# THE SUSTAINABILITY OF THE NATIONAL HEALTH INSURANCE SCHEME IN THE KINTAMPO MUNICIPALITY: THE ROLE OF SERVICE PROVIDERS AND FIELD AGENTS



by

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## CERTIFICATION

I hereby declare that this submission is my own work towards the CEMBA degree 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, except where due acknowledgement has been made in the text.



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## DEDICATION

I dedicate the entire work to Almighty Allah for taking care of my life throughout my education, and to my dear mother, Madam Fatima Abubakari for her advice and support towards my success in education, and finally to my children: Buhari, Khadijah, Abdalla and Aminah.



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## ABSTRACT

This study provides an assessment of the role of service providers and field agents in the sustainability of National Health Insurance Scheme taking Kintampo Municipality as the case study. It provides an empirical platform for assessing how the health service providers and field agents are helping in the sustainability of the scheme. Kintampo Municipality was chosen because it was among the first National Health Insurance Schemes that were inaugurated by the then President John Agyekum Kuffour on 18th March, 2004. Questionnaires, interview and focal group discussion were the data collection instruments employed. The data were analyzed using tables, percentages, graphs, charts and diagrams. The study revealed that the health service providers and field agents play major roles in the sustainability of the National Health Insurance Scheme in Ghana. However, the extent to which health service providers and field agents achieve their roles in the municipality was limited by factors such as untimely release of funds by government, political interferences, limited health facilities to meet the high coverage of the scheme, lack of logistics for field agents, training and motivation. The following recommendations were made from the findings: The government should release funds early to the scheme, there should be intensive education of residents on the health insurance concept, the health facilities should be expanded and more health personnel should be trained to cater for the growing population in the municipality.

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## ABBREVIATIONS

| | |
|---|---|
| BAR | - Brong Ahafo Region |
| CDI | - Centre de deveppement integre |
| CHI | - Community-Base Health Insurance |
| CHPS | - Community-Based Health Planning Services |
| FGD | - Focus Group Discussion |
| GDRG | - Ghana Diagnostic Related Grouping |
| GHS | - Ghana Health Service |
| GK | - Gonosasthya Kendra |
| ILO | - International Labour Organisation |
| JHS | - Junior High School |
| KMHD | - Kintampo Municipal Health Directorate |
| KMMHIS | - Kintampo Municipal Mutual Health Insurance Scheme |
| LI | - Legislative Instrument |
| MHMT | - Municipal Health Management Teams |
| MOH | - Ministry of Health |
| MPCU | - Municipal Planning Coordinating Unit |
| NHI | - National Health Insurance |
| NHIA | - National Health Insurance Authority |
| NHIS | - National Health Insurance Scheme |
| ORT | - Oral Rehydration Therapy |
| PNDC | - Provisional National Defense Council |
| P & T | - Post and Telecommunication |

SEWA - Self Employed Women's Association

SHS - Senior High School

WHO - World Health Organisation



# CHAPTER ONE

# INTRODUCTION

Health insurance is a type of insurance that pays for medical expenses prior to health service delivery. It is sometimes used more broadly to include insurance covering disability or long-term nursing or custodial care needs. It may be provided through a government-sponsored social insurance program, or from private insurance companies. It may be purchased on a group basis (e.g., by a firm to cover its employees) or purchased by individual consumers. In each case, the covered groups or individuals pay premiums or taxes to help protect themselves from high or unexpected healthcare expenses. Similar benefits of paying for medical expenses may also be provided through social welfare programs funded by the government.



## 1.1 Background to the Study

Scarce economic resources, low or modest economic growth, constraints on the public sector and low organizational capacity explain why the design of adequate health financing systems in developing countries, especially the low income ones, remains cumbersome and the subject of significant debate. In 1980s, a cost-recovery for health care via user fees was established in many developing countries usually as a response to severe constraints on government finance. However, most studies alert decision-makers to the negative effects of user fees on the demand for care, especially that of the poorest households (WHO, 2003).

