Kwame Nkrumah University of Science and Technology, Kumasi, Institute of Distance Learning

FINANCING HEALTHCARE IN GHANA UNDER NATIONAL HEALTH INSURANCE SCHEME (NHIS), THE SUBSCRIBERS PERSPECTIVE

By

Dei-Owusu Ampofoh (Bachelor of Commerce)

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July 2011

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A Thesis submitted to Institute of Distance Learning, Kwame Nkrumah University of Science and Technology in partial fulfillment of requirement for the degree of

COMMONWEALTH EXECUTIVE MASTERS OF BUSINESS ADMINISTRATION

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Certification

I hereby declare that this submission is my own work towards the CEMBA and that, to the best of my knowledge, it contains no material previously published by another person nor material which has been accepted for the award of any other degree of the University, and due acknowledgment has been made in the text with all citations.

Dei-Owusu Ampofoh / PG3035409	…….	……
Student Name & ID	Signature	Date

I certified in accordance with presentation of project work in the institute supervision.

Mr. George Obeng Takyi	……	……
Supervisor(s) Name	Signature	Date

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……	……	…….
Dean, IDL. Name	Signature	Date

Abstract

English proverb says that “Health is Wealth”. Your health is the most precious wealth that God has given you. Financing Health Care in Ghana has been a major challenge for the various passed Governments. The implementation of the cash and carry compounded the utilization problem by creating a financing barrier to health care access especially for the poor.The gap between the ‘haves’ and the ‘have nots’ keeps widening. Hence the appropriate way of financing healthcare in Ghana under National Health Insurance Scheme (NHIS), the subscribers perspective. The objectives was determination of premium if it is based on sound actuarial principles, time taking to meet the expenses from service providers as they fall due, subscribers capacity to pay economic premium and how the health needs of the people are met as motivation for membership renewal. The study was conducted in Atebubu-Amanten district through a survey. Multi stage and simple random was used to select the sample size and data was collected using a questionnaire and interviews. The findings show that the scheme cannot meet it claims from service providers with it total premium collected. The people are poor and hence cannot pay economic premium, 58% earned monthly income between 50 Ghc – 150 Ghc as compared to treatment of healthcare cost of 58.08 Ghc to 182.50 Ghc. NHIS card guarantee unrestricted access for clients to service providers. There is no specialist in any of the health facilities in the area. Equally important finding was that premiums collected locally are not invested. This is a treat to sustainability of the scheme should subsidies from central Government stop coming. Based on the findings of the study the following recommendations were made: Economic premium should be charge to cover cost of healthcare. The Government should empower the people economically to earn enough to pay economic premium. Premiums collected should be invested in other investment portfolios to earn additional fund for claims payment.

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CHAPTER ONE

INTRODUCTION

Background of the Study

Financing Health Care in Ghana has been a major challenge for the various passed governments. Since independence lot of governments have come out with a number of policies in taking care (financing) of health care bills in the country. Immediately after the independence health care provided to the people was free in the public health facilities. This meant that there was no direct out of pocket payment at the point of consumption of health care in public health facilities. Financing of health in the public sector was, therefore entirely through tax revenues. The sustainability of this form of financing became questionable as the economy began to show signs of decline and there were other competing demands on the same source.

This situation continued until 1985 when the then government introduced the user fees for all medical conditions except certain specified communicable diseases. The free health care policy was badly implemented in that communicable diseases such as tuberculosis (TB) and pandemic influenza which were suppose to have been exempted; in practice nobody enjoyed this facility. Also, a guideline for implementation was not provided and no conscious system was designed to prevent possible financial leakages. In the ensuing years the standard of health care provision fell drastically due to inadequate funding. There was acute shortage of essential drugs in all public health facilities. Most importantly, the introduction of user fees termed as “cash and carry” payment mechanism resulted in the first observed decline in the utilization of health services in the country. In spite of this, the government went ahead to institute full cost recovery for drugs as a way of generating revenue to address the shortage of drugs.

The implementation of the cash and carry compounded the utilization problem by creating a financing barrier to health care access especially for the poor. It is estimated that out of eighteen percent (18%) of the entire population who require health care at any given time, only twenty percent (20%) are able to access it. This implies that about eighty percent (80%) of Ghanaians who need health care cannot afford it and, consequently more premature deaths. In line with Ghana Poverty Reduction Strategy (GPRS), the government initiated a policy in 2002 to deliver accessible, affordable and good quality health care to all Ghanaians especially the poor and most vulnerable in society (NHI Policy Framework for Ghana, MOH, Aug. 2004).

Hence the introduction of National Health Insurance Scheme (NHIS) as a health care financing alternative. The vision of government in instituting health insurance scheme in the country is to assure equitable and universal access for all residence of Ghana to an acceptable quality package of health care. The NHIS in Ghana grew out of an election promise made in 2000 by then incoming New Patriotic Party to abolish user fees (traditionally known in Ghana as 'cash and carry'). These have constituted a well-documented barrier to health care in Ghana since the 1980s, and attempts to alleviate them with a system of exemptions have not been very successful. As a proportion of total public sector funding, user fees constituted 13%–14% in 2005.

Act 650, 2003 and the subsequent Legislative Instrument (LI. 1809) of 2004 do not specify the goals of the policy, but the original focus from the party manifesto was clearly on removing financial barriers to utilization of health care. The NHIS aimed to build on these organizations by introduction of district-based mutual health insurance schemes (DMHIS). It was designed as a mandatory health insurance system, with risk pooling across district schemes, funded from

members' contributions and a levy on the value-added tax (VAT) charged on goods and services, from which a broad minimum package of care could be funded. Insurance work on the basic principle of pooling of financial resources from many people and use them in the event of the need of a member. Health Insurance is a system whereby a group of people contribute some amounts of money (premiums) into a common pool (fund) to take care of their health needs. The law of large numbers basically relies on the principle that the larger the pool, the more predictable the amount of losses will be in a given period. Since not all members of the pool are of the same age or in the same health condition, we can assume not all of them will be making a claim at the same time.

The NHIS Act, 2003 (Act 650) allows only three types of health insurance in Ghana: the District Mutual Health Insurance Scheme (DMHIS), Private Mutual Health Insurance Scheme and Private Commercial Health Insurance Scheme.

The research or project work focused on the financing of health care under the DMHIS with particular reference to three key stakeholders namely subscribers, operators and service providers. By subscribers, the research looked at sources and levels of incomes and family sizes as well as the other economic factors that affect them. Under the operators' perspective the research looked at the sources of finance available to the scheme, how reliable they are in the sustenance of the insurance scheme. It also looked at the management of the schemes to fulfill the purpose of their establishment. From the service providers' perspective, the work looked at the impact health Insurance has brought to bear on their services in terms of finances and operations. It also looked at the subscribers relationships with the service providers. However, it is important to note that, the system of health insurance that is being practice in Ghana is a

hybrid form of social health insurance (SHI), with government paying contributions for those who are unemployed and are poor, who would otherwise have difficulties in contributing. However, its distinct feature is that it is not funded exclusively on public finance, but instead spreads the responsibility of health care financing among households as well.

Statement of the problem

The debate about the most appropriate way of financing health care delivery has been an issue since the colonial era. After independence, successive governments have tried in different ways to find better and acceptable ways to finance health care services in Ghana. Although the cash and carry system led to more rational indenting of drugs and user fees were to reduce Government burden on health care, it nevertheless resulted in reducing outpatient attendance.

As a result the National Health Insurance Scheme (NHIS) was introduced as an alternative health care financing to enable subscribers get access to quality health care at a minimum cost. Health Insurance is a system whereby a group of people contribute some amounts of money (premiums) into a common pool (fund) to take care of their health needs (risk).

By design, the approved member contributions comprising premium and registration fees ranged from a minimum of GHC 7.20 to GHC 48.00 (NHI Policy Framework for Ghana, MOH, 2004).

Available evidence indicates that there are huge differences between what are paid as subscriber fees (as indicated above) and what are incurred as cost (per head) for treating healthcare. For instance, according to a 2010 report by Ghana Health Service (GHS) Atebubu District, cost of health care ranges from GHC 58.08 as general average cost of treating an illness to an upper limit

of GHC 182.50 as cost of treatment. The statistics above indicate that the schemes do not charge economic premiums. Also, whereas the average annual household income in Ghana is about GHC 1,217.00 (GLSS 5, pg.105, 2008) that of Atebubu-Amanten District is GHC 952.00 (AADA Annual Report, 2009) which forms about three-quarters of the national average. This development is a manifestation of the fact that the people are poor and cannot afford economic premiums. This is a serious challenge to the risk pooling principle in insurance therefore, could jeopardize the successful operation of the scheme.

The question is: can health insurance subscribers of the schemes contribute enough to sustain the health insurance scheme as a source of financing health care in Ghana, giving the current economic conditions within the national and global environments.

Objective of the study

The general objective of the study is to find out the most appropriate ways of financing healthcare in Ghana, in the perspective of subscribers of the national health insurance scheme. To achieve this, the study looked at the following sub-objectives:

- ✓ Determination of premium if it is based on sound actuarial principles (insurance).
- ✓ Time taking to meet the expenses (claims) from service providers as they fall due (cost containment).
- ✓ To find out Subscribers capacity (economic/social cultural background) to pay economic premium.
- ✓ How their health needs/demands is met to serve as basis of motivation to renew their membership.

Research Questions

- Is the premium paid for National Health Insurance Schemes enough to qualify as an insurance project/and not cash and carry?
- Is the subscriber earning enough income to pay for their premiums as and when it is due?
- Is there enough coverage of service providers to the reach of the subscribers to encourage and motivate them to sustain the interest of the scheme?
- Is the premium collected invested to keep the scheme sustainable?

Purpose of the study

The major purpose is to determine how to sustain national health insurance schemes from premium as a source of financing health care in Ghana.

Significance of the study

The study will help contribute to some of the ways of financing of health care in Ghana. The study therefore is significant, for its findings will be used to assist policy formulation for the implementation of healthcare funding decisions. It will also serve as a case study for insurance professionals; academia who need information on practical and successful health care financing.

