

Mental Health Insurance in Ghana: Prospects and Challenges

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ABSTRACT

Background: Mental, neurological and substance use disorders are poorly resourced and prevalence of these disorders is 10–13% in Ghana with only 10% of those affected seeking formal psychiatric treatment. The NHIS coverage gap for mental health has consistently been a cost burden on households, with high out-of-pocket expenses. But it was a turning point in November 2024 when four mental health conditions joined the NHIS benefits package, reflecting a positive step towards improved financial protection and treatment opportunities.

Objective: This review aimed to examine, through secondary data, the prospects and challenges of mental health insurance in Ghana, in order to identify policy options for strengthening the mental health financing system.

Method: The peer-reviewed literature, government publications, national statistics and international literature were used to conduct this secondary-data review, which was completed between 2012 and July 2026. Relevance and credibility of the evidence were evaluated, and the evidence was presented in a narrative form thematically.

Results: There was a rise in NHIS coverage from about 40% in 2014-2015 to 68.6% for the 2021 census period. Progress also includes digital enrolment reform and promises to increase the provision of integrated mental health care. However, challenges still exist, such as payment delays by NHIS, a lack of psychiatric professionals, poor psychotropic medicine supply chains, and stigma linked to spiritual interpretation of mental illness.

Conclusion: The growth of NHIS coverage for mental disorders is a significant progress towards achieving equity in healthcare coverage. But deeper strides will take place if claims are processed better, medicines are available, workers are distributed more effectively, and stigma and misconceptions about mental illness are addressed.

Keywords: Mental health insurance, National Health Insurance Scheme (NHIS), secondary data review, universal health coverage, Ghana, health economics.

Background

Mental health has increasingly come to the fore in global health policies. It has become a recognized fact that it is not a side issue, but is essential to the productivity of the economy and the stability of society. Despite this, resources allocated to mental health in low- and middle-income countries (LMICs) are still far removed from the burden of mental health conditions as compared to the overall burden of mental, neurological and substance use disorders, which constitute a disproportionately large share of global years lived with disability, with LMICs typically spending less than 2% of national health expenditure on mental health. In Ghana, this is clearly evident.

Several million people, or about 10-13% of the population, suffer from a mental health disorder, including common disorders of mood and anxiety, as well as more severe disorders including schizophrenia and bipolar disorder. Less than 10% get formal psychiatric treatment, and there is a significant unfilled treatment gap. Many, however, resort to prayer camps or traditional healers, either with or without clinical treatment, but often in lieu of it. The impact is unevenly distributed and affects families as they take on the cost of lost productivity from an ill family member and the burden of informal care.

But in the face of this burden come a number of real opportunities for optimism. In 2021, Ghana was selected as a priority country for the WHO Director-General's Special Initiative for Mental Health (n.d), which is aimed at achieving integrated person-centred mental health care for an additional 5.2 million Ghanaians. The overall NHIS coverage has also grown significantly from approximately 40% of the population in 2014-2015 to about 68.6% during the 2021 census, and the implementation of digital reforms like linking NHIS membership to the Ghana Card and mobile renewal (International Trade Administration, 2023). Ghana's government further indicated to the United Nations the launch of a Mental Health Levy and continued integration of mental health services in primary care (Permanent Mission of Ghana to the United Nations, 2025). These developments collectively point to a much better future for mental health insurance in Ghana than 10 years ago, albeit there are still significant obstacles to overcome, as revealed in the secondary literature examined here.

Financing Mental Health Care: The NHIS Story

One of the more manageable levers to pull on the policy lever to reduce this treatment gap is financial protection. Ghana was one of the first countries in sub-Saharan Africa to introduce a prepaid health financing system with the National Health Insurance Scheme (NHIS) (Act 650 of 2003) and finally merged the NHIS under Act 852 (2012). The scheme achieved good outcomes in the area of GOP and IHP use but, for the majority of its life, mental health was not included in the standard benefits package. While the issue is still being addressed, government funding for psychiatric services came mainly from direct appropriations from the Mental Health Act of 2012 (Act 846), a line which has always been insufficient, and which has left psychiatric patients vulnerable to high out-of-pocket expenses.