Alternative health financing systems exist, de-linking utilization from direct payment, and thereby protecting the population, especially the most vulnerable groups, from having to resort to various copayment mechanisms. Financing of health delivery is based either on general tax revenues and/or social health insurance contributions. Mutual Health Insurance

Schemes have evolved rapidly as alternative financing institutions in the health sector in recent years. Their objective generally is to provide an alternative to user fees through community risk-pooling mechanisms, and to ensure access to health care of acceptable quality to their members (Atim, 1998). A tax funded health system may not be easy to develop, due to the lack of a robust tax base, a low institutional capacity to collect taxes and weak tax compliance (WHO, 2003).



Social health insurance has traditionally started by insuring workers. A further nationally organized expansion of social health insurance to the self-employed and non-formal sector is especially demanding. Other financing methods which would circumvent these health care difficulties are therefore explored, including the direct involvement of communities in health financing (WHO, 2003).

### 1.1.2 The Concepts of Health Insurance in Ghana

Before the introduction of the National Health Insurance Scheme (NHIS), Ghana has operated a cost-recovery health delivery system known as the 'cash-and-carry' system since 1985. With this system patients were required to pay up-front for health services at government clinics and hospitals. This, however, pushed health care far beyond the reach of the ordinary Ghanaian for which many were not seeking health delivery services from hospitals and clinics resulting in needless deaths. The challenge since 1981 has been how to find the best combination of Government-Peoples-Partnership that would meet each other part of the way and satisfy the needs and pockets of Ghanaians as well as the Government's finances in the healthcare sector.

'Cash and Carry' the system of healthcare financing introduced by the PNDC survived until 2004 when the present health insurance system came into being. Even then a large number of Ghanaians (about 30 percent) still subsist on cash and carry for their healthcare requirements as they have not registered to join the NHIS. This is one of the major challenges facing the Government and the Management of the National Health Insurance Authority (NHIA, 2009).



Under 'Cash and Carry', patients were required to pay for drugs and some medical consumables, as and when they visit hospital, while the state bore all other costs including consultation, salaries and emoluments for doctors, nurses and other healthcare workers in state hospitals. 'Cash and Carry' also provided for free medical care for the aged above 70 years, children under five years and pregnant women for their ante-natal care, all under an exemption program implemented with that system of financing, thus, cash and carry.

Under 'Cash and Carry', people went to hospital only when they were very sick and had money to pay for the stipulated health expenditures. The result of this is that most often people went to hospital when they were really very sick and often at the terminal end of their lives. It was pointed out that 'cash and carry' constrained citizens from assessing healthcare except when they were in very dire situations (NHIA, 2009).

As part of the social interventions and health reforms provided by the government of Ghana to improve and expand the health service delivery and infrastructures in the country respectively, the government of Ghana introduced the National Health Insurance Scheme (NHIS) in the Country in 2003. This was to enable any ordinary Ghanaian to

access quality health care in the country. President Kufuor at the lunch (18th March, 2004) of the scheme attributed an 'unacceptable' 80 per cent of ill-health and early deaths in Ghana to infectious diseases, pregnancy and child-related problems and accidents. He said in future, such ailments will be catered for under the Health Insurance Scheme. Before the NHIS, there were pilot programs in the Dangme West District in the Greater Accra Region and Nkoranza District of the Brong Ahafo Region as a means of laying a firm foundation for what eventually became the National Health Insurance Scheme (NHIA, 2009).



### 1.2 Problem Statement

Mutual Health Organizations have exhibited promise in their ability to attract members, efficient finance care and to provide access to their members for their health care needs (Crier, 1999). However, the Mutual Health Organizations remain relatively young and work remains to be done to ensure their long-term sustainability and their potential to leverage quality improvements in the health sector. Evidence from a study undertaken by Kelly and Quijada (2001) in three countries indicates that Mutual Health Organizations themselves consistently identify quality as a priority. A lot of research has to be carried out to identify the weaknesses and strengths so as to make informed and proper recommendations to the management and policy makers of the scheme.