The present study would be beneficial because most of the success of health insurance management depends on the management of finances. Unless health insurance develop and employ a technique out of which they can achieve the satisfaction of highest possible degree, they may feel a sense of non-fulfillment and might even fail in achieving their basic goal, that is the achievement of surplus or positive net worth.

Scope and limitation of the study

The research work covered Atebubu -Amanten District Mutual Health Insurance Scheme with 75,065 members, out of one hundred and forty-five (145) Health Insurance Schemes nationwide (NHIA, Brong Ahafo 2010 Annual Review Meeting report).The study concentrated on only those who have subscribed to health insurance scheme as a source of financing their health care needs. This was due to time and cost constrains.

Methodology

Methodology is about anything that has to do with procedures or techniques of investigation, that is, the set of techniques used in one piece of research. It is all about the methods used in the study of the research. The methodology of this research was broken down into the following sub-headings: Population and Sample - the entire group of elements that the researcher was interested to investigate. An element on the other hand, is a single member of the population (Jankowicz, 1991). Atebubu-Amanten District is the population for the study. Sample is a selection of part of group or an aggregate of population with a view of obtaining information about the whole. The Sample was taken from Subscribers to National Health Insurance Scheme in the Atebubu-Amanten, Service Providers and Management (Operators) of the Scheme for the study. Data collection was from two sources: primary and secondary sources. Data was

analyzed through the responses from the survey and result keyed into statistical package for social sciences (SPSS) version 16.0 software which was used for statistical analyses. Chi Square was used to test the hypotheses.

Organisation of chapters

- Chapter one gives the background of the study of health insurance in Ghana as well as the problem statement of the research. It also spells out the objectives, research questions and significance of the study.
- Chapter two looked at the literature review, conceptual frame work and summary of some related studies and reports concerning health insurance financing health care in other countries.
- Chapter three discusses the methodology used in the study in the areas of design, area of study population, sample, data collection and data analysis.
- Chapter four focused on data analysis, and discussions.
- The final chapter, five contains major findings, recommendations and conclusion.

References

Appendices

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

The concept of the study was looked at with the various related literatures reviewed in line with stakeholder's interest, determination of insurance premium, and subscribers' capacity to pay economic premium. The health needs of people and sources of finance for NHIS in Ghana, and other country's health care financing and health expenses.

2.1 Concept of the Study

Everybody need good quality healthcare when he/she is ill. This healthcare goes with cost, and to finance the cost of this healthcare system we resort to use health insurance scheme. Insurance is pooling of resources (premiums) paid by members (policy holders) to indemnify them against any future occurrence of risks (illness/sickness). The premium paid should be sufficient enough, invested to indemnify future occurrence of risk. This premium paid should be able to sustain the insurance scheme. The scheme objective is to provide access to healthcare services to its members. This services goes with cost and for someone to accept to pay for cost, the one paying must be satisfy with the benefits he/she derives from it. To achieve this, the schemes have to market its product to convince people that they will get the satisfaction for money paid. Moreover pay its service providers the cost of healthcare rendered to the clients. The subscriber would subscribe to health insurance scheme where he/she knows that his/her health needs will be

taken good care of at the point of sickness. The ability of the subscriber to subscribe to the insurance scheme depends on

availability of income. The service providers are interested in schemes ability to pay for the cost of healthcare services rendered to the clients.

2.2 Determination of Insurance Premium

Insurance is a mechanism where a pool is established, with many people facing similar risks contribute into a common fund, and out of the fund, those who suffer loss are compensated; meaning, insurance involves a sharing of or pooling of risks among a large group of people. The origins of insurance go back many years, and can be traced to members of a community helping out others who suffered loss in some form or other.

You would be prepared to help out a neighbour who suffered some calamity, since you or your family could similarly be aided by others when you required such help. This eventually became more formalized, giving rise to insurance companies as we know them today (Amartey E., 2007). With this development, the sharing of risk is no longer confined to the scope of neighbours or community members one knows, but rather among all those who chose to buy policies from a particular company. Although there are many different types of insurance, the underlying, basic principle is similar. A company, known as the ***insurer***, agrees to pay out money in the form of a compensation, which is here referred to as benefits, at specified times, upon the occurrence of specified events causing financial loss. In return, the person purchasing insurance, known as the

insured, agrees to make payments of prescribed amounts to the company. These payments are known as premiums. The contract between the insurer and the insured is referred to as the insurance policy. The risk is thereby transferred from the individual facing the loss, to the insurer. The insurer in turn reduces its risk by insuring a large number of individuals. Consider the

following example, which admittedly, is vastly oversimplified, but designed to illustrate the basic idea of premium determination, see appendix A.

Premium determination under National Health Insurance Scheme (NHIS)

The premium determination under the national health insurance is the contributions from members of the scheme. "Contributions of members shall be determined by the governing body of the scheme. The contribution shall be paid in such manner as the governing body of the scheme shall direct". (Source: National Health Insurance Act, 2003 "Act 650" pg. 15) Since the socio-economic conditions of all residents in Ghana are not the same so also the contributions paid are not the same. The premium paid under national health insurance scheme is not based on any standardised scientific actuarial principles but based on socio-economic conditions and affordability (ability to pay) of the residents in the district. The state legislation also established National Health Insurance Fund which is "to provide finance to subsidize the cost of provision of healthcare services to members of district mutual health insurance schemes licensed by the council". (Source: Act 650 pg. 26) This was done to bridge the gap between the premiums paid by the people and the cost of healthcare.

However, in other business organisations a percentage of an employee's salary is use to finance part of their health care cost of the workers (premium) and the remaining cost born by the

employer. Workers of Guinness Ghana Breweries limited (GGBL) use 3% of their salaries to finance health care cost. (Collective agreement between Guinness Ghana Breweries Limited and industrial and commercial workers union of Ghana on behalf of GGBL junior employees, 2001).

2.3 Subscribers Capacity to pay Economic Premium

Financing methods can influence consumers' decisions to seek medical care and how much and what type of medical care they seek. Consumers with no cost-sharing requirements are more likely to seek and use health care because they don't have to make direct payments for their care. Likewise, consumers with high cost-sharing requirements are somewhat less likely to seek and use care. Financing methods may influence medical providers' decisions as to what treatments to offer and how frequently to interact with patients. According to Judith R. and Pamela B.,-2002, the methods used to finance personal health care service play a major role in shaping a country's health care system. Personal health care include services such as hospital care, physician care, dental services, and drugs that are provided directly to individuals. How this care is financed influences people access to health care which also depends on the type of health care provided, and the mechanisms used to allocate health care services.

2.4 Health need of People

According to Mililani Trask, May 2004 - The "acute health needs" of indigenous peoples cut across socio-economic boundaries, and the underlying causes of poor health for indigenous people included colonization, homelessness, poor housing, poverty, lack of reproductive health rights, domestic violence and addiction. Health care should be envisaged from an indigenous perspective, which encompassed mental, physical and spiritual health. Nearly 60 million

Americans living in rural and frontier America tend to have the same types of health problems and need for services as individuals who live in urban and suburban areas. However, comparable health care services are unavailable in many rural areas. The provision of health services in rural areas is often dependent upon a handful of providers including possibly one or two specialty health providers, primary care physicians, staff in rural hospitals and nursing homes, school counselors, social workers, ministers, law enforcement personnel, and self-help groups (National Institute of Mental Health [NIMH], 2002).

Rural areas have many unique characteristics, many of which affect access and utilization of health services. For example, women head 46 percent of rural households, and, of these families, twenty-seven percent (27%) are below the poverty level, compared to 9% of male-headed rural families. The elderly are represented disproportionately in rural areas. African Americans are over-represented in the rural South whereas a significant number of Native Americans and Alaska Natives live in rural and frontier areas in the West (U.S. Department of Health and Human Services [DHHS], 2001). Most rural countries have no practicing psychiatrists, psychologists or social workers. This will have a negative effect on using insurance as healthcare financing alternative. Because the rural people's health needs are not adequately well catered for, it will be a disincentive for them to pay premiums (contributions) towards services in which they are not satisfied with. This shows that the health needs of the people are not adequately met especially those in the rural areas as health professionals are not enough there compared to the cities.

The health needs of the people in Atebubu-Amanten District are also not quite different from those outlined by Mililani Trask. Moreover, the distance between the health facility and the people are far for them. The doctor to patients; and nurse to patients ratios are also high in the

area. Couples with these are lack of necessary equipments in those health care facilities to cater for the health needs of the people at theater for surgery. This may result in other forms of meeting their health needs apart from medicinal ways, like self medications, shrines and herbalist. This may defeat the objective of health insurance as a source of financing healthcare, when they refuse to contribute to join the scheme.

2.5 Sources of Financing of Healthcare in other countries under Health Insurance scheme

(i) Healthcare system finance in Australia

Australia has a mixed public and private health care system. The core feature is public, taxation-funded health insurance under Medicare, which provides universal access to subsidized medical services and pharmaceuticals, and free hospital treatment as a public patient. Medicare is complemented by a private health system in which private health insurance assists with access to hospital treatment as a private patient and with access to dental services and allied health services. There is a strong reliance on out-of-pocket payments. In Ghana some private insurance companies like State Insurance Company (SIC) and Star Assurance Company have health insurance package for their clients who subscribe for their health needs to be cater for. It is in grades where some cover full cost of health care; others cover part of the health care cost.

National health insurance: Compulsory national health insurance (Medicare) is administered by the Australian government. Medicare is funded mostly from general revenue and in part by a 1.5 percent levy on taxable income, though some low-income individuals are exempt or pay a reduced levy. Individuals and families with higher incomes (AUS$73,000 [US$67,151] and AUS$146,000 [US$134,299] per annum, respectively) who do not have an appropriate level of private hospital insurance coverage have to pay a Medicare levy surcharge, which is an

additional 1 percent of taxable income. In 2007–08, the revenue raised from the Medicare levy (including the surcharge) funded 18 percent of total federal government health expenditure. Other federal, state, and territory government health expenditure is funded from general tax revenue, including the goods and services tax (GST), with some revenue raised from patient fees and other nongovernment sources. In 2007–2008, governments funded 69 percent of total health expenditures, with 43 percent funded by the Australian government and 26 percent funded by state and territory governments. The Department of Veterans' Affairs covers eligible veterans and their dependants by directly purchasing public and private health care services. In the case of Ghana the aged and less than 18 years of age are exempted from paying premiums. However government workers contribute 2.5% of their SSINT deduction to health insurance fund to be taken care of their health needs.

