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Financing Health Care in Ghana: The Case of National Health Insurance Scheme (NHIS)

By

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DECLARATION

I hereby declare that this submission is my own work towards the award of the **MSc/MPhil/PhD** and that, to the best of my knowledge, it contains no material previously by another person or any material which has been accepted for the award of any other degree of the University, except where due acknowledgement has been made in the text.

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DEDICATION

This thesis is dedicated to Mr. Alexander Fritz Ofori, Erica Nunana Ofori and Fritz Nutifafa Ofori for the inspiration and encouragement when I started this programme.

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ABSTRACT

Health financing is a growing problem in developing countries, hence the introduction of a social health insurance systems, such as National Health Insurance Scheme (NHIS). The aim for implementing NHIS in Ghana is to analyze payment mechanisms and identify gaps for improving health financing. Despite significant progress, challenges like inadequate funding, poor management practices, and fraudulent activities hinder its effectiveness. The research focuses on examining financing sources, evaluating internal and external tactics, and addressing difficulties in funding the NHIS. The study's objectives are to investigate the internal and external financing sources for the NHIS, assess the NHIS's effectiveness in terms of healthcare access and financial security, examine the tactics used to enhance the NHIS, and explore potential solutions to Ghana's funding challenges. The study examines Ghana's health financing system, focusing on the NHIS in the Oti regions. It reviews literature, discusses strategies for improvement, and evaluates performance. The research methodology employed aspects involving a combination of primary data from structured interviews and secondary data from existing sources. The data analysis involved examining the NHIS's payment mechanisms, assessing the NHIS's performance indicators, and identifying challenges in financing the scheme. The findings provided insights into the financing effectiveness of the NHIS in Ghana. Overall, the study contributed to the understanding of Ghana’s health financing structure and provided recommendations for strengthening the NHIS. The study addressed the gaps and challenges in healthcare financing, Ghana can enhance access to high-quality medical care for its citizens.

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LIST OF ABBREVIATIONS

FFS	Fee for Service
GHS	Ghana Health Service
MOH	Ministry of Health
NHIA	National Health Insurance Authority
NHIL	National Health Insurance Levy
NHIS	National Health Insurance Scheme

NHS	National Health Service
OOP	Out of Pocket Payment
PNDC	Provisional National Defense Council
SSA	Sub-Saharan Africa
SSNIT	Social Security and National Insurance Trust
UNICEF	United Nations International Children's Emergency Fund
WB/IMF	World Bank/International Monetary Fund
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.0 BACKGROUND

By design, health financing is a major issue for developing countries, worldwide. According to Mossialos et al. (2002), five categories of health financing exist and are based on; tax, social health insurance, voluntary and private insurance, cash- and- carry, and donations. To achieve sustainable health financing on the global scale, entities such as the United Nation and the World Health Organization (WHO) among others, have designed various strategic policies to be adopted by nations.

Ghana has achieved major improvements to its healthcare system over the years, many Ghanaians still struggle to get access to high-quality medical care. In order to solve this issue, the NHIS was set up in 2003 to give beneficiaries financial security and expands access to healthcare services. The NHIS has been successful in increasing access to healthcare services and reducing financial barriers for Ghanaians, particularly those in rural areas and with low socio-economic status. However, the scheme faces several challenges, including inadequate funding, poor management practices, and fraudulent activities, which undermine its effectiveness.

Additionally, Ghana's healthcare financing system is heavily reliant on external aid, and the government's budgetary allocation to the healthcare sector remains low. This study aims to analyze the NHIS's payment mechanisms, such as premiums, co-payments, and provider reimbursements, to identify gaps and potential areas for improvement in healthcare financing in Ghana. The findings of this study can inform policy decisions aimed at strengthening the NHIS and achieving universal health coverage in Ghana. Despite the NHIS's advancements, Ghana's healthcare financing remains an issue. In order to better understand how healthcare is paid for in Ghana, this study will concentrate on the NHIS.

1.1 PROBLEM STATEMENT

In recent times, developing countries worldwide, have embarked on reforms to increase access to health through social health insurance schemes. The design and implementation of these schemes has varied across countries and regions, based on the diversity of the nature of social aspects and populations that forms the target groups that require health services.

Common as the issues are on the global scale, the NHIS implementation in Ghana has also been having serious financing issues based on diverse factors, which have reduced the effectiveness of the program in providing beneficiaries with high-quality healthcare services. For example, low enrollment rates, insufficient government financing, and ineffective money management are some of these issues, that require critical assessment for improvement.

1.2 OBJECTIVES OF THE STUDY

The study examined how Ghanaian healthcare is paid for as well as the long-term viability of the NHIS. The specific objectives are to:

- Assess the financing of NHIS to ensure equity in coverage and quality delivery.
- Investigate internal and external financing sources for the NHIS and evaluates the consequences for the sustainability of the program in terms of effectiveness through healthcare access, financial security, and health outcomes.
- Investigate funding sources that may have helped performance to examine the internal and external tactics used to enhance the NHIS and determine how well they performed in attaining the goals of the program.
- Examine the difficulties Ghana faces in funding the NHIS and to determine potential solutions.

1.3 RESEARCH QUESTIONS

Questions requiring answers to accomplish the objectives are:

- What are the Ghanaian NHIS's financing sources, and how do they affect the long-term viability of the program?
- What are the sources of funding that have contributed to the NHIS's success in Ghana in terms of healthcare access, financial security, and health outcomes?
- What internal and external tactics have been used, and how successful have they been in accomplishing the goals of the scheme been?
- What are the difficulties Ghana faces in funding the NHIS, and what are some potential solutions?

1.4 STUDY SIGNIFICANCE

Results of this study will shed light on how Ghana finances healthcare, with a particular emphasis on the NHIS. The study will also add to the body of knowledge of health finance and offer policymakers advice on how to enhance healthcare financing in Ghana.

1.5 METHODOLOGY

The study deployed primary data from the NHIS and the health sector in the Oti regions of Ghana. Surveys and interviews were conducted to gather qualitative data, while random sampling data was collected from the population, which was divided junior and senior personnel categories. Close-ended questions were included in the surveys. The research comprised a population of 100 people, including 35 junior employees and 65 senior employees from the target group in the Oti Regions of Ghana. The study deployed various indicators to measure the performance of the NHIS, such as enrolment rates, claims reimbursement rates, cash-and-carry expenses, among other factors.

1.6 SCOPE AND LIMITATIONS

The study focused on how Ghana's healthcare system is financed with the NHIS. In terms of the unwillingness of the staff members that took part in the study, the researcher had several

constraints. Several employees may be hesitant to participate fully because they are concerned that the research will disrupt their already hectic schedules. Some staff of the national insurance service were entertained for fear of being victimized by their superiors.

Others would expect a financial reward for their time spent conducting interviews and filling out questionnaires. The researcher overcame the limitation by assuring the employees that the study was conducted solely for academic purposes, assuring the participants that the information provided was kept private, ensuring that the questionnaire was not excessively long, and promising to share the study's final report and results with the organization.

1.7 ORGANIZATION OF THE STUDY

The research was broken down into five (5) major sections or chapters. The first chapter of the study was devoted to the introduction, while the second chapter was devoted to a review of applicable literature. The third chapter tries to provide an overview of the study's methods. The last two chapters, four and five, focus on data presentation and interpretation, as well as discussions, conclusion and recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

The funding for Ghana's healthcare system comes from a variety of sources, including grants from donors, government funds, and private funding. However, the Ghanaian healthcare system has struggled with funding issues, which has reduced access to healthcare for many Ghanaians.

2.1.1 Evolution of Health Care Financing in Ghana

After independence, access to health care facilities was free, however, due to the competing financing needs of other economic sectors, this could not be sustained for long. In the 1970s, other forms of health financing, such as the usage fee, which requires internally generated funds by the health care facilities, were introduced to reduce government expenditure and protect tax-exempt citizens with particularly serious illnesses. The implementation of this new concept, however did not last long due to change of government regime; this led to the enactment and passing of the Hospital Fees Act 387 that paved way for a nationwide fee system (Nyonator and Kutzin, 1999).

The nationwide fee-paying system turned out to be grossly inadequate, and culminated in the introduction of cash-and-carry system in the mid-1980s and the subsequent withdrawal of government subsidies. This new system was aimed full cost recovery to aid in the expansion and improvement of services, and also reduce abuse through frequency of visits. This policy change, however, deterred the poor from seeking health services because of cost thereby magnifying inequalities in the health system, and the eventual under-utilization of essential health services (Johnson and Stoskopf, 2009).

The search for a viable, secured, workable and sustainable financing system health care system led to the passage of a nationwide legislation, Law 650 in 2003 pave way for the current NHIS, which was seen as an effective mechanism to remove the financial barriers to accessing health care. Funding to support the NHIS was based on the following tools:

- A 2.5 per cent excise tax on public working group;
- A mandatory 2.5 per cent wage deduction from employee and employer contributions in the formal sector and;
- A tiered bounty from the informal sector; under the 2003 Act, each county should have a professional insurance scheme, membership of which is open to all residents.

In addition, the law provides for 650 exceptions for the poor and needy, and has the inception, attained a membership coverage of 45% by 2008, which translates to 145 accredited and operational district systems (Department of Health, 2008). Furthermore, the scheme has recorded rising numbers of accredited providers over a 5-year period, spanning 2003-2008 and established incentive schemes that includes the Free Mothers policy, regional coordination offices, new national membership card and ICT platform and rising number of patronages of the facility. The increase in patronage is consistent with other government funding of programs, in the range of 7.7-108 million GHC from 2005-2007 (Ministry of Health, 2008).

