



GLOBAL SOCIAL TRUST,

A project of international solidarity between Luxembourg and Ghana

Information paper

(1) The Global Social Trust (GST) pilot project: Investing in health in Ghana

Solidarité Syndicale, the NGO of the Confédération syndicale indépendante of Luxembourg (OGB-L), the International Labour Office (ILO) and the Government of Ghana represented by its Ministry of Health, have entered into an agreement to implement the Global Social Trust (GST) pilot project in Ghana. This pilot project will provide a cash benefit to poor pregnant women and mothers with children under the age of five in Ghana and which thus supports the extension of health insurance in Ghana. To this effect voluntary contributions will be collected amongst members of the OGB-L in Luxembourg.

Background in the context of health insurance in Ghana

During the summer of 2003, the Government of Ghana passed legislation, the National Health Insurance Act 2003 (Act 650), which put into effect a new National Health Insurance System. The National Health Insurance System (NHIS) will consist of almost 140 District and sub-metro Mutual Health Insurance Schemes (DMHIS) which will be financed by a combination of personal contributions from persons in the informal economy (approximately US\$8 annually for adults), a social insurance transfer of 2.5% for all members of the Social Security National Trust (SSNIT) and a 2.5% health levy (i.e. a VAT type indirect tax). The system is co-ordinated and supervised by the National Health Insurance Council (NHIC) which is managing *inter alia* the National Health Insurance Fund (NHIF). This Fund receives the proceeds from the contributions and the levy and will subsequently allocate it to the DMHIS. As part of the new national health insurance system, the Government of Ghana has made a commitment to “devise a mechanism for ensuring that the basic health care needs of indigents are adequately provided for”¹. An initial mechanism has been put in place, but the number of potential beneficiaries of such provision and the need to reach the poor, present a significant challenge to the overall financing, implementation and success of the new system.

The Ghana Poverty Reduction Strategy (GPRS) highlights the commitment of the government

¹ National Health Insurance Act 2003 (Act 650)

to ensuring access to health care through the improvement of basic health care for the poor. The strategies include "...bridging gaps in access to health, nutrition, and family planning services, ensuring sustainable financing arrangement that protects the poor, and enhancing efficiency in service delivery..."².

Ghana: Health indicators

Indicator	Value (year)
Life expectancy at birth (years) males	56.0 (2004)
Life expectancy at birth (years) females	58.0 (2004)
Healthy life expectancy (HALE) at birth (years) males	49.2 (2002)
Healthy life expectancy (HALE) at birth (years) females	50.3 (2002)

Source: WHO, National Health Data, 2006

Despite some improvements in many health indicators, including mortality and morbidity, further improvements still need to be made. Life expectancy at birth in 2004 was 56 years for males and 58 years for females, and healthy life expectancy 49.2 and 50.3 years respectively (2002 figures)³.

According to statistics for Ghana, there are significant links between poverty, infant mortality and child development. In 2003, the under-5 mortality rate was 95 per 1,000 births, but this rose to 138.8 in the poorest quintile. Immunization rates ranged from 79.3% in the top quintile to 49.6% in the lowest. Likewise, 9.1% of children were under height in the top quintile and 20.3% in the lowest⁴.

Ghana: Health financing indicators, 2003

Indicator	Value (year)
Total health expenditure as a percentage of gross domestic product (GDP)	4.5 (2003)
General government expenditure on health as percentage of total expenditure on health	31.8 (2003)
Private expenditure on health as percentage of total expenditure on health	68.2 (2003)
Per capita total expenditure on health at international dollar rate	98 (2003)
Per capita government expenditure on health at international dollar rate	31 (2003)

Source: WHO, National Health Data, 2006

In 2003, total health expenditure per capita amounted to US\$98 and total health expenditure represented 4.5 per cent of GDP. Approximately 68 per cent of this expenditure was constituted by private out-of-pocket payments.

In Ghana, approximately 18.7 per cent of the population is formally covered by a health protection scheme. The estimated staff-related access deficit indicates that the equivalent of 66 per cent of the population has no access to health services⁵.

² Ghana Poverty Reduction Strategy 2003-2005, *An agenda for growth and prosperity, Volume I: Analysis and policy statement* (Accra, 2003).

³ ILO. *Social Health Protection: An ILO strategy towards universal access to health care. Draft for consultation* (Geneva, 2007), pp. 47.

⁴ UNDP, data for 2003

⁵ ILO. *Social Health Protection: An ILO strategy towards universal access to health care. Draft for consultation* (Geneva, 2007), pp. 24. The estimated staff-related access deficit refers to the rate if Thailand is chosen as the benchmark.