Ghana has prioritized universal coverage of health care and has therefore put in place policies and programmes to meet this goal. Even though success has been achieved in different aspects of the health sector, health care delivery remains inadequate especially for the poor people and other disadvantaged groups. The task confronting the health

sector remains difficult; life expectancy remains low (60 years), morbidity of preventable diseases remains high; malaria, diarrhoea and other preventable diseases account for about 40% of child mortality and maternal mortality is still high (WHO, 2003).

In recent times, most of the District Mutual Health Insurance Schemes in the country are running into distress by their indebtedness to health care providers which compelled the health care providers to deny services to card bearing members of the NHIS. Some of the service providers have threatened to withdraw the services of health insurance clients if the amount owed by the schemes is not paid (GHS, 2008). The concern therefore is whether the National Health Insurance Scheme would be sustainable in future. There is therefore the need to examine the concepts of the National Health Insurance Scheme to ascertain the viability and its sustainability.

The health care providers are expected to provide quality health care to the NHIS card bearers to ensure trust in the system. Again, the field agents popularly known as collectors are also expected to play positive role to ensure the sustainability of the scheme in the municipality notwithstanding the challenges they face in their daily activities. If the functions of these groups are not properly checked then the future of the National Health Insurance Scheme would be bricked. In the light of these developments, the research hopes to look at the role of service providers and field agents in the sustainability of the National Health Insurance Scheme in the Kintampo Municipality.

### 1.3. Objective

The objective is categorized into general and specific.

### 1.3 .1 General Objective

The aim of the research is to assess the role played by the health care (service) providers and the field agents in ensuring the sustainability of the National Health Insurance Scheme by studying the case of the Kintampo Municipality.

### 1.3. 2 Specific Objectives



The specific objectives are to:

1. Identify the role played by service providers in ensuring the sustainability of NHIS in the Kintampo Municipality.
2. Evaluate the contributions of field agents in the sustainability of health insurance in Kintampo Municipality.
3. Indentify the challenges faced by the service providers and field agents in the implementation of health insurance scheme in the municipality
4. Make recommendations on policies governing the sustainability of NHIS.

### 1.4 Research Questions

The following research questions were addressed.

1. What are the roles played by the service providers in ensuring the sustainability of NHIS in the Municipality?
2. What are the contributions of field agents to ensure the sustainability of NHIS in the Municipality?
3. What are the challenges faced by the service providers and field agents in the implementation of health insurance scheme?

## 1.5 Overview of Research Methodology

The information used in this research was through both primary and secondary sources. The primary data were gathered through questionnaires and extensive face-to-face interviews with health insurance workers, health care providers and field agents of the National Health Insurance Scheme in the Kintampo Municipality. The data were analyzed using tables and charts. A multistage sampling technique was employed in selecting the study municipality, health facilities and participants. The municipality was clustered into 10 sub-districts based on the MHMT's demarcation. These design and methods were employed because the researcher wanted to have accurate and authentic information for his work. Again, the researcher wanted a fair representation of the respondents. The design and the methods enabled the researcher to finish his work on schedule because right people were contacted for the information. The complete enumeration done on all the heads of health institutions enabled the researcher obtained relevant and first hand information for his work.

The secondary data were obtained from textbooks, articles, journals, magazines, newspapers, handouts, annual reports and the internet.

## 1.6 Significance of the Study

The research will be of tremendous value to persons and institutions. It could serve as a teaching material to trainers, teachers and instructors who impact knowledge and skills of Health Insurance Schemes and Ghana Health Service. The findings would again benefit Management of Health Insurance Schemes, Kintampo Municipal Health Management Team, Ghana Health Service, National Health Insurance Authority, Government and

other stakeholders on effective strategies to adopt to achieve quality health care to sustain the NHIS in the country.

In addition, prospective researchers and or students can use it as secondary data and part of their literature review.



## 1.7 Scope and Limitations of the Study

The research was mainly based on the roles of service providers and field agents in the sustainability of NHIS in the Kintampo Municipality. Among the limitations of the study are the following.