Concurrently, however, the increases in coverage have become a strain on the NHIS, since revenue are mainly dependent on tax, amounting to 90–95% from SSNIT and VAT levies. Implications are that, dependency rises with national income instead of membership (Department of Health, 2008), hence success in terms of coverage, culminates in reducing financial viability. This situation serves as a huge challenge, since it will eventually undermine the sustainability of the scheme as far as positive response to it is concerned.

Furthermore, ID backlogs are printed from a central source, whereas the success of the NHIS technically requires universal coverage, that could reduce the burden of access to the facilities that are often associated with centralized access and distribution systems.

2.1.2 Health Care Financing in Africa

Health financing reforms in developing countries pose a challenge to better health care as governments face resource constraints, despite the imposing nature of its importance (Leighton, 1995). Motivated by the increasing demand to fulfill the traditional obligation to provide free health care, Vogel (1988; 1990) identified three policy categories in sub-Saharan Africa that bothers on increasing of revenue as follows:

- Cost recovery from user fees, community-based and social funding, among others.
- Improving allocation and management of existing medical resources.

- Improving private sector participation in state-subsidized health systems.

Faced with declining levels of government participation, many nations in the developing world have focused reforms on the first of the above listed strategies. Based on this system, stake holders commonly use cost-recovery from user fees for services and dispensing of medicines (Langenbrunner et al., 2001). In practice however, cost accrual are from community health insurance, prepaid plans, and private health insurance. The other two categories outlined by Vogel (1988; 1990) bothers on enhancing efficiency and effectiveness, however they are often held in low prestige in many countries.

Since 1994, some 20 African countries, including Ghana have embarked on health sector cost-recovery reforms with the primary goal of increasing revenues (Lavy and Germain 1995). This emphasizes the fact that cost reimbursement may be appropriate in sub-Saharan Africa, given the amount of revenue generated, *vis-a-vis* how the revenue is used for its intended purpose and expected impact on beneficiaries of the scheme (World Bank 1994). In effect, cost-recovery goals bother on demand and usage patterns, and actions to meet healthcare costs for those who need them. Designing a pricing structure to encourages efficient use of the service, promotes appropriate levels, strengthens referral patterns, and encourages the use of low-cost preventive measures.

It is important to avoid common pitfalls such as; not keeping rates up to date and overpaying for exemptions, failing to collect payments from government services for recipients of public health care or social programs. It is often asked whether reimbursement affects access to healthcare. It has been argued that usage fees pose far fewer barriers to usage than expected, particularly for basic services. Leighton (1995), found out from a study conducted in Cameroon that when fees are charged and quality is improved, a sick person is 25% more likely to re-visit a government clinic.

Contrarily, cost recovery can make accessing of health services more difficult, especially for poor people. Poor households have less cash and are less likely to rent or sell assets to pay for healthcare, however, the evidence on health-based purchasing power is inconclusive, since rates and utilization studies have examined income levels. Few studies have shown that poor people are quality conscious. Hourly rates for health care are higher than for the non-poor but not necessarily at the level of user charges (Nolan and Turbat, 1993). Social and private funds are other source of funding for healthcare in sub-Saharan Africa, yet, individual funding in this region exceeds social funding of traditional universal health care in Western medicine.

In Africa, social financing of health insurance takes many forms, but in general the main form of social financing comes from state-designed structures (Vogel, 1990; Ekman, 2004). For example, the formal sector in Senegal and Mali has compulsory social security coverage, while countries like Zaire, Zambia, Nigeria, Liberia, Senegal, Zaire and Kenya, among other states have varied kinds of government designed funding systems for the relevant population (Vogel, 1990). Other forms of financing, not limited to the public sector, are also practiced in countries such as: Guinea-Bissau (Community Advance Fund for Primary Health Care); and Kenya (Harambee Catastrophic Diseases Movement Fund). Private group and individual insurances also exist in Ivory Coast, Ghana, Kenya, Senegal and Zimbabwe (Forgia and Griffin, 1993; Atim, 1998). Proponents of social finance believe that if successful, the scheme will ensure equitable access to quality care by limiting benefits and keeping premiums affordable given anticipated usage patterns. It is emphasized that it can be secured (Filmer et al., 1997).

2.1.3 Funding Mechanisms

The healthcare systems of the developed nations depend on the combination of the many financing systems, which may either be tax, grants, donations among others. Typical combinations of the systems bother on the impact of efficiency, effectiveness, and equity. For example, Belgium Italy and UK commonly rely on direct taxes for funding, most of the

Scandinavian countries depends mainly on regional/local taxes (Mossialos et al., 2002). Though taxes can be a consistent source of funding, Mossialos (1997) believes that there could be a problem during some annual public spending negotiations when competition from some areas of the economy, hence governments are often entreated to separate the health care budgets from other sectors of the economy.

2.1.4 Social Health Insurance

Social health insurance involves payment of contributions into a health fund, where the implementation in any countries depends on the collection agencies and their functions. For example, in some East European countries such as Croatia, Estonia, Hungary and Slovakia, the collection agency is a single health insurance fund; independent cash registers are appointed in France, delegated to local branches of the national cash registers are mandated in Romania. In Austria, the Czech Republic, Germany, Lithuania and Switzerland outsource such duties to independent individuals, while in Luxembourg, the the duty transferred to an amalgamation of insurance funds (Hoffmeyer and McCarthy, 1994). In any case, the mode of collections are deemed more transparent and therefore more acceptable to the public, since the funds are believed to be better protected from political interference (Jesse and Schaefer, 2000).

2.1.5 Medical Savings Account

The medical savings account system mandates that individuals make regular contribution of a portion of their periodic income to a subscribed health account, however, the public fund pays for low-income citizens (Hsiao, 1995). Only few countries, including Singapore, the USA and, more recently, China, practices this kind of insurance system. In Singapore, the scheme is supplemented by mandatory insurance that requires premium payments. In the USA, this account is combined with other deductible medical insurance that covers.

2.1.6 Cash and carry system

Cash and carry system require that a direct payment are made at the point of delivery. Default sources are three-folds, which include services not covered by any insurance, partially covered health insurance benefits and, services entirely funded with pooled revenue that may require additional funds. Van et al. (1993) argued that cash and carry payments are permissible in sectors where situations where general health care systems are absent or too meagre to meet health care system requirements. This structure, however, often promotes inequality in healthcare access which erodes solidarity between diverse kinds of people of unequal standing and with or without health conditions.

2.1.7 Loans, Grants, and Donations

Loans, Grants, and Donations system is very prevalent in developing countries, where donor agencies, bilateral and multilateral donor nations willingly commit to the course of distressed nations. Such support accounts for almost 20-50% percent of health expenditure in Africa (Schieber 1997). The system is always having always been heavily criticized for lack of evidence for any increased net spending on health care. Over reliance on the system does not support sustainability since funds can easily be re-channeled to meet other priorities by the donor agencies. Also, acquisitions would also have to be paid to ensure that debts are not piled to the detriment of future generations.

2.1.8 Health insurance financing models

Insurance financing models can be divided into: McIntyre defines classic social health insurance as state-regulated by law with regular, income-related compulsory contributions and minimum level (McIntyre et al., 2003). Private health insurance schemes empower the individual to make voluntary contributions, however, private insurance companies can be affected by the massive exclusion of certain disease classes.

2.1.9 Funding of Ghana Health System

Healthcare in Ghana is primarily funded by direct and circular tax revenues, with employees contributing 5% of their income to a social security association called SSNIT (Price Waterhouse Coopers 2009; Mensah et al. 2010; Akosua and Abor 2011). Rates range from zero (0) earnings below 180 Ghana Cedis to 28 for earnings above 720 Ghana Cedis. The corresponding levy contributes about 5.2% to the overall healthcare expenditure. Another source of funding is from Trade tax.

The debate over the Ghanaian healthcare tax has focused on whether it leads to lower grants, retail profits, or higher prices. Some pens assume equal burdens on consumers and shareholders, while others assume a burden of 10 on consumers and 90 on corporate shareholders (Martinez-Vazquez 2008; Akazili 2010). Trade taxes also contribute to Ghana's total health expenditure. The circular tax administration, VAT (Handbasket), is used to fund the healthcare sector, with an overall rate of 15. The current handbasket rate includes a main element of 10 and two industry-specific factors of 2.5 each (Price Water House Coopers 2008; Akazili 2010).

The energy tax is also a source of support for the Ghanaian health sector, contributing 8.5% to total tax revenue in 2005. The main types of energy in Ghana are hydrocarbon derivatives. Those who do not have access to electricity often consume more kerosene, which erodes incomes, since the commodity is a constantly purchased item (Akazili 2010). Piece by piece, the import duty from the support sources listed below also contributes significantly to support the Ghanaian healthcare sector. Import duties passed on to consumers are often assumed to have the same prevalence as Handbaskets Martinez-Vazquez (2008). Import duties are the third largest contributor to Ghana's total health expenditure, accounting for 8.0% of the country's total.

Health care is funded through health insurance benefits, including premiums from the informal sector, deductions from salaries to the Government Health Insurance Scheme, and payments

from the Government Health Insurance Fund. Out-of-fund payments account for 48% of Ghana's total health expenditure. Current sources of support for the Ghanaian health sector include 47 direct and circular donations, 48 payments from outside the fund, and 4.3 from other sources (Akazili 2010; Yevutsey and Aikins 2010; Armah-Attoh and Awal 2013; Owusu-Sekyere et Bagah 2014).

2.1.10 The National Health Insurance Scheme in Ghana

The government-funded NHIS was established in Ghana in 2003 as a means of providing affordable healthcare services. The program was introduced to reduce out-of-pocket copayments to enhance equitable system of health financing. NHIS covers service cares such as ambulatory, residential, maternity, emergency and some prescription medicines. The program is funded through a combination of sources, including government contributions, payroll taxes, and membership bonuses.