The ILO's commitment in Ghana in the context of health care

The ILO has been assisting the Government of Ghana since 2002, through the provision of technical advice in the form of a national health budget; and advice on institutional structures, medium term financing and implementation of the National Health Insurance Scheme.

The ILO has in particular been working on a small pre-pilot project in the Dangme West district to develop methodologies for identifying the poor and increasing their access to healthcare through the subsidizing of their health insurance premiums. The project was funded by the Government of the Netherlands and supported by the Government of the United Kingdom. Over a three-year period, this project reached between 3'000 and 4'000 individuals (around 3-4% of the district population) and granted them access to healthcare which they did not have before.

Presently the ILO is working on a project developing a national and a regionalized health budget to provide the government with policy tools to assist them in ascertaining the financial viability of the NHIS and to test proposed policy options. Through a survey in the Dangme West district an assessment of the type and quality of access to care; the views of insured members; the extent the different types of health services are utilized, is being conducted. The first results of the survey conducted in the Dangme West district show that the intervention by the ILO and exemptions by the Government have made it possible for 58% of respondents who otherwise would not have availed themselves of access to healthcare to enjoy it⁶. Furthermore, a monitoring mechanism is being established through the development of a set of performance and quality indicators for the effective and efficient running of District Mutual Health Insurance Schemes in Ghana.

The Dangme West district is located in the Greater Accra Region and it shares boundary with the Eastern and Volta regions to the north and the west respectively. The population (as at June 2006) was about 110,000. It is a rural district with most of the population living in scattered small communities. There is wide spread poverty in the district with the major economic activities of the population being subsistence farming and fishing⁷.

The GST pilot project in Ghana: benefit, benefit delivery and obligations of the recipients

The cash benefit, for poor pregnant women and mothers for the youngest child up to 5 years of age will be paid subject to the meeting of certain conditions. Initially these will be:

- obtaining the prescribed pre-natal care for mother and child
- obtaining a level of post-natal care for the mother and child⁸
- completing prescribed health check-ups⁹ for each child in the family up to 5 years of age.

Full details of the conditions of receipt of the benefit will be prepared in relation to key factors preventing maternal and infant mortality. These will be prepared in consultation with the

⁶ See Opong, R. et al: *Survey report on Dangme West district mutual health organization*, (forthcoming 2007).

⁷ Ibid.

⁸ According to the World Health Report 2005: *Make every mother and child count* (Geneva, 2005), "...three quarters of all neonatal deaths could be prevented if women were adequately nourished and received appropriate care during pregnancy, childbirth and the postnatal period..."

⁹ According to the schedule of essential vaccinations but at least once a year.

National Health Insurance Council, the Ministry of Health and other national and international stakeholders. The aim is also to provide an incentive for pregnant women to register in the National Health Insurance Scheme and hence support the rapid extension of health insurance coverage in Ghana, and provide some cash income for the poorest families at a time when the children and women in the families are most vulnerable and thus have a direct positive impact on poverty and especially poverty related maternal and child mortality and health problems.

The level of the benefit has been tentatively set at an approximate amount of US\$ 10 per month¹⁰. The project will test the adequacy of the benefit level and may propose a change of this level during the course of the project.

It is proposed that the benefit will be delivered through the district mutual health insurance scheme which will initially assist in the identification of the beneficiaries on the basis of a set of criteria to be established in collaboration with the district and the national stakeholders. However, the project team following an analysis of the situation may decide to propose that the benefits of the project be delivered through another local or national organization.

The National Health Insurance Act has been law for some four years, and hence, the project builds on existing initiatives and practice in Ghana. In addition, project benefits will only be financed by contributions from individuals in Luxembourg for an initial phase of up to 5 years. The project must also show that the schemes can be self-sustaining, and then the project can establish the conditions under which a nation-wide introduction can be achieved. The project will not be in competition with the legal obligations of the government under the National Health Insurance Act and there is no danger that the resources of the project are used to simply substitute for national resources. The idea also builds on local community involvement. Local communities have to complement social transfers by participating in the identification procedures of the poor and the registration of beneficiaries. The experience of the present pre-pilot has shown that involving the community in the identification process can be successful.

It is proposed to pilot the project first in the Dangme West district. However, the project team following an analysis of the situation may decide to pilot the project in another district.

The Dangme West pre-pilot is on a limited scale, but has demonstrated the potential for supporting the poorest in society through a relatively robust subsidization mechanism. The proportion of the poorest identified in Dangme West may be atypical of other regions. However, the project would further develop the selection criteria for beneficiaries to establish indicators of real need, which go beyond cash income. The project would also offer the opportunity to test different levels of cash benefits in order to ascertain the optimum level, which encourages membership of district mutual health insurance schemes whilst encouraging maternal and infant health improvements for the poorest.