All that changed, however, at the end of 2024, at least on paper. The NHIS benefits package was expanded to include outpatient treatment, as well as the first three months of hospitalisation for four mental health conditions – depression, bipolar disorder, anxiety disorder and schizophrenia – from 1 November 2024 (National Health Insurance Authority, 2024 as cited in the Ghanaian Times; World Health Organization, 2026). The policy shift is important for its interpretation in relation to the secondary evidence reviewed in this study: many published policy papers written at a time when coverage of mental health services in Ghana was not yet in place or was only recently being introduced describe operational challenges such as drug stock out, slow reimbursements, and an imbalanced workforce – issues which will determine whether the policy translates into real or name-only access at the time of implementation in November 2024.

Objective

The objective of this review is to examine, through secondary data, the prospects and challenges of mental health insurance in Ghana, in order to identify policy options for strengthening the mental health financing system.

METHODS

Study Design

This study used a secondary data review design, also known as a documentary or desk-based review, in which existing published and official data were identified, appraised and synthesised rather than collected directly from patients or service providers. This design was chosen because it enables the prospects and

challenges of NHIS mental health coverage to be examined using existing government statistics, peer-reviewed research and international agency reports.

Data Sources

There were three kinds of secondary sources employed. The PubMed and Google Scholar databases were used to search for literature that met the inclusion criteria. Only peer-reviewed academic papers covering the period from 2012 to July 2026, when the search was conducted, were included and limited to studies on NHIS financing, mental health service utilisation, and community-based health insurance in Ghana and other LMIC contexts. Official and Government statements comprised statements by the Ghana Statistical Service (2021 Population and Housing Census), Ghana National Health Insurance Authority, and statements from the Government of Ghana to international institutions like the United Nations. International agency publications consisted of reports and initiative pages from the World Health Organization and market intelligence from the U.S. International Trade Administration. The Ghanaian Times, a reputable national news reporting outlet, was only used to confirm the operational date of the NHIS benefits expansion in November 2024, compared against WHO's own report of the same policy change.

Search Strategy and Selection Criteria

Searches combined the terms 'Ghana', 'National Health Insurance Scheme', 'mental health', 'insurance coverage', 'community-based health insurance' and 'health financing', together with database-specific filters for publication date (2012-2026 — the 2012 start reflects the point at which the NHIS was consolidated under Act 852, and the range extends only to July 2026, when the search was conducted, rather than the end of a completed calendar year) and for peer-reviewed status where academic databases were used. Sources were included where they reported empirical findings, official statistics, or documented policy positions directly relevant to NHIS financing or mental health service utilisation in Ghana or a comparable LMIC setting; sources were excluded where they were opinion pieces without an underlying data source, or where their relevance could not be verified against the original publication.

Data Extraction and Synthesis

Each source was reviewed, and the relevant indicators, findings and figures were extracted into a structured dataset recording the indicator, its value or finding, the year and geographic scope, the source and source type, and (where applicable) a working link to the original publication. This dataset is provided as a supplementary file alongside this paper. The extracted evidence was then synthesised narratively around the review's core themes - coverage growth, benefit-package reform, and the structural barriers to access - allowing the discussion in Section 4 to draw directly on a transparent, traceable body of secondary evidence rather than on newly collected primary data.

Ethical Considerations

This study used publicly available secondary sources and did not involve direct recruitment or interaction with human participants; therefore, no primary data collection was undertaken. Every source, however, was judged before being used; sources were prioritised according to their authority and relevance, with official statistics and peer-reviewed publications given greater evidential weight, while grey literature and news reports were used selectively to corroborate specific policy developments or dates.

RESULTS

Table 1 and Figure 1 summarise the growth in overall NHIS coverage over the review period, and Table 2 lists the full set of secondary sources assessed for this review.