Private insurance: Private insurance contributes 7.6 percent of total health expenditure. Since 1999, 30 percent of private health insurance premiums are paid by the Australian government through a rebate. The rebate increases to 35 percent for people aged 65 to 69 years, and to 40 percent for those aged 70 and older. In mid-2009, 44.6 percent of the population had private hospital insurance, and 51.3 percent had General Treatment coverage (which includes ancillary services). Lifetime Health coverage encourages people to take out private hospital coverage early in life, and to maintain their coverage, by offering people who join a health fund before age 31 a relatively lower premium throughout their lives, regardless of their health status. People over the age of 30 face a 2 percent increase in premiums over the base rate for every year they delay joining, although fund members who have retained their private health insurance for more than 10 years are no longer subject to this penalty. Private health insurance is community-rated, and

provided by both for-profit and nonprofit insurers. In Ghana private insurance is organisational base and provided by both for profit and non-profit insurers.

Out-of-pocket expenditure: Out-of-pocket spending accounted for 16.8 percent of total health expenditure in 2007–08. Most of this expenditure is for medications not covered by the PBS, dental services, aids and appliances, and copayments on medical fees. (Source: International Profiles of Health care Systems pg.9)

(ii) **Healthcare system finance in Germany**

Statutory Health Insurance (SHI): The SHI scheme is operated by about 180 competing health insurance funds (called "sickness funds"): autonomous, not-for-profit, nongovernmental bodies regulated by law. The scheme is funded by compulsory contributions levied as a percentage of gross wages up to a certain threshold. Earnings exceeding €3,675 (US$5,408) per month or €44,100 (US$64,897) per year (in 2009) are exempt from contribution payments. As of July 2009, the insured employee (or pensioner) contributes 7.9 percent of the gross wage, while the employer (or the pension fund) adds another 7.0 percent on top, so the combined maximum contribution is around €548 (US$806) per month. This includes dependents (non-earning spouses and children), who are covered through the primary sickness fund member. Unemployed people contribute in proportion to their unemployment entitlements, but for long-term unemployed people with a fixed low entitlement (so-called "Hartz IV"), the government pays a fixed per-capita premium. As of 2009, a uniform contribution rate is set by the government and, although sickness funds continue to collect contributions, all contributions are centrally pooled by a new central health fund, which allocates resources to each sickness fund based on a risk-adjusted

capitation formula. This formula takes age, sex, and morbidity from 80 chronic or serious illnesses into account. Sickness funds will therefore receive considerably more for patients with cancer, AIDS, or cystic fibrosis than for the “ordinary” insured. Since 2009, sickness funds may charge the insured person an additional nominal premium if the received resources are insufficient (or pay back funds that are left over). So far, just one small sickness fund has raised an extra premium. Since 2004, there has been a growing amount of tax-financed federal subsidy for „insurance extraneous “benefits provided by the SHI (especially coverage of children). These expenses are considered to be of common interest and therefore are (partly) covered from general taxes. In 2007, the SHI scheme accounted for 61 percent of total health expenditure.

Private health insurance (PHI): Private health insurance plays a substitutive role in covering the two groups who are mostly exempt from the SHI (civil servants, who are refunded part of their health care costs by their employers, and the self-employed), as well as high earners who choose to opt out of the SHI scheme. All pay a risk-related premium, with separate premiums paid for dependents; the risk is assessed upon entry only, though contracts are based on lifetime underwriting. Private health insurance is regulated by the government to protect the insured from facing premiums that increase massively with age and from being overburdened by premiums if their income decreases. As of January 2009, private insurers offering substitutive coverage must take part in a risk-adjustment scheme (separate from SHI) that requires them to offer basic insurance for persons with ill health who are assigned to PHI because of previous insurance or profession and who could otherwise not afford a risk-related premium. In addition, recent legislation aims to intensify competition between insurers. Private health insurers are forced by law to set aside savings (i.e., “aging reserves”) for old age from insurance premiums while the insured are young in order to slow the increase of premiums as they age. Previously, these aging

reserves remained with the insurer when a person cancelled a policy or changed to another insurer. As of January 2009, individual aging reserves are transferable if privately insured persons change to another insurer. PHI also plays a mixed complementary and supplementary role, adding certain minor benefits to the SHI basket, providing access to better amenities such as single/double hospital rooms, and covering some copayments, especially for dental care. In 2007, PHI accounted for 9.3 percent of total health expenditure. (Source: International Profiles of Health care Systems pg.20)

(iii) **Healthcare system finance in United States of America (USA)**

Medicare: Medicare is a social insurance program for the elderly, some of the disabled under age 65, and those with end-stage renal disease. Administered by the Federal Government, the program is financed through a combination of payroll taxes, premiums, and federal general revenues.

Medicaid: Medicaid is a joint federal-state health insurance program covering certain groups of the poor. Medicaid is administered by the states, which operate within broad federal guidelines. States receive matching funds from the federal government, varying among states from 50 percent to 76 percent of their Medicaid expenditures.

Private insurance: More than 1,200 not-for-profit and for-profit health insurance companies provide private insurance. They are regulated by state insurance commissioners. Private health insurance can be purchased by individuals, or it can be funded by voluntary premium contributions shared by employers and employees on an employer-specific basis, sometimes varying by type of employee. Employer coverage is the predominant form of health insurance coverage. Some individuals are covered by both public and private insurance.

Out-of-pocket spending: Out-of-pocket payments, including both cost-sharing insurance arrangements and expenditure paid directly by private households, accounted for 12 percent of total national health expenditures in 2007, which amounted to US$890 per capita.(source: International Profiles of Health care Systems pgs.54-55)

2. 6 Sources of Finance for National Health Insurance Schemes (NHIS) in Ghana

Internal Sources of Finance:

The Act 650 establishes a National Health Insurance Fund, with the objective of providing finance to subsidize the cost of provision of healthcare services to members of the DMHIS, part of which is to be set aside for the healthcare cost of indigents. The main sources of money for the Fund are: the National Health Insurance Levy, and the 2.5% of each person's 18.5% contribution to SSNIT. and 2.5% VAT levy. The Government of Ghana also gives budgetary support to the schemes through it annual national budget (source: Act 650, section78). Premium paid by members to enroll into the schemes are another source of funding. The premium paid ranges from Ghc 7.20 to Ghc 48.00. The schemes also do investments to realize additional funds to manage the insurance schemes (source: L.I 1809, 2004).

So far, over 145 Metropolitan, Municipal and District Mutual Health Insurance Schemes (DMHIS) have been in operation since 2004. The schemes are operating efficiently and paying

claims for services rendered to their members. The NHIS covers 95% of sickness such as communicable and non-communicable diseases like malaria, tuberculosis (TB) and diabetes and many more that are enshrined in schedule II of part I of L.I. 1809 in regulation 19(I) that talk of minimum healthcare benefits to clients of the scheme. The remaining 5% born by the members alone are those healthcare services like Rehabilitation other than physiotherapy, Appliances and prostheses including optical aid, hearing aids, orthopedic aids and Assisted Reproduction example Artificial insemination and gynaecological hormone replacement therapy and few others. (Source: L.I 1809, 2004)

External Sources of Finance:

At the inception of the health insurance scheme, nearly US$ 5 million that came from the Heavily Indebted Poor Countries Initiative (HIPC) were used to fund the scheme at the district level (IRIN, 18 March 2004). Ghana continues to receive "general budget support for the implementation of the GPRS [Ghana Poverty Reduction Strategy] through the Multi-Donor Budgetary Support (MDBS) facility. "Some donors have considered shifting their support increasingly to general national budget support. The MDBS framework does not contain any conditions as to resource allocations for health, but the disbursements (from the performance tranche) depends on a set of triggers and targets including some for the health sector, which should encourage the Government of Ghana to give sufficient priority to the health sector" (MOH, April 2005, p. 62). Other sources are the donor support from international financial bodies like IMF, World Bank and international NGOs like DANIDA.

2.7 Health Expense

This involves the cost incurred from the whole of healthcare chain system in its entirety. This comprises costs: at records, consulting, laboratory test, pharmacy, theater and admissions, infrastructures, equipments and human resources. According to Dee W. Edington (2003) of University of Michigan, the high costs of healthcare are affected by three factors that exert upward pressure on cost. They are: aspects of the health status; certain health behaviors and Prescription of drug use. It is also possible that the health status and health behavior factors lead to higher utilization of prescription drugs. However in the case of Ghana these healthcare expenses to patient comprise drugs, consulting, investigations and other auxiuary services. All these are funded by the patient alone if he/she is not a registered member of National Health Insurance Scheme. The benefits derived from these healthcare services are out-patient services, in-patient services, oral

health services, eye care services, maternity care and emergencies are the packages covered under NHIS in Ghana. Other healthcare services cost outside those mentioned are borne by the patient under NHIS and there is no co-payment of insurance currently in place. However, in Germany there are two other factors that may increase the cost of healthcare. They are: the structure of the healthcare insurance industry and particulars of the healthcare benefit, that is, the services covered, the deductible required before the health plan pay for the care, the co-pays for prescriptions, office visits, procedures, and hospitalizations, and any co-insurance amount required receiving healthcare. (Velami G., 2004)

CHAPTER THREE

METHODOLOGY

3.0 Introduction

The chapter started with the profile of Atebubu Amanten district, the history and the operations of the scheme, the methods used in research design, the population and sample for the study as well as data collection also looked at. The chapter ended with analysis of the data.

3.1 Atebubu-Amanten District Profile

The Atebubu-Amanten District is one of the nineteen (19) districts in the Brong Ahafo Region of Ghana. This district was known as the Atebubu District until the year 2004 when the Pru district was carved out of it. The district covers a land area of 1996km2 with a population of 98,359. The district population is currently growing at 3% which is higher than national rate of 2.6%. The population is dominated by males (50.9%). (2010 population and housing census) .This could partly be attributed to the continuous influx of mostly male settler farmers from Northern Ghana into the district. Soils in the district range from the sandy loams and are poorly drained. Crops that can be potentially be supported by these soils included rice, vegetables, yams, cassava, maize, sorghum, soya beans, cow pea and tobacco. Out of the total 820km road networks in the district, only 280km representing 34.1% of the network is in good condition with the rest in fair and bad condition. (DADU 2010). The proportion of the illiterate population (60%) in the district is higher than the regional and national average of 48% and 42.1% respectively. Though the participation of both sexes is low, the dropout rate for girls is more pronounced at all levels of academic progression. There are total of ten (10) health facilities located in the various parts of the district.