In addition, the NHIS ensure sustainability and reduce unnecessary use of healthcare. Despite its achievements, the NHIS faces challenges such as inadequate funding, poor management practices and fraudulent activity that undermine its effectiveness. The system also faces problems of low coverage in rural areas and poor quality of care in some healthcare facilities. Efforts are being made to improve the sustainability and effectiveness of the NHIS. These efforts include increasing resources and implementing measures to reduce fraud and waste, improve administrative practices and accountability, and expand care for underserved populations.

2.1.11 Management of the National Health Insurance Scheme

The National Health Insurance Authority (NHIA) is strictly government controlled and has the mandate to implement the scheme in Ghana and ensures all related functions as required by regulation are met. Paramount among the authority's mandate is the arrogation of authority to

healthcare providers and monitoring performances to ensure the overall efficiency of all NHIS operational systems (NHIA, 2013).

The management team is composed of a General Manager and Technical Directors, with management structures decentralized to the regional levels to ensure accountability and transparency, that bothers on all ancillary measures enshrined in the policy management (NHIA, 2013; Dor et al., 1996; Carrin and James, 2004). The payment systems within the scheme can either be retrospective or prospective. This means that the insurer will reimburse healthcare providers for the expenses associated with medical services delivery. This encompasses payment methods such as Fee-for-Service and Diagnostic-Related Grouping (DRG).

Some argue that Fee-for-Service (FFS) is effective in ensuring the provision of sufficient healthcare services because the reimbursement amount is tied to expenditure, which helps to address the common issue of under-provision (Kutzin, 2000). The challenge of this is excessive delivery of care and unnecessary medical interventions that can compromise on health care quality and sustainability of finances (Morris et al., 2007; Evans, 1984).

In their assessment of healthcare performance in Ghana, Witter and Garshong (2009) observed that the previous pricing system employed by the NHIS led to increased healthcare and administrative expenses. Conversely, the use of DRG was seen as a potential solution to reduce inefficiencies and excessive production because the tariffs are predetermined, thereby motivating providers to control costs (Scheller-Kreinsen et al., 2009). However, these cost containment measures could potentially result in a decline in the quality of healthcare services, as noted by Cylus and Irwin (2010) and Silverman and Skinner (2004). Furthermore, it's worth noting that DRG tariffs are typically adjusted based on the type of provider, which could lead to disparities in healthcare access. Larger urban providers might pay higher tariffs to enhance their services, potentially disadvantaging smaller, rural facilities.

The per capita payment system is a commonly employed prospective payment approach in health insurance systems in low-income nations. In this system, healthcare providers receive payment in advance of delivering services to insured individuals. In a basic per capita system, the provider's compensation is determined by the number of individuals assigned to them, whereas in a more intricate per capita system, the payment rates are adapted based on risk posed to customers.

The per capita system is believed to enhance efficiency and reduce administrative costs for both the provider and the insurer, as well as encourage providers to offer preventive health services to their clients. However, the per capita system may also lead to under health care, dumping, and cream-skimming, which can negatively impact access to health care. Studies have shown that private providers may provide poor standard care to their patients or engage in miserliness and dumping due to the per capita system. To address these concerns, it has been suggested that facilitating greater choice for consumers and competition between providers may alleviate the health quality concerns associated with per capita schemes.

As per Weisbrod (1991), the introduction of professional ethics and legal liability regarding medical malpractice serves as a deterrent for healthcare providers, discouraging actions that could jeopardize the quality of care. Nonetheless, the effectiveness of these measures in lowincome environments remains questionable, especially considering the limited availability of healthcare facilities.

The NHIS initially implemented both service charge and DRG systems, which were found to escalate healthcare expenses for the NHIA, as documented by Freiku (2011). In 2012, these models were replaced with a per capita system. However, concerns arise regarding the potential negative impact of the per capita fee on NHIS members' healthcare access due to the inadequate and unequal distribution in rural areas.

2.1.12 Definitions of Equity in Healthcare

Equity in healthcare is defined by egalitarian principles, including equal use and access between social groups. This principle emphasizes the need to distribute healthcare according to health needs, promoting equal use and choice for more or less advantaged social groups. The principle of health needs emphasizes that health service distribution should be based on an individual's level of health care needs, rather than their socioeconomic status.

This approach aims to ensure equitable access to healthcare, considering differences in individuals' ability to convert health resources. However, this principle acknowledges that people with the same health needs may need different resources due to different levels of endowment. For NHIS coverage, this principle of fairness means that enrollment is unfair when enrollment is skewed along socio-economic lines. Mooney (1983) contends that incorporating principles of fairness into research poses a formidable challenge because of the complexities involved in assessing healthcare requirements and treatments to ensure an equitable allocation. Achieving both horizontal fairness (equal treatment for equal needs) and vertical fairness (unequal treatment for unequal needs) can be particularly challenging.

Equity studies often present health needs as health conditions but determining a person's illness degree is challenging due to the varying medical practices and patient compliance. Equal treatment is also difficult due to the varying degrees of illness and the emphasis on use as the basis for achieving equitable access (Mooney et al., 1991). Critics argue that this definition does not fully reflect the entire access to healthcare, making it essential to consider other factors when addressing health needs.

The utilization equity principle, which centers on the allocation of healthcare resources and people's capacity to utilize them, is frequently criticized for its failure to consider individuals' choices regarding whether to utilize a specific health service or not (Thiede et al., 2007; Oliver and Mossialos, 2004; Mooney, 1983). Additionally, this principle tends to neglect variations in the quality of healthcare services, concentrating solely on the quantity of services available.

Although this principle is commonly employed in studies of horizontal and vertical equity to assess health needs and utilization, it may not fully account for the demand and supply factors that influence the healthcare-seeking process (LeGrand, 1991).

To comprehend the fairness aspects of healthcare access fully, it's essential to take into account both the factors influencing demand and those influencing supply, as these elements play a critical role in achieving fairness in healthcare access. A study that solely quantifies access based on usage might not uncover the intricate dynamics between the healthcare system and its users. While the distribution of healthcare resources according to vertical and horizontal fairness principles might be seen as equitable in Ghana, applying these principles in empirical research can be challenging, particularly when assessing healthcare access using a qualitative research approach that bothers on equity (Braveman and Gruskin 2003).

The definition of equity in health care can be applied to health care as it addresses social determinants of health, including more and less disadvantaged social groups. These groups are based on socioeconomic, race/ethnic, gender, geographic, and age characteristics and are associated with certain benefits and constraints in society. These groups raise equity concerns as they affect individuals' ability to access health care, highlighting the need for further clarification on these key concepts.

Braveman and Gruskin's (2003) classification of health inequality highlights significant and persistent differences between social groups. They argue that an inequality in healthcare access is unfair if it is systematically at the expense of disadvantaged groups. They argue that inequalities that counter socially disadvantaged groups are automatically unjust due to an unjust social structure. This definition is particularly relevant to the study of equity in health for three reasons.

- The study tackles the matter of making value judgments when assessing fairness by investigating consistent disparities between more and less privileged social groups without passing judgment on the fairness of these disparities.
- The researcher can delve deeper into the social group experiencing a specific inequality to identify the underlying factors affecting it.
- The approach considers equity in healthcare, enhancing the comprehension of process factors that influence inequalities.

Braveman and Gruskins' (2003) definition of health equity emphasizes the impact of social, political, and economic factors on the distribution of health resources and the benefits they provide. This approach allows for discrimination against disadvantaged social groups, but it cannot assess inequalities between individuals due to group differences. This dissertation adopts the concept of equity in access to healthcare, focusing on equality between disadvantaged social groups.

Other justice definitions are sometimes used to complement it, as Braveman and Gruskins' definition does not specify what should be adjusted in healthcare. The concept of fairness offers a more suitable basis for defining what constitutes fairness in healthcare, including factors like health insurance enrollment and the availability of healthcare resources, in order to promote fairness among different social groups.

2.1.13 Sources of Funding for the NHIS

The National Health Insurance Scheme (NHIS) in Ghana is funded through a combination of sources including government contributions, payroll taxes and membership premiums. These sources of funding have been vital in supporting the work of the NHIS and providing financial protection to Ghanaians. The Government is donating funds to the NHIS through budget allocations to help cover the cost of health services for vulnerable populations, such as five-

year-olds, pregnant women and the elderly. The government also provides grants to support premium payments for those on low incomes.

2.1.14 Payroll taxes are another source of funding for the NHIS.

These taxes are collected from formal sector workers and their employers and used to support operations. In addition, the NHIS has introduced cost-sharing mechanisms such as copayments and deductibles to ensure sustainability and reduce unnecessary use of healthcare. Membership awards are also an important source of funding for the NHIS. These premiums are paid by NHIS members and used to cover the cost of healthcare services. The NHIS offers a range of premium packages for different income levels, with premium rates varying by income level and age.

2.1.15 Donor funding is another source of funding for the NHIS.

International organizations such as the World Bank, the Global Fund and the United States Agency for International Development (USAID) have financially supported the NHIS to improve health care and improve access to health care for vulnerable populations. In summary, NHIS in Ghana is funded through a combination of sources including government contributions, payroll taxes, membership bonuses and donor funds. These sources of funding have been vital in supporting the work of the NHIS and providing financial security for Ghanaians.

2.1.16 Internal and External Strategies for Improving the NHIS

The National Health Insurance Scheme (NHIS) in Ghana is a social health insurance program that aims to provide Ghanaians with access to healthcare services at an affordable cost. The NHIS is an essential program in the Ghanaian health system and there is a need for continuous improvement to meet the health needs of Ghanaians. In this article we will discuss internal and external strategies to improve the NHIS in Ghana. One of the internal strategies to improve the NHIS in Ghana is to improve the quality of the health services provided. It must be ensured

that healthcare providers meet the required standards and provide quality services to patients. This can be achieved through ongoing training and retraining of healthcare providers, setting and enforcing standards for healthcare facilities, and regular monitoring and evaluation of healthcare services.