Table 1 and Figure 1 showed that Ghana's overall coverage of the National Health Insurance Scheme (NHIS) had improved significantly from 2014-2015 to 2021. The proportion of NHIS coverage of the population had risen from around 40% in 2014-2015 to 68.6% in the 2021 census period. This was about

28.6 percentage points higher than the period of review. The result suggested that over time, a significantly higher percentage of the Ghanaian population had been insured under the national health insurance scheme. An increase in coverage was also linked to reforms of the NHIS enrolment and renewal process, including digital reforms such as linking NHIS membership to the Ghana Card and introducing mobile renewal services (International Trade Administration, 2023).

The trend indicated in Figure 1 was also evident in the figures in Table 1 and indicated that overall coverage of NHIS had increased significantly in the period covered. There was a need for continued progress towards financial protection and access to health care services in Ghana, and the increase in people covered by standard health insurance was a strong building block. The financial implications of this expansion were also important for mental health, since the NHIS coverage of mental health services could help lower financial obstacles to accessing formal mental health care services for a person or household. However, general NHIS coverage did not automatically mean that mental health services were available, but that depended also on the availability of mental health personnel, medicines, adequate facilities, functional health care delivery systems, and so on.

In general, the results of Table 1 and Figure 1 indicated that Ghana had made significant strides in the coverage of health insurance in the period from 2014–2015 to 2021. This rise from around 40% to 68.6% was significant for the population covered and provided a positive base for growth in mental health insurance. The overall rise in NHIS coverage also offered important background on the following rollout of mental health coverage in November 2024. However, the extent to which the increased insurance coverage was translated into better access to mental health care depended on how well the mental health benefit was put in place and whether there were any structural barriers that needed to be overcome in the health system.

Table 1. Growth in Overall NHIS Coverage, 2014-2015 to 2021

Period	NHIS coverage (% of population)	Source
2014-2015	~40%	International Trade Administration, 2023
2021 (census)	68.60%	International Trade Administration, 2023

