance to increase the NHI Levy (53). In Ghana capitation was identified as a provider payment method in the legislation, however the NHIS decided to put the policy on hold after pilot tests (10, 11, 35, 36). Further, Ghana's NHIA was granted new policymaking responsibilities to develop the NHIS Service and Medicine List and Tariffs with the replacement of Act 650 by Act 852 (10). In Zambia, the MOH determines the rates of contribution of members, but the NHIMA is responsible for setting policy on how indigents will be financed (18). However, Kenya's MOH remained responsible in the finance mechanism policy domain by passing national-level policies that direct the NHIF financing mechanisms (15, 54).

Discussion

MOH statutory powers

Countries need to balance policymaking authority between existing bodies like the MOH and the new NHI bodies. In the countries we analyzed, NHI's policymaking powers are derived from the MOH's statutory or constitutional powers. In all four countries policy documents suggest that the MOHs were responsible for the conception and development of the NHIs (14, 17, 21, 52).

Creation of the NHIs, in itself, is the government acknowledging the creation of new policy powers. However, in each of the countries analyzed the Minister or MOH retains authorities granted through the enabling legislation to create regulations. Ministers and MOHs are, therefore, able to assert their policymaking power on certain issues related to NHIs by passing regulations even after the NHIs are established. Another way MOHs continue to exert policymaking authority is through their appointment of board members and creation of committees. The institutions where board members are selected from are pre-defined in the legislation, but their appointment and ultimate authority comes from the Minister of Health. It is these board members who are granted power to establish committees and appoint members. The roles of the Board and the committees are to advise on and, in many cases, create policies. South Africa goes even further by allowing the Minister of Health to create Ministerial Committees which advise the Board and Minister on policy. The Benefits Advisory Committee is even granted power to create treatment guidelines. This suggests that in order for NHI legislation to be enacted, Ministers of Health must be granted some form of regulatory power and committee oversight prior to adoption of the legislation.

Benefit design and selection

Benefit design and selection is fundamental to operationalizing an NHI. The focus countries exhibit key differences in how the benefit package is designed and selected. The MOH in Ghana, Kenya, and Zambia create medicines lists and service lists for health insurance. The key difference is that in Ghana the NHIS has some freedom to adapt the MOH medicines list into the NHIS services and medicines list covered by the benefits package. The NHIs in Kenya and Zambia are directed by the MOH to insure specific medicines and services specified by the

MOH. This suggests that Ghana's NHIS has more of a policy role in selecting benefits than NHI management counterparts in Zambia and Kenya. In South Africa the current draft legislation indicates the NDOH will take a directive role as in Kenya and Zambia. The legislation would also add the Ministerial-appointed Benefit Advisory Committee, which is granted explicit responsibility to create treatment guidelines for the NHI Fund. South Africa's NDOH could consider a more active NHI Fund role in designing and selecting benefits.

Contracting and accreditation process

Countries face competing needs to accredit service providers and facilities quickly to maximize access while ensuring providers and facilities meet high-quality standards of care. In Ghana, Zambia, and South Africa, service providers must also be accredited by relevant regulatory bodies, adding another layer of complexity to the accreditation process. The NHI has both an incentive to accredit hospitals quickly in order to expand access to members and a responsibility to do due diligence in accreditation to ensure quality standards (55). The NHIF in Kenya reformed the contracting process by suspending pre-assessment audits and accreditation fees (14), suggesting a potential conflict between wanting to expand the number of facilities and the need to maintain and improve compliance with quality standards (55). Ghana and Zambia have elected for the NHI to work with other regulatory bodies to accredit service providers, which aligns with South Africa's proposed approach. South Africa should consider how multiple accreditation steps may affect access to health providers. One way to ensure that facilities and service providers meet quality standards while providing equitable access is to begin the accreditation process during the transition period before members begin using and accessing health services.

Relationship with private health insurance schemes

Private health insurers will likely continue to offer services after an NHI is adopted. Determining the relationship between the NHI and private providers is an important part of the transition process. Private health insurers either directly compete with or provide complementary services to the NHI. In Ghana, private health insurers compete with NHIS, but are required to provide the minimum benefit package and are credentialed by the NHIS (56). South Africa's stated goal is to shift private medical schemes to be complementary to the NHI (21). This would significantly impact existing private health insurers and the governing Medical Insurance Scheme Act legislation. Ghana defined the role of private health insurers in Act 852 and the NHIS developed the private health insurance guidelines detailing the specifics of the relationship with private insurance schemes. South Africa's current draft legislation does not explain this relationship nor is there an indication that a policy or guideline for private insurance schemes will be discussed. Key considerations for South Africa are to describe the role of private health insurance schemes in the legislation and to use the legislation to provide a legal framework for the relationship. We did not find sufficient policy documents to describe and interpret the relationship between the NHI and private health insurance schemes in Kenya and Zambia.