Financing

The Partner OGB-L ONG Solidarité Syndicale of Luxembourg will finance (from voluntary contributions from Luxembourg employees) the activities of the pilot project in Ghana for a period of up to five years. Provided that the partners of the project agree, the period could be extended, if that seems desirable, at the end of the five-year phase. The Luxembourg partner (in collaboration with the Social Insurance System) would mount a fundraising campaign among persons covered by the Luxembourg social insurance. The aim is to enroll as many long-term

¹⁰ Basically follows the example of the South African Child Support Grant which is approximately 110 Rand per month in 2001 (approximately 12.78 US\$).

voluntary contributors as possible. The proposal is to ask employees in Luxembourg to contribute 5 Euros per month on a voluntary basis. Contributions from members would constantly refuel the funds potentially available to the project to extend the support. Since the actual size of the project is not fully predictable, as it will be determined by the number of actual contributors in Luxembourg, the pilot project will have to follow a gradual implementation procedure (i.e. it would start with one district and then gradually as funds becomes available for financing the cash benefit for a five year period it would integrate a further district and so on).

Organisation, supervision and guidance

The Luxembourg partner OGB-L ONG Solidarité Syndicale has concluded a Memorandum of Agreement with the ILO and the Government of Ghana by which it agrees to collect the voluntary contributions from individuals in Luxembourg, manage the funds thus collected, transfer the funds to Ghana as they are needed and audit the use of the funds.

The project will be supervised by a tripartite advisory board to be approved by the Officers of the Governing Body of the ILO. The advisory board will consist of representatives of the Luxembourg partner OGB-L ONG Solidarité Syndicale, the Government of Luxembourg, the social partners in Ghana and the Government of Ghana. The advisory board will have two subcommittees:

- the Steering committee which will comprise of the Ghanaian members of the advisory board and a representative from the Luxembourg members of the advisory board. This committee will provide advice for the project execution and guide and supervise the implementation of the project.
- the Finance committee which will comprise of the Luxembourg members of the advisory board and a representative from the Ghanaian members of the advisory board. This committee would manage the contributions collected in Luxembourg, would approve and transfer these funds directly to the beneficiary district mutual health insurance scheme or local or national institution in order to finance the benefits provided by the project in Ghana to the extent required and will control the use of these funds. The committee would also assign the members of the project monitoring team (namely auditors and experts). The project monitoring team will undertake auditing (financial and performance) missions once a year but with a right to ad-hoc complementary missions. Misappropriation of funds would lead to the immediate termination of all project activities.

The partner shall set-up a project office in Accra (Ghana). The ILO shall assign a national project team to this office. The project office will be responsible for the benefit delivery in Ghana, which it will do by the establishment of contracts (between the partner in Luxembourg and the respective beneficiary district mutual health insurance scheme or national or local institution which will deliver the benefits provided by the project). The project office shall inform the partner in Luxembourg when funds are required to be transferred by the partner of Luxembourg directly to the respective district mutual health insurance schemes or national or local institution, in order to finance the benefits provided by the project.

Project activities

The national project team will undertake the following activities:

- (1) Identification of pilot districts and potential beneficiaries once enough contributions have

- been collected to ensure the financing of benefits for one community;
- (2) Training of local health insurance staff;
 - (3) Determination of benefit level in accordance with a set of regulations to be developed;
 - (4) Accounting and verification of payments;
 - (5) Submission of bi-annual progress reports to the project advisory board;
 - (6) Providing logistical support to the auditing missions by the project monitoring team;
 - (7) Drafting and submission of the final project report to the project advisory board and to the ILO;
 - (8) Support to the Government of Ghana in the drafting of administrative guidelines and legal instruments to enable the nation-wide introduction of the cash benefit;
 - (9) Submission of annual project status reports to the ILO's Governing Body.

Budget of the pilot project and projected number of beneficiaries

The actual number of beneficiaries of the project will depend on the volume of voluntary contributions which can be collected in Luxembourg and the number of beneficiaries in Ghana who register and qualify for the benefit.

(2) The concept of the Global Social Trust Network

The first and most prominent Millennium Development Goal is to “Eradicate poverty and Hunger”. This was concretised as “Halving the proportion of people with less than one dollar a day”. One of the most powerful means to alleviate and prevent poverty are national social protection systems providing social security through schemes ranging from basic poverty alleviation, to pensions and health care schemes. However, according to ILO estimates only about 20% of the World's population has access to some formal social protection.