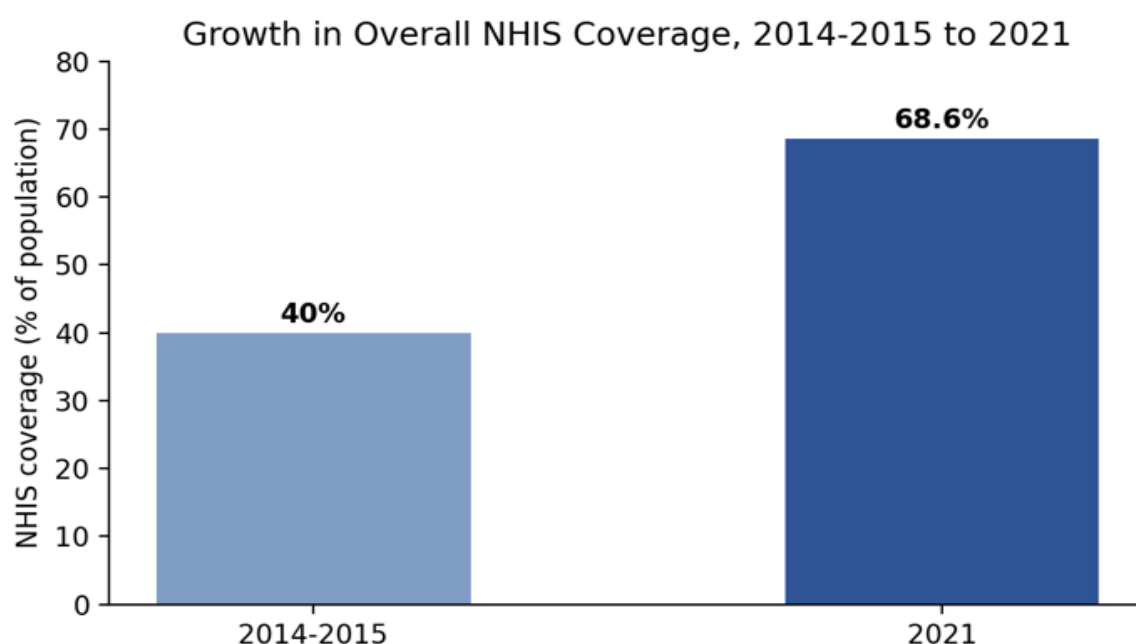


Figure 1. NHIS Coverage Growth, 2014-2015 to 2021

Source: International Trade Administration (2023), based on Ghana Statistical Service enrolment figures.

Table 2. Articles and reports Assessed in This Review

Source	Type	Key indicator / finding used
Ae-Ngibise et al. (2023)	Peer-reviewed survey	Gap between prevalence of probable mental/neurological/substance-use conditions and cases detected at primary healthcare facilities
Alkhawaldeh et al. (2023)	Peer-reviewed review	Andersen's behavioural model as a framework for insurance as an enabling factor in service use
Arrow (1963)	Peer-reviewed (theory)	Foundational risk-pooling / uncertainty theory of health insurance
Docrat et al. (2020)	Peer-reviewed systematic review	Association between insurance coverage and mental health service utilisation in LMICs
Eze et al. (2023)	Peer-reviewed systematic review / meta-analysis	Effect of community-based health insurance on utilisation in LMICs
Ghanaian Times (2024)	National news report	Confirms 1 November 2024 operational date of NHIS mental health benefits expansion
International Trade Administration (2023)	Government market intelligence	NHIS coverage growth (40% in 2014-2015 to 68.6% in 2021) and digital enrolment reform
Lu et al. (2012)	Peer-reviewed evaluation	Rwanda Mutuelles: insurance improved access only when paired with financing reform
Permanent Mission of Ghana to the UN (2025)	Official government statement	Reported Mental Health Levy and primary-care integration commitments
Sakyi et al. (2024)	Peer-reviewed qualitative study	Workforce and operational constraints in delivering district mental healthcare plans
Sen (1999)	Peer-reviewed (theory)	Capability approach framing mental health as central to substantive freedom
Weobong et al. (2023)	Peer-reviewed situation analysis	Urban concentration of psychiatric infrastructure and specialist personnel
Wijekoon Mudiyansele et al. (2024)	Peer-reviewed systematic review	Effectiveness of non-specialist and digital mental health interventions in LMICs
World Health Organization (n.d.)	International agency initiative page	Ghana's designation as a WHO Special Initiative for Mental Health priority country
World Health Organization (2026)	International agency report	Confirms integration of mental health into NHIS as part of universal health coverage reform

Growth in Overall NHIS Coverage

The overall NHIS coverage has increased from approximately 40% in 2014-2015 to about 68.6% in 2021 due to various factors, including digital reforms and mobile renewal (International Trade Administration, 2023). This trend of increasing coverage applies to the 2024 mental health benefit expansion in context: Not only is there a growing share of the population that has active NHIS membership, but the actual impact of the mental health benefits' extension is determined more by whether those in the NHIS can access them rather than if they are newly enrolled.

The 2024 Mental Health Benefits Expansion

From 1 November 2024, the NHIS benefits package was extended to cover outpatient treatment and the first three months of hospitalisation for four mental health conditions - depression, bipolar disorder, anxiety disorder and schizophrenia (National Health Insurance Authority, 2024, as reported in the Ghanaian Times; World Health Organization, 2026). This is confirmed by the WHO's own documentation of the reform, which sees the reform as one of the steps in the national effort to achieve universal health coverage for

mental health in Ghana. The secondary evidence, coupled with Ghana's designation as a WHO Special Initiative for Mental Health priority country, with the goal of integrated care for 5.2 million more Ghanaians (World Health Organization, n.d.), and the reported government commitment to a Mental Health Levy (Permanent Mission of Ghana to the United Nations, 2025), suggests that there is continued policy interest, but not just one single reform.