2.1.17 Another internal strategy is to increase the efficiency of the NHIS.

This can be achieved through the use of technology to improve NHIS administration and payment processes, cutting red tape and ensuring timely payment to healthcare providers. In addition, the NHIS can work with the private sector to leverage their technology expertise to improve NHIS awareness. One of the external strategies to improve the NHIS in Ghana is to increase funding. The NHIS relies heavily on government funding and there is a need to explore other sources of funding such as private sector partnerships and donor funding. This will help ensure the financial sustainability of the NHIS and enhance its ability to provide quality healthcare services to Ghanaians.

2.1.18 Another external strategy is to improve the regulatory framework for the NHIS.

There is a need to review and update the NHIS Act to address some of the challenges faced by the NHIS. This includes issues such as fraud and abuse, the accreditation of healthcare facilities and improving the governance structure of the NHIS. In summary, improving the NHIS in Ghana requires both internal and external strategies. There is a need for continuous improvement in the quality of health services provided, the efficiency of NHIS operations and the exploration of other sources of funding to ensure the financial sustainability of the NHIS. In addition, the regulatory framework for the NHIS needs to be reviewed and updated to address the challenges faced by the NHIS. These strategies will help improve the NHIS' ability to provide quality health services to Ghanaians.

2.2 THEORIES

2.2.1 Theoretical Review on Financing Health Care in Africa and Ghana

Healthcare financing in Africa, particularly in the context of Ghana, has undergone significant theoretical scrutiny as scholars attempt to unravel the complexities of funding mechanisms and their implications for health outcomes. The evolution of healthcare financing models is intricately linked with historical, economic, and political trajectories, shaping the theoretical frameworks applied in this domain.

2.2.2 Historical Evolution of Financing Models

The historical overview of healthcare financing in Africa reflects a transition from free care models to user fees and, more recently, to health insurance schemes. The Ghanaian experience is emblematic of these shifts (NDPC 2009; Hendriks 2010). The theoretical underpinning of these transitions involves examining the influence of political ideologies, economic constraints, and external pressures in shaping financing structures (Nyonator 2010a, 2010b).

2.2.3 Socialist Ideals and Challenges

Initially, post-independence Ghana embraced socialist ideals, providing free healthcare funded by general taxes and donor support (Nyonator and Kutzin 1999). The theoretical lens here involves assessing the socio-political motivations driving this approach and the subsequent challenges when economic downturns and structural adjustment programs necessitated user fees, leading to the 'cash and carry' system (Johnson and Stoskopf 2009).

2.2.4 Introduction of Health Insurance Schemes

Theoretical discussions surrounding the introduction of the National Health Insurance Scheme (NHIS) in Ghana (Act 650, 2003) delve into the conceptualization of insurance as a solution to financial barriers in healthcare access (Mills et al. 2012). The equity considerations and the complexities in implementing NHIS, especially concerning funding through taxes, donations, and premiums, add layers to the theoretical discourse (Akazili 2010).

2.2.5 Challenges in the Current Framework

As Ghana's NHIS faces challenges of rapid enrollment, political influences, and financial burdens (Schieber George et al. 2012; Akazili et al. 2014), theoretical perspectives come into play. Discussions center on the sustainability of tax-based financing, the regressive nature of premiums, and the implications for achieving universal health coverage (Addae-Korankye 2013).

2.2.6 Tax-based Financing and Other Revenue Sources

The theoretical underpinnings of financing Ghana's health system are intricately tied to direct and indirect tax revenue, including personal income tax, corporate tax, and VAT (Akosua Akortsu and Abor 2011). The debate on the burden-sharing between consumers and shareholders contributes to the theoretical discourse (Martinez-Vazquez 2008; Akazili 2010).

2.2.7 Implications for Health Equity

Theoretical frameworks also explore the implications of financing models on health equity. The regressive nature of certain strategies, such as flat premiums, raises questions about their alignment with principles of equity and social justice (Akazili 2010).

2.3 EMPIRICAL REVIEW

2.3.1 Performance of the NHIS in Ghana

The National Health Insurance Scheme (NHIS) in Ghana is a social health insurance program that aims to provide Ghanaians with access to healthcare services at an affordable cost. The NHIS was established in 2003 and since then has made significant strides in improving access to health services in Ghana. One of the key performance indicators of the NHIS is its membership. According to the National Health Insurance Authority's 2019 annual report, the

NHIS had a total membership of over 12 million in 2019, representing 41% of the population. This is a significant increase from 10.6 million members in 2018.

The increase in membership is due to the NHIS' efforts to improve its operations, raise awareness and remove barriers to sign-up. Another performance indicator of the NHIS is the utilization of health services. The NHIS has played an important role in improving access to health services in Ghana. According to the same report, NHIS members were responsible for 70% of outpatient visits, 75% of inpatient admissions and 80% of deliveries in 2019. The NHIS has also helped reduce out-of-pocket spending on healthcare, which has helped improve access and affordability of healthcare.

However, despite the progress made by the NHIS, the system still faces challenges. One of the challenges is the sustainability of the system. The NHIS relies heavily on government funding and there is a need to explore other sources of funding to ensure the sustainability of the system. In addition, there have been concerns about fraud and abuse within the system, which has resulted in a loss of resources and negative impact on the operation of the system.

In summary, the NHIS has made significant strides in improving access to health services in Ghana. The program has contributed to an increase in membership, the use of health services and a reduction in out-of-pocket expenditure on health services. However, there is still a need to address the challenges faced by the system such as: B. Sustainability, fraud and abuse to ensure that the NHIS continues to be successful in providing Ghanaians with access to quality health services.

2.4 CONCEPTUAL FRAMEWORK

2.4.1 Challenges of Financing the NHIS in Ghana

The National Health Insurance Scheme (NHIS) in Ghana is a social health insurance program that aims to provide Ghanaians with access to healthcare services at an affordable cost. One of the biggest challenges for the NHIS is funding. The NHIS relies heavily on government funding

and funding issues have raised concerns about the sustainability of the system. One of the challenges in funding the NHIS is insufficient government funding. The government's contribution to the NHIS comes primarily through the National Health Insurance Levy, a 2.5% sales tax on goods and services.

However, government funding has been uneven and there have been delays in releasing funds to the NHIS. This has resulted in a backlog of unpaid receivables from healthcare providers, which has negatively impacted the system's operations. Another challenge is the lack of diversification of funding sources. The NHIS did not examine other sources of funding such as private sector partnerships and donor funding. This over-reliance on government funds has made the system vulnerable to volatility in funding, affecting its sustainability.

The high cost of health services also poses a funding challenge for the NHIS. The financial sustainability of the NHIS is impacted by the rising cost of health services. The NHIS must negotiate with healthcare providers to keep healthcare costs affordable for its members. However, healthcare providers sometimes charge more than the NHIS can afford, putting a financial strain on the system. Finally, fraud and abuse of the system also poses a funding challenge for the NHIS.

Fraudulent activities such as registering ineligible individuals, falsifying claims and overcharging have resulted in a drain on the system's resources. This hampered the system's ability to provide quality healthcare services to its members. In summary, funding the NHIS poses a significant challenge that impacts the sustainability of the system and the ability to provide quality healthcare services to Ghanaians. Government needs to provide consistent and adequate funding to the NHIS, explore other sources of funding and address the high cost of healthcare services. In addition, fraud and abuse of the system must be combated to ensure that resources are used efficiently and effectively.

2.4.2 SUMMARY

This chapter provides an overview of health financing in Ghana, the NHIS, sources of funding for the system, internal and external strategies to improve the NHIS, the performance of the NHIS in Ghana, and the challenges in funding the system. In the following chapters, the methodology, data analysis, results and conclusions of the study are presented.

CHAPTER THREE

METHODOLOGY

3.0 INTRODUCTION

This study uses a case study approach to gain a comprehensive understanding of the financing of the health care system in Ghana. The researcher collected key data from a literature review and compiled a catalog to analyze the participatory role of financing health insurance schemes in Ghana. The information was then used to develop a questionnaire distributed to individuals or organizations working on the health financing system in Ghana. This method provides detailed results and is suitable for the unique situation in question, which has not been previously investigated.

3.1 RESEARCH DESIGN

This study will use a descriptive research design to examine health care financing in Ghana, with a focus on the NHIS. A descriptive research design is suitable for describing and analyzing a phenomenon or a situation. This design will allow the researcher to gather comprehensive information on healthcare funding in Ghana and the challenges faced by the NHIS. Descriptive research involves collecting qualitative data, such as gender or interaction patterns, and organizing, tabulating, and describing the data. It involves collecting events and organizing them into categories, such as gender or technology use in group situations. The study aims to answer specific research questions:

- What are the Ghanaian NHIS's financing sources, and how do they affect the program's long-term viability?
- What are the sources of funding that have contributed to the NHIS's success in Ghana in terms of healthcare access, financial security, and health outcomes?
- What internal and external tactics have been used, and how successful have they been in accomplishing the goals of the scheme been?
- What are the difficulties Ghana faces in funding the NHIS, and what are some potential solutions?

3.2 POPULATION OF THE STUDY

Sparta (2003) defines population as the group of people, things or objects from which samples are taken in order to measure them. Furthermore, according to Burns and Grove (1993), a population is defined as the set of items (individuals, objects, and events) that meet the sampling criteria to be included in a study. The study considers NHIS officials, healthcare providers and NHIS members in selected regions in Ghana as the study area. An investigation conducted by the researcher revealed that the total number of employees in the study area is estimated at 150.

3.3 SAMPLING SIZE AND SAMPLING TECHNIQUE

3.3.1 Sample Size

Gathering information from countless people was tedious and a part of the thesis spending plan. Saunders et al. (2009) recognized that using the population for such extensive information gathering and investigation would lead to poor information assessment and the ordering of errors due to the duplication of information and the inaccessibility of certain members. It is therefore important to find a representative of this population group.