This is made up of one District Hospital, five (5) Health Centres, and four (4) communities Clinic and a Maternity Home. It has a doctor-patient ratio of 1: 50,246 whilst the nurse-patient ratio is 1: 5,789. Malaria continues to be the leading cause of OPD attendance and admission, accounting for 43% and 24% respectively. It is the second cause of death in the district after hepatitis. (MOH, Ghana Health Service report, Atebubu 2010).Agriculture employs about 70% of the economically active labour force. Farming in the district is largely carried out on small-scale basis. Service and commerce sector in the Atebubu-Amanten district employs about 2% of the active labour force and contribute about 25% of their income. (ADA report, 2010)

3.2 Atebubu-Amanten District Mutual Health Insurance Scheme Profile

Activities to set up of the Atebubu-Amanten District Mutual Health Insurance Scheme started in the first quarter of 2004 where an implementation committee was constituted with membership from the departments/organizations in the district to design and carry out the implementation process, with the district assembly taking the leading role. The scheme recruited the core staff that comprised: Scheme Manager, Claims Officer, Public Relation/Marketing Officer, Accountant and Management Information System (M.I.S) Officer which form the management of the scheme. In April, 2005 the scheme registered at the register general and it was issued with certificate of incorporation and certificate to commence business. With only 7,598 members, the scheme started rendering services to insured clients under the NHIS benefit package on 1st January, 2006. This feat was achieved with support from the Atebubu-Amanten District Assembly. It provided financial support (frontloaded) to the tuned of eighty million cedis (C 80,000,000.00) for government facilities to acquire essential drugs for kick-off of the scheme.

3.3 Research Design

The research was designed to investigate the use of insurance as a source of financing health care in Ghana. The study was conducted through survey. In this situation data was collected from the population in order to determine the status of that population with respect to one or more variables It is descriptive exploratory that involves advance analysis. This design was chosen because of the nature of the sample population used. This method was chosen because of the nature of the research to collect original data for the purpose of describing the population which is too large to deal directly. The appropriate stake holders were consulted through questionnaire to the service providers, the management of insurance scheme and subscribers to health insurance scheme.

However, surveys are dependent on the cooperation of respondents. If data collection procedures are erroneous, the responses given may be inaccurate and hence the whole study is flawed. Information unknown to the respondents cannot be tapped in a survey research and others that are considered to be secret and personal encourages incorrect answers are some of the limitations in survey research.

3.4 Population

The population for the study is subscribers of NHIS in Atebubu-Amanten district, service providers and management of the scheme.

Sample and Sampling Technique

One hundred (100) subscribers to health insurance scheme; ten (10) health service providers and five (5) management staff of the scheme were selected for the study. The reason for selecting one scheme was that almost all the schemes in the country operates under the same principles and structure, headed by National Health Insurance Authority (NHIA), and it is statistically duplication of data if more than one scheme is selected.

Multistage sampling was employed to select the various large communities in the districts to give a fair representation to the people in the study. Then Cluster sample was also used in selecting the households to collect data on the work and income levels in the study. Simple random sampling was used to give each member equal and independent chance of being included in the sample. This was done through stratified and systematic random where communities were group into a common characteristics and selection was picked at random. Judgmental and Convenience sampling techniques was employed in a situation where data cannot be collected using the random sampling in the study. These helped the researcher to get information from those sample population, the information they considered to be secret and confidential.

3.5 Data Collection

Primary and secondary data was collected for this research work.

The primary data was obtained from the field survey. Questionnaires, interviews and personal observations were methods used to collect the primary data for this study.

Structured and Unstructured questionnaires were used to obtain information about the population sample in the study. This was chosen because they are easy to administer with it alternative answers and moreover, stimulate the people to think about his/her feelings or motives and to express what he/she considers to be most important. Likert scales were used in rating the questionnaires that are subjective and intangible components in this study. An interview was also used in this study to give opportunities to issues of management of schemes and service providers.

Moreover, to give opportunity to those sample population that cannot answer the questionnaires to get information from them. Observation method was used to collect information on the providers and subscribers relationship at the point of service delivery. The questionnaire was administered by the researcher and field workers of Atebubu-Amanten District Mutual Health Insurance Scheme.

On the secondary data, the study reviewed other literatures to get information related to the problem under study. The sources used include various publications of central, state and local governments. Foreign governments and international bodies' publications were also consulted for information. Books, periodicals, reports, journals, magazines and newspapers were other areas the study looked for information. Internet (World Wide Web) was also used in getting information for this study.

3.6 Data Analysis

The information collected was edited to correct errors, check for non-responses, accuracy and corrects answers. Coding was done to facilitate a comprehensive analysis of the data. To arrive at

the intended analyses, the participants' response was keyed into SPSS version 16.0 software and several sets of statistical analyses were performed. The outcome was presented in the form of:

- Tables
- Figures – Graphs/Charts/Diagrams
- Use of words (non-tabular presentation)
- Chi-Square to test the hypotheses

These were thoroughly interpreted.

CHAPTER FOUR

DATA ANALYSIS AND DISCUSSION

4.0 **Introduction**

For the purpose of the analysis and discussion the study was conducted with three identified groups which comprised the following: the management and staff of scheme where five (5) were selected; ten (10) service providers and one hundred (100) clients/subscribers to the health insurance scheme. They were interviewed to find out their general opinions about the operations of national health insurance scheme in financing their health care needs. The data was analyzed base on the objectives of the study.

4.1 Responses from the Scheme:

Table 4.1: **Basis for premium payment**

Category	No of Respondents	Percentage (%)
Ability to pay principle	3	60%
By Social Status	2	40%
Others	0	0%
Total	5	100%

Source: Field Survey, 2011

From the table 60% of the total response of 5 said that the premium payment was based on ability to pay, whilst the remaining 40% agreed that it was by social status. The rest scored 0% to the responses. This shows that the people's ability to pay was the cardinal basis in coming out with some range of premium payment.

Table 4.2: **Underlining principles of premium determination**

Category	No of Respondents	Percentage (%)
Actuarial Principles	0	0%
State Legislation	4	80%
Others	1	20%
Total	5	100%

Source: Field Survey, 2011

From the responses 4 out of the 5 which represent 80% agreed that the premium charged was a state legislation as compared to 0% of actuarial principles of insurance premium determination. This goes to confirm the outcome of table 4.1 that is based on the people's ability to pay. It can also be said that Government's motive for the programme is for poverty alleviation.

Table 4.3: **Annual Bills paid against Premiums collected from 2008 - 2010**

Category (Years)	Bills Paid (GHC)	Premiums Collected (GHC)	Percentage (%)
2008	760,690.80	71,893.00	9.45%
2009	875,631.24	54,040.00	6.17%
2010	761,101.62	55,327.00	7.27%
Total	2,397,423.66	181,260.00	

Source: Field Survey 2011

From table 4.3, a premium collected was able to pay 9.45% of the total bills in 2008. This fall to 6.17% in 2009 but increased marginally (1.10%) to 7.27% in 2010. Evidences shown on table

above that compare premiums collected and bills paid respectively for the immediate past three years (2008-2010) indicates that premiums collected paid only 7.56%(181,260.00/2,397,423.66) of total bills paid for the period. This indicates that a premium charged by the scheme is far below the cost of health care bills paid. This situation is obvious that premiums mobilized over the years are not enough to sustain the scheme; therefore, something needs to be done.

Table 4.4: **Premium Support from NHIA to Scheme (2008 – 2010).**

Category (Years)	Amount	Percentage (%)
2008	590,256.16	28.57%
2009	683,166.81	33.07%
2010	791,939.32	38.34%
Total	2,065,362.29	100%%

Source: Field Survey, 2011

Table 4.4 that show the support from NHIA for the three years to support the payment of bills incurred by the scheme. For instance, out of the total bills paid in the past three years (2008 - 2010), support from the NHIA constituted as high as 86.15 percent (2,065,362.29/2,397,432.66). This revealed that the Government is still a major stakeholder in payment of the health care bills under national health insurance scheme.

Table 4.5: **Sustainability of the Scheme**

Category	No. of Respondents	Percentage (%)
Yes	4	80%
No	1	20%
Total	5	100%

Source: Field Survey, 2011

Four of the responses representing 80% indicated that the scheme is sustainable only because the central Government through NHIA subsidies the operations of the scheme. While the remaining 20% said the premiums collected/paid by clients are far lower than the cost of operations.

If the scheme is to rely on government subsidies for it operations, the question is how regular and sustainable will it be. The survey from all the management staff revealed that the premium charged is not reflective of the economic realities. Two (2) representing 40% said that the people cannot pay economic premiums and three (3) representing 60% said Government should subsidize the premium.

The survey revealed that 100% of the premiums collected at the scheme level are not invested. The reason given by management was that it was an administration directive from the National Health Insurance Authority .This is contra to some of the basic principles of insurance as being practiced in the real world, because investment plays a major role in insurance as one of the sources in which claims are paid from.

Responses from the Service Providers:

Table 4.6: **Ownership of facility**

Category	No of Respondents	Percentage (%)
Private	4	40%
Public	6	60%
Total	10	100

Source: Field survey, 2011

Out of the ten (10) service providers surveyed, 60% are public while the remaining 40% are private.

Table 4.7: **Services provided**

Category	No of Respondents	Percentage (%)
General Services	7	70%
IPD only	0	0
ANC	1	10%
Drugs only	1	10%
Diagnostic Services	1	10%
TOTAL	10	100

Source: Field Survey, 2011

Seventy percent (70%) of them offer general health care services to the people with the remaining 30% rending ANC, Drugs only and Diagnostic services respectively. This shows that the clients will lack some specialist healthcare services when they need them, and this may affect

the motivation to join or renew their membership when it expires. This may have a negative effect on the scheme and its sustainability in the long run.