Structural Barriers Documented in the Published Literature

Independent of the specific 2024 reform, published research on Ghana's district mental health system has repeatedly documented a consistent set of structural barriers. Situation analyses of mental health services across several Ghanaian districts have found psychiatric infrastructure and specialist personnel concentrated in urban centres, leaving rural facilities comparatively under-resourced (Weobong et al., 2023). Published qualitative evidence involving primary healthcare workers and service users has highlighted operational and workforce constraints in translating national mental health policy into consistent local delivery (Sakyi et al., 2024). Evidence from a previously published cross-sectional survey of primary healthcare facilities across three Ghanaian districts identified a meaningful gap between the prevalence of probable mental, neurological and substance use conditions in the community and the proportion of cases actually detected at the point of care, consistent with the wider treatment gap described in Section 1.0 (Ae-Ngibise et al., 2023). More widespread systematic evidence from different LMICs confirms that, in general, health insurance is associated with more use of services for mental, neurological and substance-use conditions, although the extent of this association is heavily influenced by complementary supply-side factors, like availability of medications and workforce distribution (Docrat et al., 2020; Eze et al., 2023).

Comparative Evidence from Other Low- and Middle-Income Countries

Outside of Ghana, there is evidence that provides something to compare. In Rwanda, maternal and mental health benefits resulted only when health financing reforms were implemented alongside expansion of the health insurance scheme Mutuelles, and not from the health insurance scheme alone (Lu et al., 2012). A community-based health insurance systematic review and meta-analysis in LMICs had similar, though less uniform, results on the overall impact on utilization of health services, highlighting that the design and implementation of a scheme is as significant as its existence (Eze et al., 2023). There is emerging evidence on task shifting and digital mental health interventions, where non-specialists can provide mental health services in LMICs, highlighting another way of scaling up mental health services beyond relying on limited skilled personnel. There is emerging evidence on task shifting and digital mental health interventions that non-specialists can provide mental health services in LMICs, suggesting a further pathway to scale-up mental health services without only relying on the limited skilled workforce (Wijekoon Mudiyanse et al., 2024).

DISCUSSION

The secondary evidence analysed in this study is consistent with Andersen's understanding of insurance as an enabler of health service utilisation (Alkhawaldeh et al., 2023), and the broader LMIC literature that indicates that, at the point of use, reducing financial constraints is linked to increased health-seeking behaviour (Docrat et al., 2020). On the other hand, this evidence paints a picture of two sides to the story: a collection of promising but real opportunities for mental health insurance in Ghana, and a collection of similarly real and documented challenges that will determine the extent to which this promise is realized. Each will be discussed individually in the following sections.

Prospects for Mental Health Insurance in Ghana

But there are several developments identified in the secondary literature that indicate a real improvement in the future. Enrolment and retention increased significantly over the last few years, from approximately 40% of the population in the 2014-2015 survey to approximately 68.6% of the population by the 2021 survey, and the digitalization of the NHIS, like linking the NHIS card to the Ghana Card and allowing for mobile

updating, is slowly improving the enrolment and retention process (International Trade Administration, 2023). The decision to include Ghana under the WHO Special Initiative for Mental Health and the target of improving mental health care for 5.2 million more Ghanaians, as well as reported progress towards the implementation of a Mental Health Levy and greater integration of mental health services with primary care, are additional indicators of continued policy focus, rather than one-off reform (World Health Organization, n.d.; Permanent Mission of Ghana to the United Nations, 2025). Most simply, the November 2024 expansion of NHIS benefits coverage to depression, bipolar disorder, anxiety disorder, and schizophrenia opens up a first-of-its-kind opportunity to transform the existing structure of care into a more affordable, more commonly consumed care.