The sample size of the study included 50 selected staff from various finance departments of NHIS officers, healthcare providers and NHIS across the Oti region. The reason for this sample

size is to ensure that an adequate representation of the sample population is given. The need for this number is due to both the time constraint and the limited resources available.

3.3.2 Sampling approach

Sampling is a central part of any survey and several considerations. Most surveys aim to collect information about the population. In sampling, entities like individuals, organizations and communities, are selected from a population of interest, so by examining the sample we can reasonably extrapolate our results to the population from which they were selected (Trochim, 2002). The candidate takes a sample of the population for analysis.

The study used targeted sampling to select NHIS officers and healthcare providers and stratified random sampling to select NHIS members. The targeted sampling technique allows the researcher to select knowledgeable and experienced participants, while the stratified random sampling technique ensures that the sample represents NHIS membership in the selected regions. With a view to generating the information needed for the study, the researcher was free to contact the respondents of the institution and to give them questionnaires.

3.4 DATA COLLECTION

The study utilized both primary data, collected through questionnaires and interviews. Primary data was collected by the applicant for a specific research objective. The case study methodology was used, with 20 respondents selected from various NHIS officers, healthcare providers, and NHIS. Each question took approximately 25 minutes to complete.

The data was collected over two weeks, and the applicant also gathered information from department files, unpublished articles, web journal websites, newspapers, magazines, and related studies on industry changes. The data was analyzed to test the research questions presented. The study was conducted according to the case study methodology, with proper approval from directors and questionnaires managed by their offices.

3.5 DATA ANALYSES

Data analysis is a crucial aspect of research, focusing on the interpretation and interpretation of the collected data. Social science researchers have several data analysis techniques at their disposal. Although Silverman (2003) emphasizes that researchers should refrain from using text documents as a substitute for other forms of evidence, all data obtained from interviews were transcribed into texts for analysis because they are data that must be conveyed in language. The transcript is the initial step in data processing, generating processed data from interview partners' spoken words. The researcher used analytical approaches for qualitative research, including thematic content analysis, to identify key themes.

Thematic analysis is used to identify, analyze, and report models or themes in qualitative data, detecting repeating models of action and meaning (Boyatzis, 1998; Braun & Clarke, 2006). This analysis was done by reading field notes, transcripts, and articles, using memos to develop codes to organize the data structure. General themes emerged after initial examination, while sub-themes developed after deeper understanding of the texts (Miles and Huberman, 1994).

The candidate then reached out again to some of the research participants to confirm some of the preliminary issues and fill in the gaps that had arisen. Sometimes the candidate used theoretical sampling to collect and analyze specific data. This is a technique where concepts are driven by data. This technique allows researchers to discover concepts relevant to a problem and the public, paving the way for further exploration of concepts. In this technique, the researcher proceeds one step at a time with data collection, followed by analysis, and then collecting more data until one category reaches saturation (Corbin and Strauss, 2008, p. 146).

As mentioned earlier, case study designs lend themselves to topics that are relatively unknown to the researcher or to questions over which the researcher has little or no control.

Likewise, theoretical sampling enables the discovery of new or unexplored research fields.

Coding is critical to any full-text analysis and involves preliminary data analysis (Bazeley, 2011). It requires the researcher to make judgments and interpretations in the context of the text (Ryan & Bernard, 2003). The codes matched common words and terms and were then sorted to summarize the data.

Throughout the study, the candidate mainly used theoretical sampling for data collection and certain parts of data analysis. In this technique, other research participants and the data they request are deliberately selected based on their ability to further explain problems that continue to emerge in the data already collected (Bazeley, 2011; and Corbin and Strauss, 2008). In brief, the data management process involves scanning the data for items that appear to be related to the subject at hand, within the framework of the collaborative benefit related to the central theme of this study; creating more general interpretations of the key issues; clustering of similar data elements and interpretations; assigning labels to the clusters; and progressively exploring ways of formulating and writing about the problems that arise (Creswell, 2003; Huxham, 2002).

A comprehensive description of this methodological process can be found in Huxham (2002). Instead, reliability and validity are terms that some specialists in qualitative research feel uncomfortable using. However, in this study, internal validity was ensured by triangulating sources in the data collection phase, which includes archival records, personal interview data, and researchers' personal observations.

The practical approach to reliability and validity is presented in the following subsection. The questionnaire data was analyzed using the Statistical Package for Social Science (SPSS), which facilitates data conversion into decision-making variables. The analysis was based on research goals, ensuring accurate completion of questionnaires by key department respondents. The analysis began with a check on the number of collected questionnaires.

The SPSS Version 20 Descriptive Analysis Tool was used to analyze closed-loop coded responses to develop closed-loop frequencies and percentages for answering related research

questions. Each transcript was regularly checked to identify the specific features of the text. This process is consistent with Jorgensen (1989) who states that in qualitative analysis the researcher sorts data, looking for types, classes, sequences, models or wholes in order to collect or reconstruct them in an understandable way. The candidate then presented the qualitative data, which were analyzed as themes, parallel to the study objectives.

3.6 RELIABILITY AND VALIDITY OF DATA

3.6.1 Research Instruments

During the data collection for this study, the candidate selected two tools to explore respondents' views, including the questionnaire and interviews. In this study, the candidate identified a questionnaire as the primary data collection tool. One questionnaire was a printed self-assessment form aimed at obtaining information that can be gleaned from the written responses of respondents from NHIS officials, healthcare providers and NHIS in the Oti region of Ghana.

The information comes from a questionnaire similar to that of an interview, but the questions are less in-depth (Burns and Grove, 1993). The candidate collected data using questionnaires to test management's knowledge and views on the issue and its impact on the country's socioeconomic development. The purpose of the study was to ensure that the questionnaire met the objectives of the study.

The study utilized a questionnaire to gather research data, adjusting the objectives based on previous studies. The questionnaire was chosen due to its cost-effectiveness, ease of creation, and consistency in responses. It was easier to create than face-to-face interviews and provided consistent responses. The self-administered questionnaire included questions about partnerships and policy implementation. Open and closed questions were used for multiple answer choices, and open-ended questions were used to target the respondent's views, ensuring a comprehensive understanding of the subject matter. This approach was chosen due to its cost-

effectiveness, ease of creation, and flexibility. Respondents had opportunity to use their own words.

The candidate collected the information about a month earlier. Prior to the questionnaires, the candidate obtained permission from the heads of departments and interviewed several employees whose topics and research goals were determined by the candidate. The candidate interviewed specific employees to obtain information about the activities of the department. The candidate created questionnaires for respondents, avoiding statistical techniques and mechanisms of quantitative methods in the interview method.

3.6.2 Instrument Validation

Although qualitative researchers are reluctant to use the terms “validity” and “reliability” to describe understanding of reality in social constructions, due to their traditional use in quantitative research (Corbin & Strauss, 2008), these terminologies aim to Ensure credibility of the investigation process without any credibility uncertainty. The study's accuracy was verified through an audit trail, which included interviews, archival documents, and an agreement between the investigator and other submissions.

Multiple sources of data collection (triangulation) were used to ensure internal relevance and reliability. The validity and reliability of the method and data are crucial factors in determining the quality of research (Patton, 2002). Validity refers to the degree to which a measure reflects the intended design. If the measures used measure what they claim and there is no logical error in concluding the data, the study is considered valid (Trochim, 2005). Data collection began with a pilot study testing the questionnaire.

According to Creswell, the purpose of the pretest exercise (2009) is to determine whether the finding aids are appropriate for the study. The pilot study was conducted with the support of 10 staff from Jasikan Government Hospital to determine the clarity of the questions in the

questionnaires and to obtain answers. This resulted in changes to the questionnaire used to collect the data required for the study.

Information was also provided on when and when to administer questionnaires. Refine the elements of the question to measure what it is intended to do and help the candidate avoid the two elements that prevent the respondent from answering the elements correctly. Reliability refers to the consistency or reliability of a measurement technique, and this study's reliability was ensured through the development of sample selection, instrument selection, and questionnaire management tactics (Newman, 2006).

The first way to ensure the reliability of the instrument is to define specific concepts and constructions used to frame the elements, and sometimes also to define behaviors, activities and actions that emphasize the concept of the constructions used. The pilot test is a method used to assess the reliability of questionnaires, providing an alternative method for certifying the instruments' reliability.

3.7 ETHICAL CONSIDERATIONS

The study is subject to ethical principles, including informed consent, confidentiality and anonymity. Participants will be informed about the purpose of the study, their rights and their role in the study. The researcher will obtain written informed consent from participants prior to conducting the interviews. The collected data will be treated confidentially and the anonymity of the participants will be guaranteed.

3.8 SUMMARY

This chapter details the research design, population and sampling technique, data collection methods, data analysis techniques, ethical considerations, and limitations of a qualitative case study on a policy process. The study used a mix of questionnaires, reviews from the public sector, media, and policy documents from departmental files and unpublished documents. Data

was collected from various sources, including websites, magazines, books, newspapers, magazines, and websites.

The researcher used self-completed questionnaires and informal interviews to collect data from departmental participants. The challenge was to combine the questionnaire and interview to fully understand the issues and interpret them effectively. However, the survey approach has its strengths and weaknesses, such as potential bias in the objectivity of the description and reflection. SPSS was used to analyze the data and convert it into actionable variables. The analysis began by checking the number of questionnaires collected on site and whether respondents completed them correctly. The results and conclusions of the study are presented in the following chapters.

CHAPTER FOUR

DATA ANALYSIS

4.0 INTRODUCTION

This chapter presents the results of the study on health care financing in Ghana, with a focus on the NHIS. The chapter begins with an overview of the data analysis process, followed by a description of the demographics of the study participants. Then, the chapter presents the insights on the sources of funding of the NHIS, the performance of the NHIS, internal and external strategies to improve the NHIS, and the challenges of funding the NHIS in Ghana.