First, getting the consent from study participants (thus, the field agents) was a hell of problem as most of them have low level of education and did not understand why such information was request from them. Furthermore, data collection started during the raining season which contributed to difficulty in accessing respondents and reduced the pace of field work. In addition, recall of the questionnaire was a little bit tough as most of the heads of health institutions used to travel. Another problem was access to the communities. Getting means of transport was difficult as most of the roads linking these communities were in a bad shape. Finally, the financial cost influenced the decision to sample a small number.

## 1.8 Organization of the Study

The study is made up of five chapters. Chapter one deals with the background to the study, the concepts of health insurance, statement of the problem, objectives of the study, overview of the research methodology, significance of the study, limitation of the study, and lastly the organization of the study.

Chapter two focuses on the review of related literature on concepts and theories and also other authors' work considered relevant to the study. It consists of theoretical framework of the study and empirical basis of the study.

Chapter three deals with the methodology of the study. This chapter describes the Research Design, Sampling procedures or techniques, Data tools and procedures, data analysis or presentation procedure.

Chapter four deals with the discussions of results.

Finally, the summary of the findings, conclusions and recommendations of the study are presented in the fifth chapter.

# CHAPTER TWO

# REVIEW OF LITERATURE

There is a major problem of extensive literature on the National Health Insurance Scheme. However, the few that have been written by various authors have dilated extensively on the origin and baseline implementation of National Health Insurance Scheme.



This chapter is aimed at reviewing some of the research works done by researchers, educationists, organizations and committees. It looks at the overview of health insurance, universal financial protection-obstacles to implementation, characteristics of health information system in Ghana, health insurance in Kintampo Municipality, factors influencing membership, health insurance coverage and problems in the health insurance market.

## 2.1 Overview of Health Insurance

Scarce economic resources, low or modest economic growth, constraints on the public sector and low organizational capacity explain why the design of adequate health financing systems in developing countries, especially the low income ones, remains cumbersome and the subject of significant debate. Earlier on, cost-recovery for health care via user fees was established in many developing countries usually as a response to severe constraints on government finance. However, most studies alert decision-makers to the negative effects of user fees on the demand for care, especially that of the poorest households. Alternative health financing systems exist, de-linking utilization from direct

payment, and thereby protecting the population, especially the most vulnerable groups, from having to resort to various coping mechanisms. Financing is based either on general tax revenues and/or social health insurance contributions. Risk-pooling is a core characteristic of these systems, enabling health services to be provided according to people's need rather than to their individual capacity to pay for health services. A tax funded health system may not be easy to develop, due to the lack of a robust tax base and a low institutional capacity to collect taxes and weak tax compliance. Social health insurance has traditionally started by insuring workers. A further nationally organized expansion of social health insurance to the self-employed and non-formal sector is especially demanding. Other financing methods which would circumvent these organizational difficulties are therefore explored, including the direct involvement of communities in health financing (Carrin, 2003).

The health insurance concept is an emerging movement since majority of these schemes came into the scene in the 1990s in Sub-Sahara Africa. These health insurance schemes have taken the form of local initiatives, are small sized and community-based with voluntary membership. They have either been initiated by health facilities, local communities or cooperatives. Some of the schemes are small and only cover few beneficiaries and mostly limited to local craftsmen or traders. In some instances, some of these schemes cover a whole nation and many communities and include up to about one million or even many beneficiaries. They are mostly established outside of the formal employment sector (WHO, 2003).

In the second half of the 1980s, health insurance schemes for the first time emerged in the Democratic Republic of Congo, formerly Zaire. Again, in the 1990s health insurance schemes sprouted in countries such as Ghana, Benin, Mali and Kenya. Creese and Bennet (1997), found that the health insurance schemes in Kenya and Ghana originated from the search for new sources of financing health care by mission hospitals. The actual implementation of the few community–based health insurance schemes in Sub Saharan Africa has had mixed results. So far, the viability and acceptance of this new concept largely depends on several factors such as the design and management of the schemes, full community participation regulation at the level of the health care provider, quality of service and on the socio-economic and cultural context.