Persistent Challenges to Realising These Prospects

The published literature, however, cautions against reading these prospects as evidence that Ghana's access problem is already solved. Coverage clearly changes whether patients attempt to seek care, but the secondary evidence on district mental health service delivery suggests it does not reliably determine whether they receive it once they arrive (Weobong et al., 2023; Sakyi et al., 2024). Systematic reviews of comparable settings reinforce this: Lu et al. (2012) found that in Rwanda, community-based health insurance improved maternal and mental health access only when combined with broader financing reform, not on its own - a combination that, on the evidence reviewed here, has not yet fully materialised in Ghana. This study was conducted against the backdrop of Ghana's transition to its expanded mental health benefits package, and that timing shapes how the reviewed evidence should be read: the structural barriers documented in the literature - workforce concentration, infrastructure gaps, and the treatment gap identified by Ae-Ngibise et al. (2023) - are precisely the implementation risks that will determine whether the November 2024 policy change produces real gains in access or amounts to coverage that exists only on paper.

Policy and Financing Options: Turning Prospects into Access

Four directions follow from this review and appear both timely and actionable for converting Ghana's improving prospects into consistent access.

- Integration into primary care: Delivering mental health services through district hospitals and Community-based Health Planning and Services (CHPS) compounds would reduce the distance and cost barriers that continue to affect rural patients, including those with insurance coverage (Weobong et al., 2023; Sakyi et al., 2024).
- Task-shifting and telepsychiatry: Task-shifting to non-specialist providers, combined with digital and telepsychiatric services, has worked in other LMIC settings and could help ease the concentration of psychiatric expertise in Ghana's urban centres (Wijekoon Mudiyansele et al., 2024).
- Ring-fenced funding for psychotropic drugs: A dedicated funding line or levy for psychotropic medication - building on the Mental Health Levy already reported by government (Permanent Mission of Ghana to the United Nations, 2025) - could help protect drug availability from the reimbursement delays documented in the district-level literature.
- Community and multi-sectoral partnership: Partnerships between community leaders, traditional healers and faith-based organisations may help shorten the delay in seeking formal care that the secondary literature attributes to stigma (Ae-Ngibise et al., 2023).

LIMITATIONS

As a secondary data review, this study's conclusions are only as reliable as the underlying sources, and several limitations follow from that. First, much of the published academic literature on Ghana's district mental health system predates the November 2024 benefits expansion, so it cannot speak directly to outcomes under the new policy; findings are necessarily framed as risks to that policy's success rather than

as evidence of its effects. Second, national coverage statistics and government statements may reflect limitations in administrative reporting, data availability or measurement practices, and some implementation gaps may not be fully captured in publicly available sources, and may understate implementation gaps that only become visible at the facility level. Third, this review draws on a bounded set of sources identified through a defined search strategy, and while every effort was made to include the most relevant and credible evidence, it cannot claim to be an exhaustive systematic review of every study published on this topic.

CONCLUSIONS

Taken as a whole, the secondary evidence reviewed in this study indicates that mental health insurance in Ghana is a genuine and improving prospect that remains held back by a specific, identifiable set of challenges. The prospects are real: steadily rising overall NHIS coverage, sustained WHO and government attention to mental health system reform, and the landmark 2024 decision to bring four major mental health conditions into the standard benefits package. The challenges, as documented across the published literature reviewed here, are equally real: workforce concentration in urban centres, fragile psychotropic drug supply chains, reimbursement delays, and stigma continue to limit care for insured and uninsured patients alike, and coverage alone does not guarantee access. With mental health now formally part of the NHIS benefits package, the pressing question is one of implementation - how psychotropic drugs will be distributed, where the workforce will be trained, and how claims will be processed - and it is on these operational details that Ghana's mental health insurance prospects will ultimately be judged.

Author's Contribution

KA conceived the review, designed and conducted the secondary data search and extraction, synthesised the findings, and drafted the manuscript. SMYA conceived the review, reviewed and edited the draft, supervised the whole project

Acknowledgement:

None

Conflict of interest: None

Data Availability: Statement

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

Ethics

All data were drawn from public sources. No personally identifiable information was disclosed. Ethical clearance was not required for public domain analysis.

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