4.1 BACKGROUND OF THE RESPONDENTS

The study participants were NHIS officials, healthcare providers, and NHIS members selected from Oti regions in Ghana. The demographic characteristics of the participants included age, gender, occupation, and level of education. The study found that many of the participants were female, with a mean age of 38 years. Most of the participants were healthcare providers, followed by NHIS officials and NHIS members.

Table 1.1 Gender Distributions

Gender	Frequency	Percentage (%)
Male	*35*	*35*
Female	*65*	*65*
Total	*100*	*100*

Table 1.2 Age Distributions

Age	Frequency	Mid-point (X)	FX
21 - 30	22	25.5	561
31 - 40	43	35.5	1527
41 - 50	22	45.5	1001
51 - 60	13	55.5	721.5
Total	100		3810
Mean			38

Sources of Funding for the NHIS in Ghana

According to the study, the NHIS receives funding from both internal and external sources. The premiums paid by NHIS members, government financing, and interest earnings from the NHIS fund are some of the internal sources of funding. Donor financing, grants, and loans are examples of external sources of funding. According to the report, the primary funding sources for the NHIS are internal sources of finance. The pictorial analysis in respect of the internal and external sources with their breakdown are represented below.

Table 1.3 Funding Sources

Source	Percentage
Internal	65
External	35

Total	100

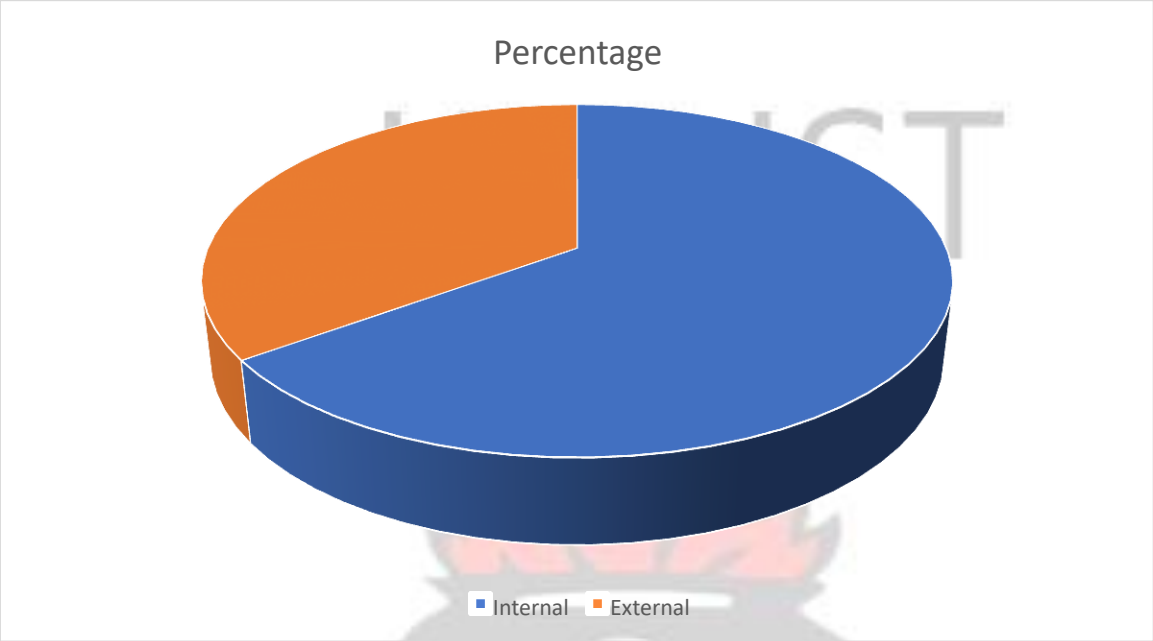

Figure 4.1. Funding Sources

Internal Sources Distributions based on its contributions to the pool

Table 1.4 Internal Sources

Internal Source	**Percentage**
Government (2.5%)	60
Subscribers (Premium)	35
Investment by NHIL (Interest)	5
Total	**100**

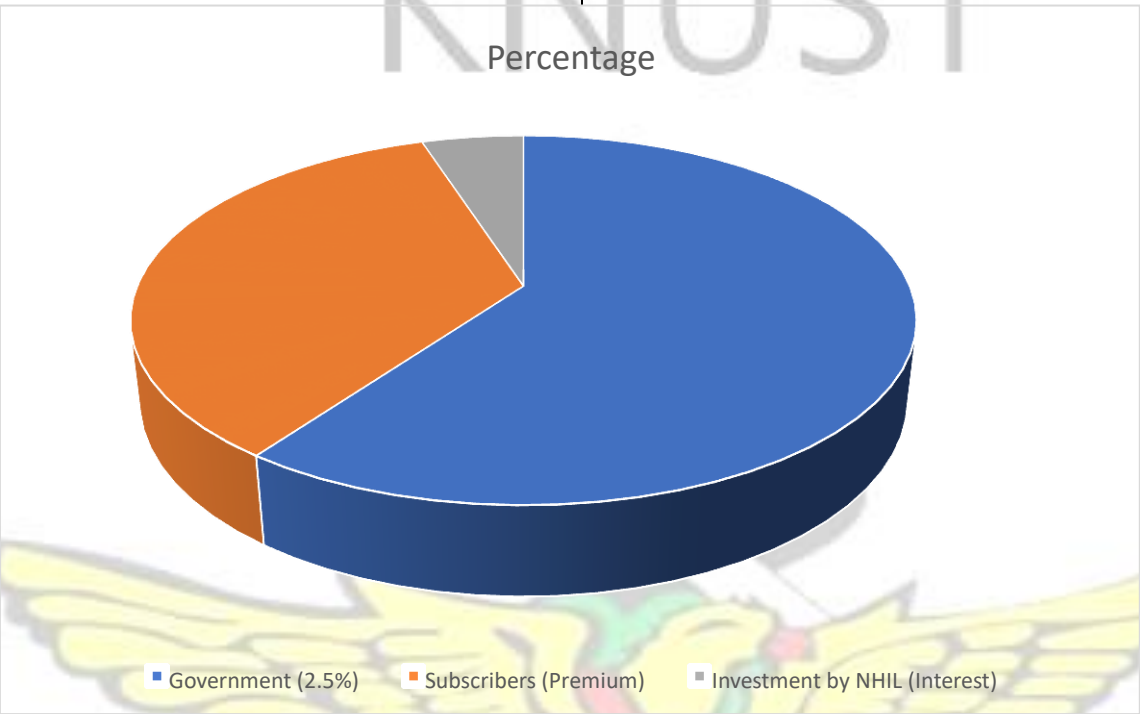

Figure 4.2. Internal Sources

Table 1.5 External Source

External Sources	Percentage
Grant	75
Loan	25
Total	100

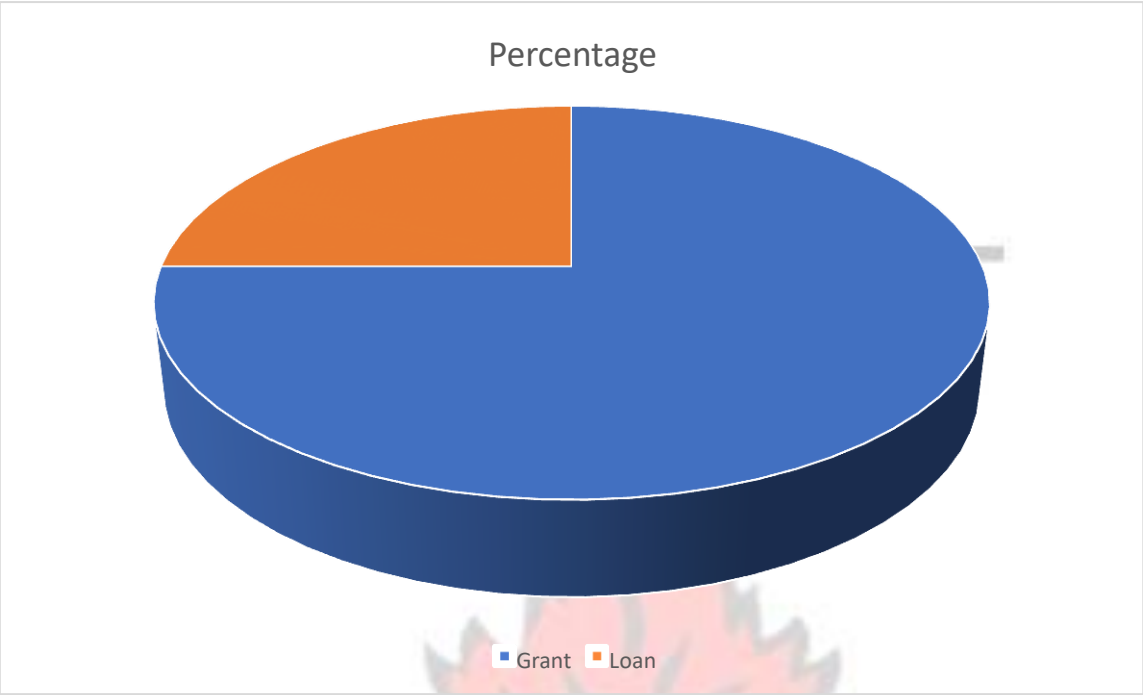

Figure 4.3 External Sources

Performance of the NHIS in Ghana

The study found that the NHIS has improved access to healthcare services for Ghanaians, particularly for the poor and vulnerable populations. However, the study also found that the NHIS faces challenges in terms of sustainability, quality of care, and equity.