## 2.2 Universal Financial Protection: Obstacles to Implementation of Insurance Schemes

Health financing via general taxation or via social health insurance are generally recognized to be powerful methods to achieve universal coverage with adequate financial protection for all against health care costs. The universal financial protection more clearly reflects the true objective of universal coverage for health care. This system is also intended to respond to the goal of fairness in financing, in that beneficiaries are asked to pay according to their means while guaranteeing them the right to health services according to need. In tax funded systems, the population contributes indirectly via taxes, whereas in social health insurance systems, workers and enterprises generally pay via contributions based on salaries (Carrin, 2003).

Many developing countries, especially the low-income ones, experience difficulties in achieving universal financial protection due to insufficient government subventions since health systems depend on the share of government tax revenue. The latter implies that only a part of the population can be reached and that, if it is reached, the amount of health service benefits offered is generally insufficient. It is difficult to substantially expand the taxable capacity in most countries. Economic growth may indeed be too modest to enlarge the tax base in a systematic way. In addition, taxes are still heavily dependent on international trade and domestic consumption, with income and asset taxes being very weak. The latter could potentially be increased but only when there exists greater acceptance of the principle of taxation according to ability to pay, and of sufficient compliance among income earners and asset holders (WHO, 2003).

Another challenge militating against health insurance scheme is the difficulty to swiftly move to social health insurance. It may be particularly difficult to arrive at a nation-wide consensus between various partners to accept the basic rule of social health insurance. Thus, guaranteeing similar health service benefits to those with similar health care needs, regardless of the level of contributions that were made. In fact, this problem may be acute in countries with significant income and asset inequality (WHO, 2003).

In addition, governments may not yet have the necessary managerial apparatus to organize a nation-wide social health insurance system. Often this problem is compounded by communication problems, such as lack of adequate roads, telecommunications and banking facilities that would inhibit a social health insurance scheme to collect

contributions and organize reimbursements, to manage revenues and assets and to monitor the necessary health and financial information.

Applicable to both tax funded and social health insurance financing, there is the factor of poor political stability, usually linked to economic insecurity that interferes with a steady development of the health sector. Indeed, implementation of increased taxes for social development or of a social health insurance policy will be prohibited or severely delayed if there is no strong and steady political support (Carrin, 2003).

The impediments to universal financial protection are recognized by most countries. This is perhaps why there has been an increasing interest in financing based at the community level, where it is thought to be easier to identify the contributing population and to collect contributions (Carrin, 2003).

Community financing for health is referred to as a mechanism whereby households in a community (the population in a village, district or other geographical area, or a social-economic or ethnic population group) finance or co-finance the current and/or capital costs associated with a given set of health services, thereby also having some involvement in the management of the community financing scheme and organization of health services (Guy, 2003).

**2.3 Characteristics of Health Information System in Ghana**

The health sector information system focuses largely on routine activities which provide information necessary for reviewing and managing operational policies within each management unit. Information is collected on input, process, output, outcome and impact

of services through routine and sentinel reporting systems. Information on clinical care and public health services measure output, outcome and impact of curative, preventive and promotional services. The focus is on demographic data, diseases and health status and service utilization information in priority areas. Financial management information measures the financial input into the health system. It provides basic accounting information to enable the measurement of costs in delivering the service package and other essential non-clinical activities. Accountability and efficiency is the main motive behind reporting in this area. Human resource information provides an understanding of staffing patterns, movement and training requirements for effective delivery of services. The integrated payroll and personnel data system contains information on labour mix at each level and relates this to the human resource standards for health service delivery. Information on drugs and logistics management measures utilisation and stock management information including data for assessing rational use of medicines. The other components of the logistics information system provide information on infrastructure, equipment and other capital inputs and allow for planning and budgeting for maintenance and replacement (Carrin, 2003).

Information in the health sector is organised along these components for each level and for each Budget and Management Centre. However for the purposes of reporting, a minimum set of indicators, the Sector-wide Indicators, have been identified and formats for reporting have been introduced to enable data to be submitted to higher levels. Within each Budget and Management Centre data collection and information organization is based on information demands appropriate for each level (Ministry of Health, 2007).