Table 4.8: **Number of insured clients served per day**

Category	No of Respondents	Percentage (%)
Less than 10 people	0	0
Between 11 – 25 people	3	30%
26 – 50 people	1	10%
51 people and above	6	60%
Total	10	100

Source: Field Survey, 2011

Sixty percent 60% of the service providers serve 51 people and above per day whilst 30% attend to 11- 25 people per day, and the rest of 10% catering for 26-50 people as shown on the table above.

Table 4.9*:* **Average monthly bills submitted**

Amt. in ranges (GHC)	No of Respondents	Percentage (%)
100.00 – 1,000.00	2	17%
1,100.00 – 2,000.00	3	25%
2,100.00 – 5,000.00	1	8%
5,100.00 – 10,000.00	2	17%
11,000.00 and above	4	33%
TOTAL	12	100

Source: Field Survey, 2011

From the above table, four (4) of the service providers submit bills of GHC 11,000.00 and above, that represented 33% of the providers selected. Three providers representing 25% submitted bills between GHC 1,100.00 – GHC 2,000.00 each month. The 17% each submitting GHC 100.00 – GHC 1,000.00 and GHC 5,100.00-GHC 10,000.00 respectively.

From the responses exactly 62.5% of providers are happy with the system of payment. This is because all claims submitted within a particular month are paid in full when it is time for payment. The remaining 37.5% are not happy with system of payment.

The survey also revealed that seventy five (75%) of the providers are not happy with the time for payment which is approximately three months interval because it contravenes with the two (2) months agreed on Memorandum Of Understanding (M.O.U).

Table 4.10: **Relationship between facilities and the scheme**

Category	No. of Respondents	Percentage (%)
Good	3	33%
Satisfactory	3	33%
Fair	2	22%
Poor	1	11%
Total	9	100

Source: Field Survey, 2011

Eleven percent (11%) representing a total of one response that the relationship between facilities and scheme is poor. Thirty-three percent (33%) of the respondents said the relationship between the facilities and scheme is good and satisfactory respectively.

From the survey, 51% of the facilities responded that most of the cases are referred to other higher level or specialized facilities outside the district. This is because the needed equipment to manage most illness are not available. This may have a negative effect on the schemes sustainability since the people would not have the zeal to renew their membership because not all their sickness can be catered for at that level.

4,4 Responses from Clients/Subscribers

Table 4.11: **Age of subscribers who were surveyed**

Category	No of Respondents	Percentage (%)
Under 18 year	48	48%
Between 19 – 69 years	50	50%
Above 70 years	2	2%
Total	100	100

Source: Field Survey, 2011

Fifty percent (50%) of the respondents were between the ages of 19- 69 and in the labour front these are the active labour force that works. Forty-eight (48%) were under 18 years. Above 70 years in the survey forms 2%. The survey also revealed that 48% of the respondents were male while the remaining 62% were female who subscribe to the scheme to finance their health needs.

Table 4.12: **Work/business of Subscribers**

Category	No. of Respondents	Percentage (%)
Trading	8	8%
Farming	61	61%
Civil Servant	24	24%
Others	7	7%
Total	100	100

Source: Field Survey, 2011

From the table 61% of the respondents are farmers as compared with 24% who are civil servants. Eight percent (8%) are engaged in trading activities as a source of their livelihood, as against 7% who earn their living in other businesses.

Out of 95 respondents from the survey on payment of additional money at the facility, 82% said that they do not pay any money aside their health insurance but 18% said they pay monies at the facility aside their health insurance.

Table 4.13: **Average money paid at the facility (drugs and others not covered by NHIS)**

Category (GHC)	No. of Respondents	Percentage (%)
50.00 – 100.00	18	86%
Between 200.00 – 300.00	2	10%
Above 500.00	1	4%
Total	21	100

Source: Field survey, 2011

Out of the 100 clients surveyed 21 of them were able to declare on average the range of money paid aside their health insurance membership. From the survey 18 peoples representing 86% said that they paid GHC 50.00 – GHC 100.00 on average aside their health insurance. Two people said that they paid between GHC 200.00 – GHC 300.00 on average which represents 10% of the respondents. However 4% said that they pay above GHC 500 aside their health insurance at the facility. This gives an average payment of 21 clients surveyed to Ghc 54.76 (1,150 / 21). This is because some of the drugs are not covered by the insurance scheme.

From the survey, 68% responded yes to the question of getting all drugs prescribed by the doctor at facility/hospital. But 32% said no, because they do not get all the drugs they want.

For this reason the satisfaction of drugs given under NHIS drugs list confirmed from the survey shown that out of the 94 responses, 79% representing 74 people said that they are satisfied with the drugs given under NHIS, but 21% of the respondents said that they are not satisfied with the drugs under NHIS. Some perceived that the drugs given are not able to cure their illness.

Table 4.14: **Average monthly household expenditure:**

Category (GHC)	No of Respondents	Percentage (%)
Between 50.00 -150.00	24	47%
201.00 – 400.00	12	24%
401.00 – 600.00	9	18%
Above 600.00	6	11%
Total	51	100

Source: Field survey, 2011

Out of 100 people surveyed only 51 people responded to their average monthly household expenditure. The rest said it was personal and were not willing to disclose them. From the survey 47% of the total respondents said that they spend on an average of GHC 50.00 – GHC 150.00; 24% of the people's expenditures are between GHC 201.00-GHC 400.00; 18% of the respondents said they spend between GHC 401.00 – GHC 600.00, and 11% spend above GHC 600.00. This gave an average monthly expenditure of GHc 141.29.

Table 4.15: **Average monthly income from business/work**

Category (GHC)	No. of Respondents	Percentage (%)
50.00 -150.00	30	58%
151.00 – 300.00	12	24%
301.00 – 500.00	6	12%
Above 600.00	3	6%
TOTAL	51	100

Source: Field Survey, 2011

From the study of 100 clients/peoples surveyed 51 clients responded to question concerning average monthly income from business/work. The rest gave reasons that its personal and did not respond. From the survey, 30 of the respondents of the total of 51 which represent 58% earned an average monthly income of GHC 50.00 – GHC 150.00. Whiles 24% of the respondents' average income was between GHC 151.00 -300.00. Only 6% of the respondents' average

monthly income is above GHC 600.00, with 12% earning between GHC 301.00- GHC 500.00. This gave an average monthly income of GHC 120.71.

4.5 **Premium Determination if it is based on sound actuarial principles (Insurance)**

According to the Act 650 of National Health Insurance Act, 2003 that established the schemes, it is stated in section 34 in the Act on the contribution by members that:

(1) A person seeking membership of a district mutual health insurance scheme shall as a prior condition for membership pay the membership contribution determined by the scheme in accordance with guidelines provided by the council.

(2) The mode and time of payment of the contribution shall be prescribed by Regulations.

(3) Notwithstanding subsection (1), Regulations shall prescribe for exemptions of certain categories of persons from the payment of contributions.

(4) Where the monthly contribution of a contributor to Social Security Pension Scheme Fund amounts to or exceeds the minimum monthly contribution required under a district mutual health scheme, the contributor shall be entitled to the minimum health care benefits under the district mutual health insurance scheme without any further contribution to the district mutual health insurance scheme.

(5) Without prejudice to sub-section (3), a pensioner under the Social Security Pension Scheme shall be entitled to the minimum health care benefit under this Act without the payment of contribution to the district mutual health insurance scheme.

From the National Health Insurance Regulations, 2004 (L.I 1809) of section 55 also stated the mode and time of payment of contribution as follows;

(1) The mode and time of payment of contribution shall be determined by each scheme.

(2) The provisions in sub-regulation (1) are subject to section 34 subsections (4) and (5) of the Act.

(3) A scheme may employ any lawful method it finds effective for the payment of contribution by its members.

Both the Act 650 and the L.I 1809 in coming out with the premium to be charged by schemes did not base it on any quantitative principles and economic indices. This makes the premiums charged by the scheme not reflective of the cost of health care. Evidence from tables 4.1 and 4.2 show that there was no basis and principles in premium determination under NHIS. According to 2010 Ghana Health Service (GHS) Atebubu-Amanten District report, average cost of health care was in the range of Ghc 58.00 to Ghc 182.50 for treatment. The responses that came from the scheme management in table 4.2 confirmed that the premium charged as at 2011 is Ghc 10.00 was not based on actuarial principles as shown on table with a score of 0%.

4.6 Health needs/demand met to serve as basis of motivation to renew their membership

To be able to determine whether the health need/demand of subscribers are met, a process to motivate them to renew their membership and in the long run help to sustain the scheme must be initiated. The table below was drawn and a hypothesis stated. A Chi Square Test was used to either reject or not to reject (accept) the claim. All these computations are shown below.