Table 1.6 Performance of the NHIS

Performance	**Percentage**
Sustainability	25
Quality of care	30
Equity	45
Total	**100**

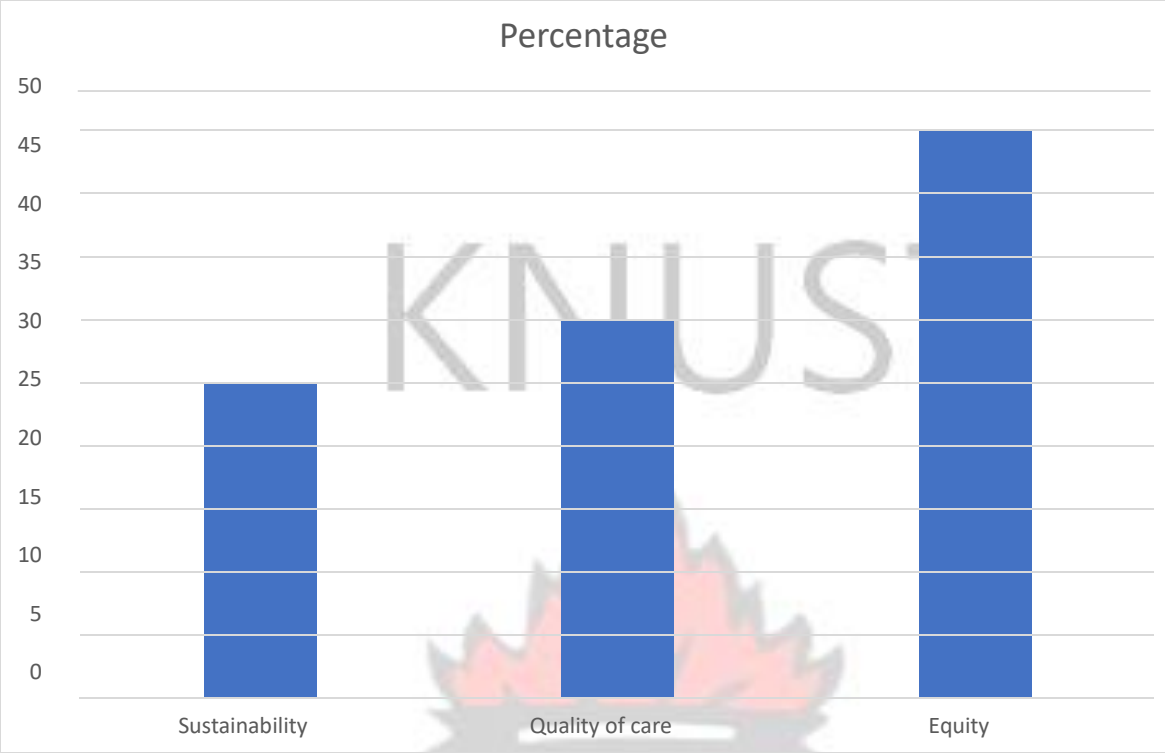

Figure 4.4 Performance of the NHIS

Internal and External Strategies to Improve the NHIS

The study found that there are both internal and external strategies to improve the NHIS. The internal strategies include increasing premiums, reducing fraud and abuse, improving the quality of care, and expanding NHIS coverage.

Table 1.7 Internal Strategies

Internal Strategies	**Percentage**
Increasing premiums	18
Reducing fraud and abuse	23
Improving the quality of care	34
Expanding the NHIS coverage	25
Total	**100**

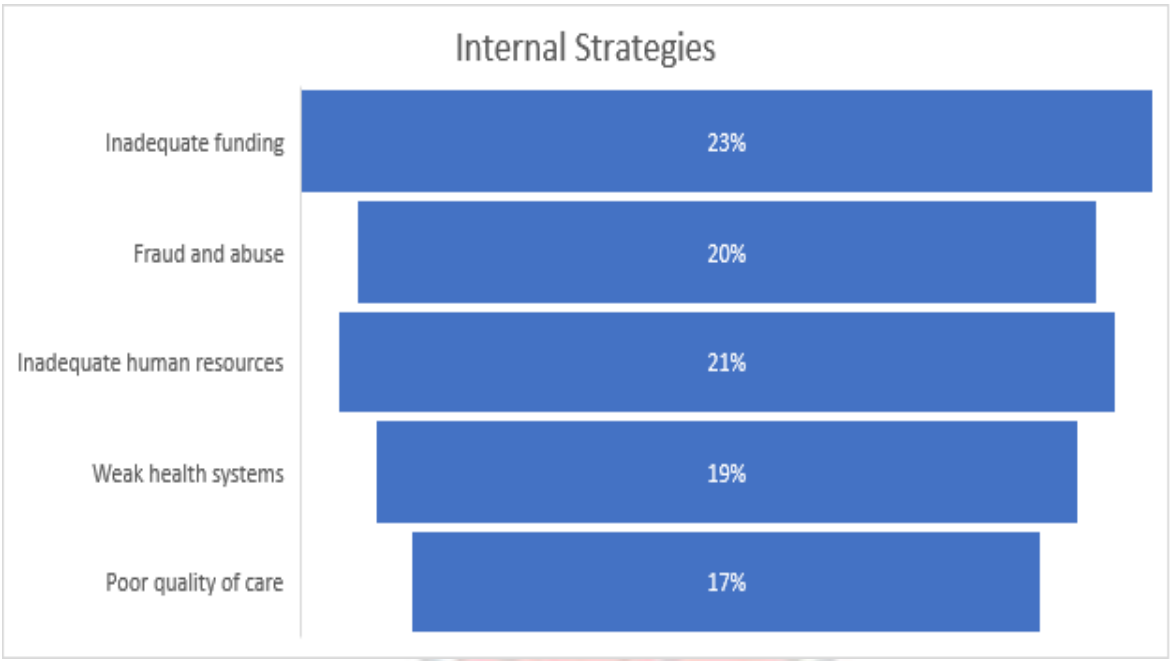

Figure 4.5 Internal Strategies

The external strategies include increasing donor support, improving the regulatory environment, and strengthening the health system.

Table 1.8 External Strategies

External Strategies	**Percentage**
Increasing Donor support	39
Improving the regulatory environment	28
Strengthening the health system	33
Total	**100**

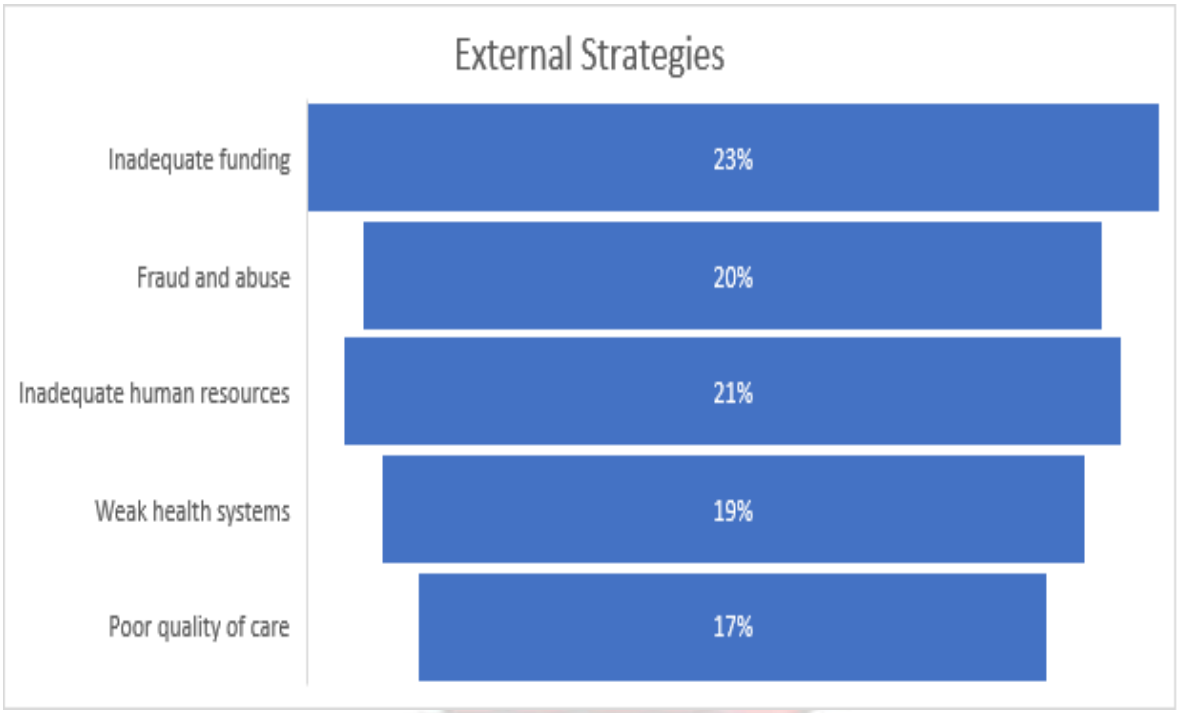

Figure 4.6 External Strategies

4.2 CHALLENGES OF FINANCING THE NHIS IN GHANA

The study identified several challenges facing the financing of the NHIS in Ghana. These include inadequate funding, fraud and abuse, poor quality of care, inadequate human resources, and weak health systems.