The Health Services in Ghana is organised at five levels namely community, sub-district, district, regional and national levels. Services provided at the community, sub-district and district levels constitute primary health services delivered in the context of a district health system. Services to communities are delivered through outreach programmes from the sub-districts and through the Community Based Health Planning and Services programme. Other services available to the communities are those offered by traditional birth attendants, chemical sellers and itinerant herbalists.



The sub-district level provides clinical, public health and maternity services through the sub-district management team. This team is required to forge a close partnership with the communities through community institutions, community based health workers and other health related institutions in their catchment area. The Sub-district health team is responsible for the overall planning, monitoring and evaluation of services as well as ensuring quality of services within the sub-district. The planning responsibility of the sub-district health team requires that they have access to information on health needs, service delivery, coverage and resource availability (Ministry of Health, 2007).

The district level is responsible for operational planning and programme implementation and is organised under clinical, public health and administrative units. Clinical services are provided by the hospitals in the district while public health activities are managed by the district health management team which is also responsible for planning, organizing, monitoring and evaluation of the package of services at the district level.

At the district level health status information is an aggregation of service outputs of all the service delivery structures at the sub-district level, the district hospitals and other

private providers. District specific information on financial, human resource, drugs and supplies, estate, transport and equipment is generated at this level. Some districts have research centers that produce significant non-routine information on the district health services.

The Region is responsible for strategic planning and it monitors performance of district and regional hospitals. Its main role is that of advisory and the provision of technical support. The current structure of the regional health administration includes the Public Health Unit, Clinical Care Unit and the Regional Health Administration Unit. Some regions have additional structures including training and diagnostic facilities (Ministry of Health, 2007).

The regional health administration assesses needs, analyses trends, provides in-service training and offers technical support to districts. Supervision, monitoring and conducting operational research on key problems are also part of the main responsibilities of regions. Information management at the regional level is centred around the two primary sources of information namely the districts and the regional hospitals. Data collected at this level facilitates the assessment of performance of these management units and provides scope for assessing trends and doing comparative analysis (Ministry of Health, 2007).

At the national level, information requires more in-depth analysis to enable the development of policies and standards for health care delivery. Again, it is at this level that outcome and impact of policy is determined indicating the need for a much wider scope of information analysis. The Regions and other tertiary facilities are the primary sources of information at the national level. The Ministry of Health in focusing on sector-

wide policy formulation, monitoring and evaluation also uses information from other sectors to enable it play its role in initiating legislation and promoting inter-sectoral collaboration in support of health objectives (Ministry of Health, 2007).

## 2.4 Concept of Sustainability

Sustainability in health insurance is the ability of all the stakeholders to make the health insurance viable and operational for a long period of time without collapsing, thus, ensuring perpetual existence of health insurance by all the stakeholders. Health insurance schemes cannot be implemented in isolation. The success of their implementation depends on factors like affordability, unit of enrolment, distance, timing, quality and trust (Carrin, 2003).

### 2.4.1 Affordability of Contributions

Not unexpectedly given the voluntary character of Community-Based Health Insurance (CHIs), affordability of premiums or contributions is often mentioned as one of the main determinants of membership. A number of schemes in the WHO Study had addressed the issue of affordability. For instance in the Nkoranza scheme in Ghana, the estimated cost of contributions varied from 5 to 10% of annual household budgets. It was recognized that such contributions could be a financial obstacle to membership. Contributions are also generally levied as flat sums, which is a disadvantage for the poorest: flat contributions are regressive, a flat-rate contribution as a percentage of income being higher for poor than for the non-poor (Carrin, 2003).

In the Rwandan Project Study, membership varied from 5.6% to 7.7% in the lowest and highest income category, respectively; yet, this difference was found not to be statistically significant. One indication though in this study that affordability matters, is that large households with more than five members had a greater probability to enroll in the CHIs than others. The explanation given is that contributions were kept flat, irrespective of household size up to seven members; the average contribution per household member was therefore less than for smaller families, inducing greater enrolment (Carrin, 2003).



In the Thiès Study, income appeared to be a significant factor in explaining enrolment. Belonging to lower and upper income terziles decreased and increased enrolment, respectively. When households classified themselves into poor and non-poor, it also appeared that the self-reported poor had a lower probability to join CHIs than the higher income households (WHO, 2003).