Table 4.16: **Responses from subscribers and service providers on services provided by the scheme (observed values)**

RESPONSE	**SERVICES**				
	INFORMATION DISSEMINATION	CUSTOMER CARE	COMPLAINT HANDLING	SERVICES RENDERED	TOTAL
YES	96	98	100	100	**394**
NO	14	12	10	10	**46**
TOTAL	**110**	**110**	**110**	**110**	**440**

Source: field survey, 2011

Before computing the test value one must state the hypothesis. The null hypothesis should be a statement indicating that there is no difference or no change. In our case the hypotheses are as follows;

Ho: Clients are happy with services provided by the NHIS

H_1: Clients are not happy with the services provided by the NHIS

Chi Square (X^2) = $\left(\sum\left(\frac{O-E}{E}\right)\right)^2$ ***- equation 4.1***

Where ***O*** = Observed value

E = Expected value

Expected value = $\left(\sum\left(\frac{row\ sum\ X\ column\ summ}{grand\ total}\right)\right)$

E_{11} = (394 X 110)/440 = 43340/440 = **98.5**

E_{12} = (394 X 110)/440 = 43340/440 = **98.5**

E_{13} = (394 X 110)/440 = 43340/440 = **98.5**

E_{14}= (394 X 110)/440 = 43340/440 = **98.5**

E_{21} = (46 X 110)/440 = 5060/440 = **11.5**

E_{22} = (46 X 110)/440 = 5060/440 = **11.5**

E_{23}= (46 X 110)/440 = 5060/440 = **11.5**

E_{23} = (46 X 110)/440 = 5060/440 = **11.5**

The Expected values can now be placed in their corresponding cells along with the Observed values as shown below;

Table 4.17**: Responses from subscribers on services provided by the scheme (observed and expected values)**

RESPONSE	SERVICES				
	INFORMATION DISSEMINATION	CUSTOMER CARE	COMPLAINTS HANDLING	SERVICES RENDERD	TOTAL
YES	96 (98.5)	98 (98.5)	100 (98.5)	100 (98.5)	394

NO	14 (11.5)	12 (11.5)	10 (11.5)	10 (11.5)	46
TOTAL	110	110	110	110	440

Source: field survey,2011

$(X^2) = \left(\sum\left(\frac{O-E}{E}\right)\right)^2$

$= (96 - 98.5)^2 + (98 - 98.5)^2 + (100 - 98.5)^2 + (100 - 98.5)^2 + (14 - 11.5)^2 + (12 - 11.5)^2 + (10 - 11.5)^2 + (10 - 11.5)^2$

$= (-2.5)^2 + (-0.5)^2 + (1.5)^2 + (1.5)^2 + (2.5)^2 + (0.5)^2 + (-1.5)^2 + (-1.5)^2$

$X^2 = 22/330$ **= 0.067**

The degrees of freedom are (R – 1)(C – 1)

Where R = row and C = column

Therefore we have;

(2 – 1) (4 – 1) = 1 x 3 = 3

Let **α** = 0.05 (i.e 95% confidence level).

From the Chi Square table, with degrees of freedom 3 and **α** = 0.05, the critical value from the table (Chi Square table) is 7.815. Hence the decision is to accept the null hypothesis since 0.067 < 7.815

Figure 4.1

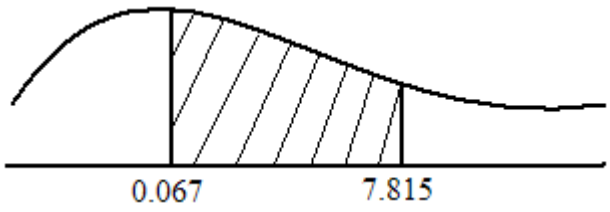

Figure 4.1: shows the distribution of the calculated value (0.067) and the table value (7.815)

Hence we therefore conclude that there is enough evidence to support the claim that clients are happy with services provided by the schemes. Hence we do accept (not reject) the claim that clients are happy with the services provided by the NHIS. This will motivate them to renew their membership in the insurance scheme. Hence it is sustainability is positive in terms of numbers.

From the results shown above it is clear that most clients are happy with services provided by the schemes and this may affect the renewals of membership positively.

4.7 Time taking to meet expenses (claims) from Service Providers

To be able to meet these expenses (claims) from Service Providers as they fall due it is important to first of all look at the time in which Providers are paid their claims. Also check the response of Providers whether they are satisfied or not with the way their claims are paid. From the responses of the ten (10) Service Providers, 75% said their claims are paid quarterly, 12.5% said monthly and also 12.5% bi-monthly. However 62.5% are happy with the system of payment and the remaining 37.5% said they are not happy with the system of payment. From the above rates, one can therefore conclude that the expenses (claims) from Services Providers are met as soon as they fall due. It is however important that more effort is put in-place in attending to the 37.5% who are not happy with the payment system. Measures should however be kept in-place to make sure that claims are promptly paid as soon as they fall due.

In table 4.3, for instance a premium collected in 2008 was able to pay only 9.45% of total bills paid by the scheme. This shows that the scheme cannot meet it claims from service providers with its total premiums collected and hence rely on Government subsidies. This is because the subscribers to the scheme are not paying economic premium to the scheme.

4.8 Subscribers capacity to pay economic premium

Evidence from the field survey on tables 4.15 and 4.14 revealed that average monthly household income and average monthly household expenditure are GHc 120.71 and GHc 141.29 respectively. As household expenditure far out weights income, it means that people do not have enough surplus income to save not to talk of acquiring assets for productive use and eliminate poverty.

It is clear from this evidence that the people are poor therefore, cannot afford economic premiums on their healthcare. This means that some form of socio-economic intervention programmes would need to be provided to empower the people economically to be able to pay economic premiums for the scheme to be sustainable. The evidence on table 4.4 shows that the fact that National Health Insurance Authority (NHIA) supports the scheme to about 86% of their bill payments confirmed that subscribers to the scheme do not have capacity to pay for economic premium.

CHAPTER FIVE

MAJOR FINDINGS, RECOMMENDATIONS AND CONCLUSION.

Introduction

This chapter covers the major findings of the study (which was based on the research questions), recommendations, and conclusion.

Major Findings

The findings were based on the research questions in the study:

(a) Is the premium paid for National Health Insurance Schemes enough to qualify as an insurance project/and not cash and carry?

From the field survey in table 4.3 the bills paid are higher than the premiums collected. This is because out of total bills paid (GHC 2,397,423.66) for immediate past three years (2008 -2010) premiums collected only paid 7.56% of bill. This shows that the scheme cannot meet it claims from service providers with its total premiums collected. This is because the premium charged Ghc 10.00 by the scheme is not enough to cover health cost that was in the range of Ghc 58.08 to Ghc 182.50 (Ghana Health Services (GHS) report, Atebubu 2010). Also, the fact that Act 650 and its L.I. 1809 established a supporting source of funding (NHIL) to backup premiums collected clearly indicates that the premiums collected locally are not enough, hence a challenge to the sustainability of the programme.

However the fact that health insurance membership ID cards are demanded from insured clients at service providers' end instead of cash at the point of service delivery qualify it

as health insurance programme but not cash and carry. However some of the clients paid cash for those drugs that are not covered by the insurance scheme.

(b) Is the subscriber earning enough income to pay for their premiums as and when it is due?

It is clear from this evidence in tables 4.14 and 4.15 respectively that the people are poor and therefore, some cannot afford economic premiums on their healthcare. From the survey 58% of the people earn monthly income in the range of Ghc 50.00 to Ghc 150.00. According to 2010 report by Ghana Health Service (GHS) Atebubu District, cost of health care ranges from GHC 58.08 as general average cost of treating an illness to an upper limit of GHC 182.50 as cost of treatment. This means that the scheme still needs government support if it is to be sustainable. This also means that some form of socio-economic intervention programmes would need to be provided to empower the people economically to be able to pay economic premiums for the scheme to be sustainable.

(c) Is there enough coverage of service providers to the reach of the subscribers to encourage and motivate them to sustain the interest of the scheme?

Strategically all healthcare facilities (except some chemical shops) within the district are covered under the NHIS programme to provide services to insured clients. Aside that, the new NHIS ID Card guarantees unrestricted access (both physical and financial) for clients to access services wherever they travel to within the country. Clients are happy with services provided under the NHIS with reference to the hypothesis test. On the part

of the drugs, 68% of the clients responded that they get almost all the drugs prescribed by the doctor. According WHO report on drugs in 2009, drugs play 95% in healthcare healing process of human life. For this reason the service providers and the scheme owns it as a duty to let the clients get the needed drugs at the point of services. From the interviews a client has to travel an average distance of 5 kilometers before reaching the nearest health facility for healthcare services which shows that physical access to health services is within the reach of clients. From the survey it came out that there is no specialist in any of the health care facility within the district. This would have a negative effective on the scheme renewal/new members because those clients who may need that specialized services which are not available will refuse to renew their membership when it expires or not join at all.

(d) Is the premium collected invested to keep the scheme sustainable?

From the survey, 100% of the premiums collected at the scheme level are not invested currently as it contravenes the act (Act 650, 2003). However management confirmed that they used to invest premiums collected in fixed deposits until November 2009 when they were directed to stop and instead remit all premiums through an account open by NHIA. The reason given by management was that it was an administrative directive from the National Health Insurance Authority (NHIA) .This is contra to some of the basic principles of insurance as practice in the real world. In the world of insurance, investment returns are used to finance the claims payments. From wall street journal, march 2010 edition: insurance companies in US used 75% of their investments' returns to pay for claims. This may be the reason why most of the claim bills are paid through government subsidies, which according

to the field survey in table 4.4 forms 86% of the total bills paid for the years under consideration. If this trend continues the scheme's sustainability may be under threat if those funds cease to come. The reason is that those sources of Government are competing with other equally important projects or needs either than health insurance alone.

Recommendations

1. The responses that came from the scheme management in table 4.2 confirmed that the premium charged is not based on actuarial principles as shown in table with a score of 0%. Economic premium should be charged to ensure that the scheme is sustainable. The premium charge should base on actuarial principles that will factor in estimated average number of attendance per year; average cost of treatment/service charge per attendance; average cost of drugs per attendance for common/ordinary diseases and prevailing rate of inflation/depreciation. That is the only way the premiums charged can match the cost of health care and to guarantee sustainability.

2. The benefit package under the National Health Insurance Scheme (NHIS) should be expanded to cover more diseases and drugs to motivate people to renew their membership when it expires and also new people to join. This will reduce money paid at the health facilities aside their insurance.

3. To procure quality services for clients under the scheme, the 37.5% of Providers who are not happy with the system of payment should be attended to because they form a significant proportion. That would encourage them to provide quality care for clients.

4. The delay in payment of bills to Providers when they fall due is unfortunate. It is therefore, recommended that payment of bills should be done promptly as agreed upon in the memorandum of understanding (M.O.U) since that could jeopardize the provision of quality service to clients.

5. It is further recommended that residents who are clientele for the scheme should be empowered economically by government to improve upon their economic status so as to be able to afford economic premium with less reliance on the state. Interventions such as Skill and Vocational Training for employment, merchandised Agriculture for rural farmers and support for small and medium enterprises (SMES) among others.

6. Community ownership of the scheme as enshrined in the Act 650 should be seriously pursued to build confidence and ownership spirit in the people to ensure its success and sustainability.

7. Lastly, vigorous cost containment and management measures should be adopted to ensure the success of the scheme. Fraud and abuse, polypharmacy and all other forms of cost escalating factors should and must be eliminated.