Financing decisions

Financing decisions include financing mechanisms, provider payment, and member payment policies. The analysis raised a question about how NHI financing policy decisions are made and which governmental body is responsible for these decisions. Financing decisions in Ghana have been directive; financing mechanisms are enshrined in the legislation, a decision made before the

creation of the NHIS. The office of the President and the MOH have also directed the NHIS to implement financing policies, including piloting a capitation program and investigating a one-time pre-payment policy (11, 36, 50, 57). However, the NHIS authority has been a technical partner in developing policy recommendations in the health financing strategy and has created financing policy including service and medicine tariffs and the NHIS premiums policy (47, 48). In Zambia, the MOH authorizes the Authority to accept money, but the NHIMA will be responsible for creating a national standard schedule of fees and charges for services. In Kenya, the MOH, through high-level, national policies, has directed financing policy for the NHIF (15). The policies in which financing decisions are made and the bodies making those decisions varied in each focus country. For example, while Ghana and Kenya both had examples of an MOH-driven financing strategy, the NHI decision-making role within the strategies varied. South Africa can consider these different models when deciding how to describe financing decisions (e.g., in the enabling legislation) and to determine which financing decisions will be delegated to the NHI and which will be made in collaboration with the NHI and another government body (e.g., MOH).

Box 1. Key Considerations for South Africa and other countries establishing an NHI

1. The four focus countries in our analysis granted Ministers of Health, through the enabling legislation, power to create regulations and some form of Board or NHI committee oversight. Countries considering NHI schemes will need to determine if Ministers and MOH will be granted regulatory power and oversight and what kind of regulatory power prior to adoption of the legislation.

2. Ghana's NHIS exhibits decision-making authority in benefit selection and design, which includes creation of a medicines list and tariffs. South Africa's NDOH and other countries could consider a similar model and provide the NHI Fund a more active role in designing and selecting benefits.

3. Accreditation is an important step to ensure that providers reimbursed by the NHI are providing accessible and quality health services. Accrediting individual providers can take many months or years, as was the case in Kenya, and which resulted in reforms to shorten the contracting and accreditation process. One way to ensure that facilities and service providers meet quality standards while providing equitable access is to begin the accreditation process during the transition period before members begin using and accessing NHI health services.

4. Ghana allows private health insurance schemes (PHIS) to compete with the NHIS but provide oversight through credentialing and ensuring private schemes comply with the minimum benefit package of services. Ghana defined the role of PHIS in Act 852 and provided guidelines for NHIS oversight of PHIS. South Africa and other countries will need to determine the role of private health insurers prior to the launch of the NHI. Countries can consider describing the relationship between the NHI and private health insurance providers in the legislation such as the types of services private health insurers will provide and if the NHI will have oversight over private health insurers.

5. Financing decisions vary by type of policy and decision-making body in the focus countries. Ghana describes financing mechanisms in detail in the enabling legislation. Ghana, Kenya, and Zambia all have examples where the MOH directs financing decision policies to the NHI. There are also examples in Ghana and Zambia where the NHIs are the financing decision-makers including on setting standard fees for medicines and services. Given this variation, countries can consider these models when deciding if financing mechanisms will be described in the enabling legislation or following adoption of the NHI. Countries should also determine which financing decisions to collaborate on or delegate to the NHI.

Conclusion

National Health Insurance schemes introduce new policymaking roles and responsibilities. Common across the four countries analyzed was the acknowledgement that the NHI schemes and authority (management and boards) do have some independence to create policies to operationalize and implement national health insurance. Ministers and MOHs retain decision-making power over the NHIs as well through regulations and appointment of board members. The conceptual framework designed for this study may be a useful tool for countries considering NHI to think about the types of policies that may need to be developed in the design, transition, and implementation of NHI schemes. As South Africa approaches the end of phase two of the NHI roll-out, we suggest some considerations regarding policy-making roles and domains that may be useful for the Government of South Africa. Given that many low- and middle-income countries are exploring national health insurance as a health financing system to increase population and health care service coverage, identifying policy domains and policy roles among the main actors could strengthen the transition process in other settings.

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