Related to policies to increase access of the poor to CHI, most schemes can be qualified as deficient. One way to increase insurance membership for poor households is to introduce exemptions. Yet, only a minority (13) of the 44 schemes surveyed in the WHO Study had exemption policies to allow the poor households to join. In one of the three districts in the Rwandan Project, attention was paid to this particular issue: in Kabutare, the local church paid for the contributions of about 3,000 orphans and widows with their family members (WHO, 2003).

One scheme that from the start introduced a pro-poor policy is the Gonosasthya Kendra (GK) Scheme in Bangladesh that differentiates contributions according to one of four

socio-economic groups (the 'destitute', 'poor', 'middle-class' and 'rich'). For instance, contributions for the destitute were 10% of the contribution proposed to the highest income category. Renewal contributions and user fees for consultations and medicine, and caesarian section were also differentiated: the poorest categories pay the smallest co-payment or face no charge as in the case of medicine. Overall affordability was an important concern to the GK Scheme. That is why contributions and other payments by households were minimized by using subsidies transferred to the scheme either from GK's own commercial ventures or from international sources. An important finding is that the membership rates among the two lowest socio-economic groups are substantially higher than in the other groups. However, after 15 years of operation of the GK scheme, 20% of the 'destitute' group and more than half of the 'poor' group had still not been reached. The contribution levels and other payments are still said to be too excessive especially for the 'poor' as well as the lower middle income group of the 'middle class' (Carrin, 2003).



### 2.4.2 Unit of Enrolment

Achieving adequate membership rates is likely to be easier when households or even villages, cooperatives or mutual benefit societies are taken as the basis of membership. In the WHO Study, almost half of the schemes surveyed had the family as the unit of membership. A number of schemes had actually switched to this type of membership, after experiencing problems of adverse selection, as a result of families signing up ill family members or family members most prone to consume health care (WHO, 2003).

Some schemes went beyond establishing the family as the unit of membership, and defined that a minimum percentage of households in a village would be required before providing insurance. In the Kasturba Hospital scheme in India, at least 75% of poor households in a village are required to sign up. When the Vietnam Health Insurance programme launched its voluntary health insurance programme for schoolchildren, it recommended insuring adequate numbers of children, via establishing a minimum of 50% per class. In Uganda, some CHIs are linked to Engozi (mutual benefit) societies; recently a rule was initiated whereby at least 60% of the members of the Engozi societies should sign up before acceptance by the CHIs (Carrin, 2003). Some schemes like the Grameen Health Plan in Bangladesh benefit from a captive market: the great majority of insured households gain membership automatically via an initial participation in the Grameen Bank credit programme. The same is true for the UMASIDA health insurance scheme: members are automatically insured, with health insurance contributions being deducted from the overall revenues of the participating organizations (Carrin, 2003).



### 2.4.3 Distance

Membership rates are often determined by the distance of the household's home from the nearest health facility where (insured) services are provided. For instance, in the GK scheme, membership among the two lowest socio-economic groups appeared to be related to distance: up to 90% of that target population from nearby villages subscribed, whereas only 35% did so for the target population in the distant villages. In the Rwandan Project Study, it was also found that households who lived less than 30 minutes from the

participating health facility had a much larger probability to enroll in the CHIs than those who lived farther away (WHO, 2003).

### 2.4.4 Timing of Collection of Contribution

The timing of collecting the contributions may matter for membership, although little empirical evidence is available. From the WHO Study, it was observed that schemes in urban areas were more inclined to establish monthly or quarterly contributions so as to match the income patterns of urban informal sector workers. Annual contributions seem to be prevalent among schemes in rural areas. However, in some schemes, such as the ORT scheme, payment schedules were held flexible, with monthly, quarterly or semi-annual payments. Flexibility was introduced as it was judged that few households were able to pre-pay for a one year or even six-month membership.