Conclusion

An English proverb says that “Health is Wealth”. It is not a meaningless saying as it defines a very important fact of life. Your health is the most precious wealth that God has given you. It is your own property and you are the sole owner of it. Therefore, it is your responsibility to look after it properly. However, it is also true that life is full of uncertainties and you never know what will happen in the next few hours. Therefore, it is also your duty to make certain arrangement so that you can take care of yourself as well as your family even if some misfortune falls upon you. It is no doubt that health Insurance scheme (HIS) is beneficial to government, the family and to the individual. A healthy and productive individual is able to make life better for him/herself, becomes an asset to his/her family and a useful resource for the development of the country.

Health Insurance is essentially a method for financing or paying for the cost of healthcare. It entails the spreading of the risk of incurring healthcare cost over a group of individuals. The advantage of Health Insurance is that, the individuals’ access to healthcare is independent of his ability to pay out of his pocket at the time of illness. Due to the numerous advantages associated with health insurance, it is therefore prudent to ensure that it succeeds and becomes sustainable.

It is however, clear that majority of the subscribers (70%) are very poor and cannot afford to pay economic premiums however, healthcare bills from providers has always been more than premiums collected. On that note, a scientific pricing of risks is necessary to achieve annual

equilibrium between premiums and claims, commissions, management expenses, overheads, reserves and profits.

The overriding task is to ensure that the premiums, together with investment earnings, are adequate to provide for the payment of benefits. It is therefore, recommended that residents in the district who are the main clientele for the scheme should be empowered economically by government to improve upon their economic status so as to be able to afford economic premiums with less reliance on the state support. Interventions such as technical skills and Vocational Training for employment, mechanized agriculture for rural farmers and support for small and medium enterprises (SMES) among others should be implemented.

Finally, cost containment and management measures to control fraud and abuse, poly-pharmacy and all other forms of cost escalating factors should be implemented to ensure the success of the scheme.

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Appendices

Appendix A: EXAMPLE OF PREMIUM DETERMINATION – Amartey E., 2007

Suppose that a certain type of event is unlikely to occur, but when it does, it causes a financial loss of ¢100,000. The insurer estimates that about 1 out of every 100 individuals who face the possibility of such loss will actually experience it (i.e.: 1% of the number of insured). If the company insures 1,000 people, it can then expect 10 losses (i.e.: 1% of 1,000 people). Based on this model, the insurer will charge each person a premium of ¢1,000 (here, we ignore certain

factors such as expenses and profits). It would collect a total amount of ¢1,000,000 and have precisely enough to cover the ¢100,000 loss for each of the 10. Each individual has eliminated his or her risk, and in so far as the estimate of 10 losses is correct, the insurer has likewise eliminated its own risk.

The example illustrates what is known as a deterministic model. The insurer in effect pretends it will know exactly how much it will pay out as benefits, and then charges premiums to match this amount. Of course, the insurer knows that it cannot really predict these amounts precisely. Use of deterministic models is justified by relying on the statistical concept known as the 'law of large numbers', which intuitively says that, if a sufficiently large number of individuals are insured, then the total number of losses will likely be close to the predicted (assuming that the original estimate of the likelihood of a loss – the 1 out of a 100 figure in the above example is correct). For greater sophistication, a stochastic model is needed, which will assign probabilities to the occurrence of various numbers of losses.

Premiums received by insurers are invested, and the resulting earnings can be used to help provide the benefits. Consider again the simple example given above, and suppose that the benefits do not have to be paid until 1 year after the premiums are collected. If the insurer can invest the money at say 5% interest for the year, then it does not need to charge the full ¢1,000 in premium, but can collect ¢1,000/1.05 from each person. When invested, this amount will provide the necessary ¢1,000 to cover the losses. Again, this example is oversimplified and there are many more complications.

Appendix B

(QUESTIONNAIRE (TO THE NATIONAL HEALTH INSURANCE SCHEME/NHIS)

PREAMBLE

This questionnaire is designed to help carry out a project work on the subject **'Financing Health Care in Ghana under national health insurance scheme (NHIS), subscribers perspective-Atebubu District'.** The purpose for the research is to fulfill one important requirement of the Kwame Nkrumah University of Science and Technology being pursued by the Researcher. The results of this questionnaire will only be used objectively by the Researcher for the purpose of the project. Subsequent usage may be made of the project's results and recommendations by the NHIS- Atebubu branch and any other third party if the need arises. All answers to this questionnaire shall be treated confidentially and objectively.

Name of Researcher: Dei-Owusu Ampofoh

Name of Respondent

(Optional)……

Instruction: Please tick the correct answer(s) out of the possible answers provided, to the respective questions below or provides (write) the correct answer where necessary.

1. When was the scheme established? (a) 2003 ( ) (b) 2004 ( ) (c) 2005 ( ) (d) 2006
2. What is the purpose for establishing the scheme? (a) provision of healthcare ( )
   (b) Pay healthcare bills of clients ( ) (c) provide access to healthcare services

3. What is your target population? (a) All the residents in the District ( ) (b) only natives (c) others (specify)……

4. How do people join the scheme? (a) upon application and payment of both registration fees and premium ( ) (b) for free ( ) (c) Others (specify)……..

5. How much does a person pay for premium (on average)? (a) GHC 10.00 ( )

   (b) GHC 15.00 ( ) (c) GHc 20.00 ( ) (d) others (specify) ……

6. What is the benefit duration of contribution paid? (a) 3-months ( ) (b) 6–months ( )

   (c) one year ( ) (d) two years ( )

7. What is the basis for your premium payment? (a) Ability to pay principle ( )

   (b) By Social Status ( ) (c) others (specify)……..

8. What is the underlying principle in determining the premium payable?

   (a) Actuarial principles ( ) (b) State legislation (Law) ( ) (c) Others……..

9. (i)Is the premium charged enough to cover the cost of operations? (a) Yes ( ) (b) No ( )

   (ii)If No, how do you cater for the short fall? (a) Government subsidies ( ) (a) Investment ( )

   (c) Others (specify) …….

10. Do you invest the premiums collected? (a) Yes ( ) (b) No ( )

11. If yes, in what form? (a) T-Bills ( ) (b) Fixed Deposit ( ) (c) Shares

    (d) Others (specify)…….

12. (i) Do your premiums reflect economic realities? Yes ( ) No ( )

(ii) If No, why? ...(a) Not able to pay ( ) (b) Government subsidies ( ) (c) Others

(Specify)……

13. What is the benefit package for members? (a) All OPD & IPD cases ( ) (b) IPD cases only

( ) (c) OPD only ( ) (d) Selected OPD & IPD ( )

(e) Others (specify) ……

14. Are the benefits customized? (a)Yes ( ) (b) No ( )

(i). If Yes, how? (a) Services ( ) (b) Drugs ( ) (c) Others (specify)

……

(ii)If No, why? (a) All services/drugs ( ) (b) Others

(specify)……..

15. Does your benefit package cover all medicines? (a)Yes ( ) (b) No ( )

16. What happens if a client requires services outside or beyond what is catered for?

(a) Self finance ( ) (b) Cease to provide ( ) (c) others (specify)

……..

17. Is there a package for co - payment under the current NHIS system? (a)Yes ( ) (b) No ( )

18. Apart from premium contributions, are there any other sources of financing the scheme?

(a) Yes ( ) (b) No ( )

19. If yes, state source(s)? (a) Government (NHIA) subsidy ( ) (b) Investments ( )

(c) Others……..

20. How would you describe the payment of premiums by clients in following years?

(i) 2008 (a) Low ( ) (b) Moderate ( ) (c) High ( )

(ii) 2009 (a) Low ( ) (b) Moderate ( ) (c) High ( )

(iii) 2010 (a) Low ( ) (b) Moderate ( ) (c) High ( )

21. What has been the performance of premium payments for the following years?

(i) 2008 (a) Good ( ) (b) Satisfactory ( ) (c) Fair ( ) Amt. ……

(ii) 2009 (a) Good ( ) (b) Satisfactory ( ) (c) Fair ( ) Amt. ……

(iii) 2010 (a) Good ( ) (b) Satisfactory ( ) (c) Fair ( ) Amt …….

22. Are your local contributions (IGF) enough to pay your bills as and when they fall due?

(a)Yes ( ) (b) No ( )

23. If No, how do you make up the difference? (a) Government (NHIA) subsidy ( )

(b)Investment ( ) (c) others (specify)……

24. Are your clients happy with your services / activities in terms of the following?

(i) Information dissemination …(a) Good ( ) (b) Satisfy ( ) (c) Fair ( ) (d) Poor ( )

(ii) Customer care …(a) Good ( ) (b) Satisfy ( ) (c) Fair ( ) (d) Poor ( )

(iii) Complaints handling…(a) Good ( ) (b) Satisfy ( ) (c) Fair ( ) (d) Poor ( )

(iv) Services rendered ….(a) Good ( ) (b) Satisfy ( ) (c) Fair ( ) (d) Poor ( )

25. What is the relationship between the scheme and providers? (a) Good ( ) (b) Satisfactory ( )

(c) Poor ( )

26. How do you guarantee quality care for your members? (a) Constant monitoring of provider activities

( ) (b) empowering clients on their rights ( ) (c) enforcement of quality standards ( )

(d) Others (specify)

……

27. Indicate your annual bill payments for the following years

(a) 2008……..

(b) 2009……

(c) 2010……..

28. How often do you pay your service providers? (a) Monthly ( ) (b) Quarterly ( )

(c) Fortnightly ( ) (d) others (specify)……..

29. Is the sustainability of the Scheme guaranteed?

(a)Yes ( ) (b) No ( )

30.(i) If Yes, how? ..(a) Government subsidies and Premiums payment ( ) (b) Investments ( )

(c) Others (specify)…….

(ii)If No, why?..(a) Cannot meet operation cost ( )

(b) others (specify)…….

31. What are the major challenges to the operations of the scheme?

……

……

……

32. Give your suggestions towards the sustainability of the Scheme

……

……

……

Appendix C

QUESTIONNAIRE (TO THE SERVICE PROVIDERS/HEALTH FACILITIES)

PREAMBLE

This questionnaire is designed to help carry out a project work on the subject **'Financing Health Care in Ghana under national health insurance scheme (NHIS), subscribers perspective-Atebubu District'.** The purpose for the research is to fulfill one important requirement of the Kwame Nkrumah University of Science and Technology being pursued by the Researcher. The results of this questionnaire will only be used objectively by the Researcher for the purpose of the project. Subsequent usage may be made of the project's results and recommendations by the NHIS- Atebubu branch and any other third party if the need arises. All answers to this questionnaire shall be treated confidentially and objectively.