The basic idea, mission and objective of the GST

The basic idea is to request people in the richer countries, i.e. the OECD countries to contribute on a voluntary basis a rather modest monthly amount (5 € per month) to a Global Social Trust which will be organized in form of a global network of National Social Trusts supported by the ILO. The GST will:

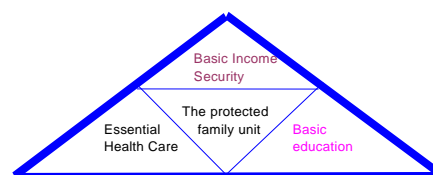
- invest these resources to build-up basic social protection schemes in developing countries; and
- sponsor concrete benefits for a defined initial period till the basic social protection schemes become self supporting.

The mission of the Global Social Trust Network is to systematically reduce poverty in developing countries through a partnership that invests in and sponsors the development of sustainable national social protection schemes for people and groups which have been excluded

from the economic benefits of development. The underlying principles of the Global Social Trust Network are global social responsibility and social partnership.

Benefits, benefit delivery, obligations of recipients

The GST aims to support all national action that aims at extending the coverage of basic social security. The concrete set of benefits will be determined in line with national, regional or local priorities on a case to case basis. It is expected, however, that the main benefit systems supported through the GST will be combined national and community initiatives which finance essential health care, basic income security benefits and finance basic education. The beneficiaries are families as shown in the following basic family protection triangle.



The basic family protection triangle

It is expected that there will be contractual arrangements between community based initiatives and existing national social protection systems aiming at building modest but sustainable, pragmatic and pluralistic nationwide social protection networks. The GST will operate through the implementation of major national assistance programmes in countries for a period of between 5 to 10 years. These programmes will be based on explicit agreements, between the GST and national governments or national agencies, which will stipulate the obligations of both sides. These contracts will be based on financial and operative transparency and a tough monitoring and supervisory machinery.

Basic operational principles

The GST would operate under 10 major guiding principles:

- The basic philosophy is the exercise of global social commitment by individual and possibly corporate or institutional contributors.
- It will build on initiatives taken in recipient countries which demonstrate the commitment to self-help.
- The GST will build on social partnerships in donor and recipient countries and on partnerships between organizations in donor and recipient countries.
- It will sponsor and support programmes tailor made and responsive to the most pressing social security needs at a local, regional or national level.

- It will consist of a decentralized system of funding combined with a centralized system of project vetting, appraisal and support.
- It will maintain political independence and respond exclusively to priority needs.
- Wherever possible it will utilize existing social administration structures in recipient countries and will help to foster sustainable pluralistic social protection networks.
- It will support strategies for the extension of social security through a combination of investments in the administration and time-bound subsidies building on local, regional and national level commitment.
- Operations will be fully transparent, ethical, accountable and subject to regular performance and financial audits.
- Support will be additional to existing social security resources as the GST is intended to provide resources that supplement what governments are currently able to provide.

Characteristics and impact of the GST

The GST does not intend to compete with other International or Global Funds or existing charities operating in the field of international development. It aims at different donors, follows a different rationale and has the distinct objective of investing in good long-term social governance as one prerequisite for development. It is a people-to -people TRUST that seeks long-term presence in the emerging system of global social governance.

The GST could grow into a major international financial North-South transfer operation. If between 5 and 10 % of the employees in the OECD countries were to contribute an average of about 5€per month, then the GST could collect in its stationary state (i.e. after an introductory build-up phase of about one decade) between *1 and 2 billion € per annum*. *It is estimated here that within the first 1.5 to 2 decades of its existence the GST could reach about 100 million people, i.e. help to lift them out of severe poverty through the provision of basic social security.*

Organization, governance and the role of the ILO

It is suggested to build the GST as a decentralized network rather than a centralized money collection and disbursement agency. The design suggested here favours a strong participatory responsibility of the individual financiers. The network approach envisages the gradual building up of national organizations (National Social Trusts) confederated in a global organization but with full national budgetary independence. National organizations would launch national membership campaigns, collect contributions, manage the funds, decide on the use of funds and audit projects financed by the respective national organizations. National organizations would be supported by a Technical Secretariat at the global level that would identify, prepare, implement country programmes under the supervision of a Global Board and will be governed by a Global Assembly. The ILO would provide and host the Technical

Secretariat. While the ILO will thus have a key role in the design, the promotion, the start up and the funding of the GST, it will not be an “ILO fund”. Rather it will be a partnership demonstrating solidarity between workers, employers and governments of developed and developing countries.