Table 1.9 Challenges of Financing

Challenges	**Percentage**
Inadequate funding	23
Fraud and abuse	20
Inadequate human resources	21
Weak health systems	19
Poor quality of care	17
Total	**100**

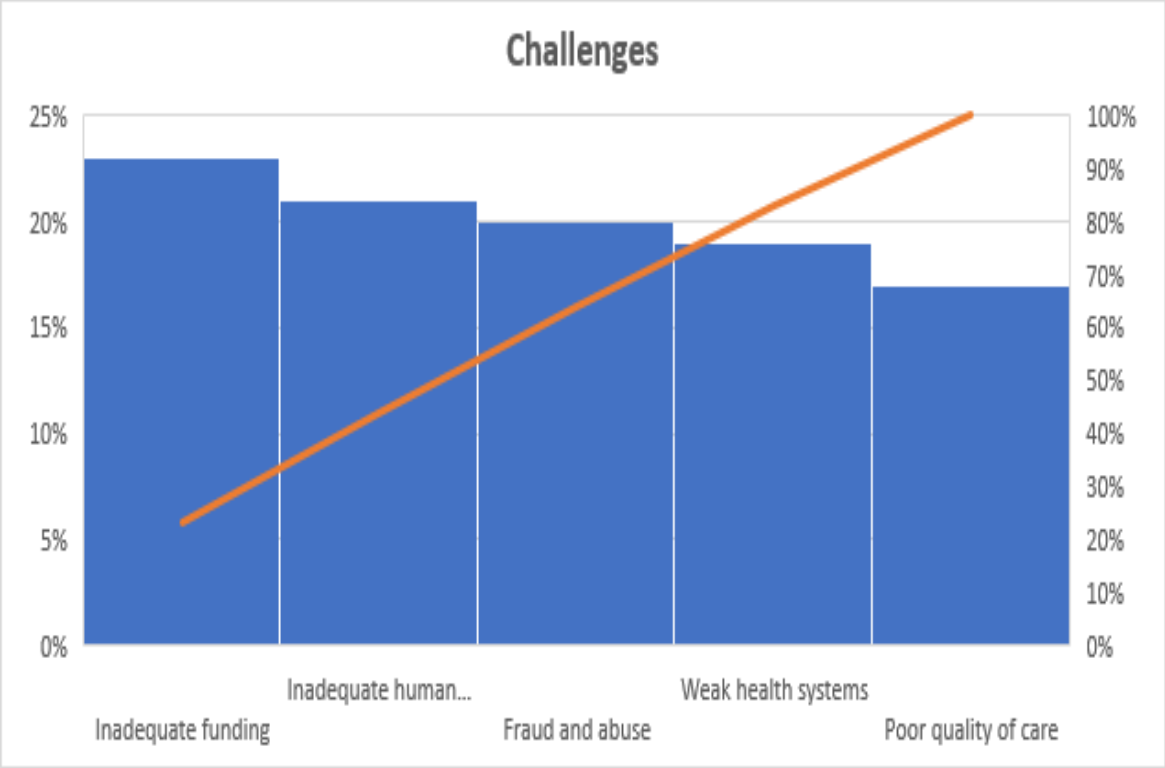

Figure 4.7. Challenges of Financing

In conclusion, the research on how to pay for healthcare in Ghana was given in this chapter, with an emphasis on the NHIS. The chapter has covered the demographic information of the research participants, the NHIS's performance, internal and external measures to enhance the NHIS and the difficulties in Ghana's NHIS financing. The study's findings will be presented in the following chapter.

CHAPTER FIVE

FINDINGS AND CONCLUSIONS

5.0 INTRODUCTION

This chapter summarizes the main findings of the study on health care financing in Ghana, with a focus on the NHIS. The chapter discussed the implications of the study results for policy and practice in Ghana. The findings and recommendations of the study, as well as suggestions for future research and issues for policy and practice, have been summarized in this chapter. According to the report, in order to ensure the long-term viability and efficiency of the NHIS in providing health services to Ghanaians, efforts should be made to overcome the problems it is facing.

5.1 SUMMARY OF FINDINGS

The main conclusions of the study on the cost of healthcare in Ghana, with a particular emphasis on the NHIS, are summarized in this chapter. According to the study, both internal and external financial sources are used to support the NHIS, with internal funding serving as the primary source of funding. According to the report, Ghanaians now have better access to healthcare services, especially the poor and vulnerable populations. The NHIS does, however, have difficulties with equity, care quality, and sustainability. The analysis found various internal and external ways to strengthen the NHIS, including raising premiums, cutting down on fraud and abuse, and boosting donor support. Insufficient funding, low quality of data, and other issues with the NHIS's financing were also noted in the report. The study also identified several challenges facing the financing of the NHIS, including inadequate funding, poor quality of care, and weak health systems.

Discussion of Key Findings about Objectives of the Study

The research's conclusions are consistent with its goals. The study found that, Assess the financing of NHIS to ensure equity in coverage and quality delivery was a major issue of the scheme, since the middle- and upper-class population preferred private insurance providers or are ready for the cash and carried system of operation for quality health care. The internal and external financing sources for the NHIS, as well as their effects on sustainability, were examined in the study. The study was able to examine the difficulties in Ghana's NHIS funding. In view of the objective of the study *"to Investigate internal and external financing sources for the NHIS and evaluates the consequences for the sustainability of the program in terms of effectiveness through healthcare access, financial security, and health outcomes."* the study, the NHIS is funded by both internal and external sources, with internal sources serving as the primary sources of funding while the secondary sources were attributed to the external sources. This was demonstrated by the data indication 65% of the funding for NHIS was from individua primum of 35%, NHIS leavy imposed as an indirect tax on goods and services contributing 60% and investment income adding only 5% to the internal pool. In addition, the external source was 35% as a contribution from other doners such as 75% grants and 25% loan. In relation to the objective of *"Examine the difficulties Ghana faces in funding the NHIS and to determine potential solutions."* The study did discover, however, that the NHIS had problems with equity, care quality, and sustainability. It was found out that inadequate funding of the scheme constitutes 23%, fraud and abuse accounted for 20%, with 21% was associated with inadequate human resources, whiles 17 and 19% was as a result weak health systems and poor quality of care respectfully. These exposes and weaken the entire scheme by calling into question its sustainability in the mare future. The study came up with several internal and external NHIS improvement solutions that could help with some of these issues.

Implications of the Study Findings for Policy and Practice

The results of this study have significant ramifications for Ghanaian policy and practice. According to the report, Ghanaians now have better access to healthcare services, especially the poor and vulnerable populations. The NHIS, though, has issues with equity, care quality, and sustainability. The study came up with several internal and external NHIS improvement initiatives that might be used to tackle some of these problems. These findings can be used by Ghanaian policymakers to enhance the NHIS and guarantee that all Ghanaians will continue to have access to healthcare services.

In summary, the emphasis is on the National Health Insurance Scheme and the study sought to explore how healthcare is financed in Ghana (NHIS). The study looked at the NHIS's funding sources, performance, and internal and external plans for improvement, as well as obstacles to supporting the program. The study discovered that the NHIS has internal and external funding sources and has enhanced access to healthcare services for Ghanaians, especially for the underprivileged and vulnerable groups. The report did note, however, that the NHIS faced difficulties with equity, care quality, and sustainability. The NHIS can be improved using both internal and external tactics, however, the program also confronts issues with insufficient financing, fraud, and abuse.

5.2 CONCLUSION

According to the findings, financing healthcare in Ghana, notably through the NHIS, is a complicated subject with both advantages and disadvantages. Even though Ghanaians now have easier access to healthcare services, the NHIS still has a lot of sustainability, care quality, and equity concerns to overcome. According to the study, initiatives should be taken to solve these issues to guarantee the long-term viability of the NHIS.

5.3 RECOMMENDATIONS

Based on the study findings, several recommendations can be made for policy and practice.

These include:

• Increasing funding for the NHIS to ensure its sustainability.

• Implementing measures to reduce fraud and abuse in the NHIS.

• Improving the quality of care provided through the NHIS.

• Expanding coverage of the NHIS to include more vulnerable populations.

• Strengthening the health system to support the NHIS.

5.4 RECOMMENDATIONS FOR FURTHER RESEARCH

Areas for Further Research While this study provides important insights into the financing of healthcare in Ghana, there are several areas for further research. These include:

• Further research to examine the effectiveness of internal and external strategies to improve the NHIS.

• More research on the challenges faced by the NHIS in providing quality care.

• Research to examine the impact of NHIS coverage on health outcomes.

• Further research to explore the role of the private sector in healthcare financing in Ghana.

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APPENDIX

Survey Instrument

BACKGROUND OF RESPONDENT

Institution of Respondent ……..……..

Position of Respondent in the institution ……..……..

What is your Gender? MALE [ ] FEMALE [ ]

What is your Age? 20-29 [ ] 30-39 [ ] 40-49 [ ] 50 and above [ ]

Indicate highest level of education obtained (Tick only one)

i. No formal education [ ] ii. Primary education [ ] iii. Junior High school [ ] iv. Secondary/Technical/Vocational [ ] v. University/Polytechnic [ ] vi. Other (specify)……...

How long have you been working at your sector? 1-5yrs [ ] 6-10yrs [ ] 11-15yrs [ ] 16-20yrs [ ] More than 20yrs [ ]

Questions

1. How familiar are you with the National Health Insurance Scheme (NHIS) in Ghana? a) Very familiar

b) Somewhat familiar

c) Not familiar at all

2. Have you ever enrolled in the NHIS?

a) Yes

b) No

3. How do you perceive the quality of healthcare services provided by the NHIS? a) Very good

b) Good

c) Average

d) Poor

e) Very poor

4. How do you currently finance your healthcare needs?

a) Out of pocket payment

b) Insurance (not NHIS)

c) NHIS

d) Others

5. Have you ever experienced any challenges accessing healthcare services through the NHIS? If yes, what were those challenges? ……

……

6. Do you think the current funding mechanism for the NHIS is sustainable? a) Yes

b) No

7. Do you think the government should increase its financial contribution to the NHIS? a) Yes

b) No

8. In your opinion, what measures can be put in place to improve the financial sustainability of the NHIS? …….

…..……

9. How important do you think NHIS is in providing access to healthcare services in Ghana? a) Very important

b) Important

c) Somewhat important

d) Not important

10. Would you recommend the NHIS to others?

a) Yes

b) No

c) Not sure