Name of Researcher: Dei-Owusu Ampofoh

Name of Respondent (Optional)……..

Instruction: Please tick the correct answer(s) out of the possible answers provided, to the respective questions below or provide (or write) the correct answer where necessary.

1. Is your facility a private or public one? (a) Private (b) Public

2. What services do you render?

(a) General ( ) (b) OPD only ( ) (c) ANC ( ) (d) Drugs only ( ) (e) Diagnostic services

(e) Others (specify)…….

3. For how long have you been providing health care services to the public?

(a) Under one year ( ) (b) Two years ( ) (c) 3-5years ( ) 6 years and above

4. Are you NHIS accredited facility? (a)Yes ( ) (b) No ( )

(i) If yes, for how long? (a) one year ( ) (b) between 2-4 years ( ) (c) above 5 years ( )

(ii) If no, why? (a) Unprofitable ( ) (b) bureaucratic ( )

(c) Others (specify)……

5. How many insured clients do you attend to per day? (a) Less than 10 people ( )

(b) Between 11-25 peoples ( ) (c) 26- 50 ( ) (d) 51 peoples and above ( )

6. On average how much do you submit as your bill for the month?

(a) GHC 100.00 – GHC 1,000.00 ( ) (b) GHC 1,100.00 – GHC2, 000.00 ( )

(c)GHc 2,100 – GHc 5,000.00 ( ) (d) GHC5,100 -- 10,000.00 ( ) (e) GHc 11,000 and above

7. How would you describe the relationship between your facility and the scheme?

(a) Good ( ) (b) Satisfactory ( ) (c) Fair ( ) (d) Poor ( )

8. Do your facility stock customized drugs? (a) Yes ( ) (b) No ( )

9. If yes, why? (a) For price differences ( ) (b) for control purposes ( )

(c) Others (specify)…….....

10. Is your facility satisfies with the prices of services/drugs list provided by NHIA and MOH?

(a) Yes ( ) (b) No ( )

11. If No, why? (a) Prices do not reflect on market prices ( ) (b) inadequate coverage of most

Services/drugs in the list ( ) (c) others

(specify)……..

12. What is the duration for payment from the scheme to the provider? (a) Monthly ( )

(b) Bi-monthly ( ) (c) Quarterly ((d) Semi-annually ( ) (e) one year or more ( )

13. Are you happy with the system of payment? (a)Yes ( ) (b) No ( )

(i)If yes, how? (a) Good ( ) (b) Satisfactory ( ) (c) Fair ( )

(ii)If No, why? (a) Bad ( ) (b) Poor ( )

14. Give two reasons why or not health insurance is better that the 'cash and carry' system

……..

……..

15. How do you treat your customers when they visit your facility for care?

(a) Good ( ) (b) Satisfactory ( ) (c) Fair ( )

16. Do your facility able to provide all the services/drugs the client's needs as in the health insurance package? (a) Yes ( ) (b) No ( )

17. If no, what happen? (a) Referral ( ) (b) leave it

18. Do you have special drugs stock for NHIS clients? (a) Yes ( ) (b) No ( )

19. If Yes why? (a) For cost purposes ( ) (b) for control purposes (c) Others:……

20. How do you rate the relationship between the scheme and your facility?

(a) Good ( ) (b) Normal ( ) (c) Satisfactory ( ) (d) Fair ( )

21. What are the average ratios for the following before the introduction of NHIS (where applicable)?

i. Doctor – Patient ratio……

ii. Nurse – Patient ratio

……

22. What are the average ratios for the following after the introduction of NHIS (where applicable)? i. Doctor – Patient ratio……

ii. Nurse – Patient ratio ……

23. What is the minimum average distance a person travels to reach the nearest health facility?

(a) Less than one kilometer ( ) (b) 2 – 3 kilometres ( ) (c) 4 – 5 kilometres ( )

(d) Above 5 kilometres

24. What are the major challenges to the facility with the Health Insurance as a partner in the chain of healthcare delivery system?……

25. Do you have any suggestions? .....

……..

Appendix D

QUESTIONNAIRE (TO THE NATIONAL HEALTH INSURANCE SCHEME SUBSCRIBERS/CLIENTS)

PREAMBLE

This questionnaire is designed to help carry out a project work on the subject **'Financing Health Care in Ghana under national health insurance scheme (NHIS), subscribers perspective"- Atebubu District.** The purpose for the research is to fulfill one important requirement of the Kwame Nkrumah University of Science and Technology being pursued by the Researcher. The results of this questionnaire will only be used objectively by the Researcher for the purpose of the project. Subsequent usage may be made of the project's results and recommendations by the NHIS- Atebubu branch and any other third party if the need arises. All answers to this questionnaire shall be treated unanimously and objectively.

Name of Researcher: Dei-Owusu Ampofoh

Name of Respondent (Optional)……..

Instruction: Please tick the correct answer(s) out of the possible answers provided, to the respective questions below or provide (or write) the correct answer where necessary.

1. Demographic data.

i. How old are you? (a) Under 18 ( ) (b) between 19 – 69 years ( ) (c) above 70 years ( )

ii. Sex…Male ( ) , female ( )

iii. Marital Status….(a) Married ( ) (b) Single ( ) (c) Devoice ( )

vi. Occupation…(a) Trader ( ) (b) Farmer ( ) (c) Civil Servant ( )

(d) Others (specify)……..

1. Are you a registered member (holder of Health Insurance ID card)? (a)Yes ( ) (b) No ( )

2. If No, why? (a) Cannot Afford ( ) (b) Don't Know ( ) (c) Other (specify)…….

3. If yes, how did you enroll? (a) Free ( ) (b) Cash payment ( ) (c) Others (specify)……

4. If cash, how much did you pay? (a) Ghc 4.00 ( ) (b) Ghc 16.00 ( ) (c) Ghc 5.00 ( )

(d) Other (specify) ……

5. How often do you renew your membership when it expires? (a) Every year ( )

(b) Two years or more ( ) (c) Not at all ( )

6. How long have you been a member? (a) one year ( ) (b) 2- years ( )

(c) 3- years ( ) (d) 4-years and above ( )

7. What is your opinion on the fees paid? (a) Low ( ) (b) Moderate ( ) (c) High ( )

8. What is your opinion about benefits you have derived from the national health insurance scheme? (a) Excellent ( ) (b) Good ( ) (c) Satisfactory ( ) (d) Fair ( )

9. Are you satisfied with the services/benefits rendered by service providers? (a)Yes( ) (b)No ( )

(i) If Yes, how? (a) Good customer care ( ) (b) Get needed drugs and services ( )

(ii) If No, why? (a) Poor customer care ( ) (b) Don't get needed services and drugs ( )

10. Do you get the attention/treatment you expect anytime you visit a service provider?

(a)Yes ( ) (b) No ( )

11. Do you pay additional money at the hospital/facility when using your NHIS membership card to access health care? (a) Yes ( ) (b) No ( )

12. If yes, how much do you pay (on average)? (a) Ghc 50.00 – Ghc 100.00 ( )

(b) Between Ghc 200.00 – Ghc 300.00( ) (c) above Ghc 500.00 ( )

13. Do you get all the drugs prescribed by the doctor at the hospital? (a) Yes ( ) (b) No ( )

14. If No, where do you get it from? (a) Buy it ( ) (b) Collect from pharmacy/chemical shop ( )

(c) Others (specify)……

15. Do you get drugs prescribed by doctors/medical assistants outside the NHIS drug list?

(a) Yes ( ) (b) No ( )

16. If yes, where do you get them from? (a) Buy them ( )(b) Others (specify)……

17. Are the drugs given at the facility able to cure your illness? (a) Yes ( ) (b) No ( )

18. Are you satisfy with the drugs given under NHIS? (a) Yes ( ) (b) No ( )

19. If no why? (a) Low quality ( ) (b) Not enough to cure my illness ( )

(c) Others (specify)…….....

20. Do you go for reviews at the same facility first visited for healthcare? (a) Yes ( ) (b) No ( )

21. If No why? (a) Not satisfy with the services/drugs given ( ) (b) Got healed of my illness ( )

(c) Others (specify)……

22. Do you receive health care somewhere apart from the accredited hospital/health centre/clinic?

(a) Yes ( ) (b) No ( )

23. If yes, where? (a) Herbalist ( ) (b) Spiritualist ( ) (c) Shrines ( )

(d) Others (specify)…….

24. How much do you pay on average? (a) Less than Ghc 50.00 ( )

(b) Between Ghc 100.00 – Ghc 200.00 ( ) (c) Other (specify)…….

25. What is your average monthly expenditure? (a) Between Ghc 50.00 – Ghc 150.00 ( )

(b) Ghc 201.00 – Ghc 400.00 ( ) (c) Ghc 401.00 – Ghc 600.00 ( )

(d) Above Ghc 600.00 ( )

26. How much income do you get from your work/business per month?

(a) Ghc 50.00 – 150.00 ( ) (b) Ghc 151—300.00 ( ) (c) Ghc 301 – 500.00 ( )

(d) Ghc 600.00 and above

27. Are you happy with the services / activities of Health Insurance Scheme in terms of the following?

(i) Information dissemination …… (a) Yes ( ) (b) No ( )

(ii) Customer care …… (a) Yes ( ) (b) No ( )

(iii) Complaints handling …… (a) Yes ( ) (b) No ( )

(iv) Services rendered …… (a) Yes ( ) (b) ( )

28. Are you happy with the services / activities of Health Service Providers (hospital/health centres/clinic/chemical shops) in terms of the following?

(i) Information dissemination …… (a) Yes ( ) (b) No ( )

(ii) Customer care …… (a) Yes ( ) (b) No ( )

(iii) Complaints handling …… (a) Yes ( ) (b) No ( )

(iv) Services rendered …… (a) Yes ( ) (b) N0 ( )

29. Do you have any suggestions? .....

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