Other schemes link the time of payment of the contribution with a suitable event in the community. For instance, burial societies in Uganda (the above mentioned engozi societies) use their monthly meetings for the collection of premiums, either for the first-time members or for those who renew their membership. In Bwamanda, the nurse of the community based health centers collects the annual contribution at the time when Bwamanda's development cooperative, the Centre de Développement Intégré (CDI), purchases the cash crops from the population. In the GK scheme, a similar situation is observed as premiums are paid to the community nurse during home-visits. And in the Grameen Health Plan, the contribution is collected from the accounts that members have in the Grameen Bank micro-credit scheme (WHO, 2003).

### 2.4.5 Quality of Health Care

The quality of care offered through the CHI is another factor to be considered. The latter was highlighted in an evaluation of the Maliando scheme in Guinea-Conakry. Focus group discussions were organized with 137 persons sampled from the member and non-member population. In the 12 discussions that were held, quality of care was mentioned 383 times by participants as an important factor in the population's attitude towards this particular scheme. Most of the time, participants referred to rapid recovery, good health personnel, good drugs and a nice welcome at the participating health facilities as the most important features of quality. When membership was discussed specifically, lack of quality of care was cited as the most important cause of non-enrolment (WHO, 2003).

Several participants in the above mentioned focus group discussions said they would prefer not to enroll but rather seek care elsewhere (and admittedly paying more) in order to receive better quality care. Health care at private health facilities could thus well be preferred to health care offered by the public health facilities associated with the Maliando scheme (WHO, 2003).

Knowledge and attitudes towards the CHI scheme in Hanang District, Tanzania, were also accessed via focus group discussions with members and non-members. In addition, exit interviews were held at participating facilities and one non-participating facility. The issue of quality was also raised in the discussions and exit interviews. One of the reasons for non-membership invoked was the fact that members did not have access to better quality care at mission health facilities. As yet, only health care in public health facilities was part of the health insurance benefit package (WHO, 2003).

### 2.4.6 Trust

The existence of entry-points in the community, such as a micro-credit scheme, a development cooperative or other social groups, may facilitate the establishment of CHI. If such existing initiatives have won the population's trust, it may become easier to start up a CHIs. Information from some selected schemes is worth mentioning. For instance, initiated by the Catholic mission in Bwamanda, the development cooperative in Bwamanda (CDI) started as an integrated development project at the end of the 1960s. Primary and secondary schools, which were already run by the same mission, were integrated in the CDI project. The CDI gradually improved agricultural activities in the area: it introduced soya as a new crop aside from existing cash crops, such as coffee, and organised the purchase of produce at guaranteed prices. This resulted in fairly stable economic conditions in the Bwamanda region throughout the 1970s and 1980s which has enhanced the capacity and willingness of the population to enroll in the Bwamanda Scheme initiated by the CDI (WHO, 2003).

A simultaneous introduction of a development initiative can also be beneficial for CHIs. When people notice their economic situation improves, trust is created resulting in a possibly greater response to CHIs. The GK health scheme, for instance, was embedded into a broader development project. In fact, the initiators realized that a comprehensive approach to development and uplift of the rural population, and particularly of girls and women, was the only sustainable way to improve the health situation in the region. Several socio-economic activities were thus gradually developed and female education and employment was promoted wherever possible, through micro-credit and through employment in traditionally male occupations (WHO, 2003).

Some credit schemes were entry-points for CHIs. The Grameen Bank, for instance, showed interest in promoting health insurance, among others, to reduce default in credit reimbursement; the reasoning was that insured credit scheme members would be protected from major financial loss due to illness, so that they would be able to respect credit reimbursement schedules. A similar reason was invoked by the SEWA scheme before they established their health insurance scheme. Of course, as low-income groups basically constituted the membership of these credit schemes, health insurance was also seen to greatly benefit these groups by avoiding or reducing catastrophic expenditure.

Finally, trust can be enhanced when people see that their preferences matter. For example, in Rwanda, the Government has shown stewardship by stimulating improved democratic governance in the health sector; the CHIs are therefore invited to engage in transparent and participatory decision-making. Every scheme has now a general assembly, where members are able to interact with the scheme's administrative council about needs, concerns, suggestions for improvements etc. This interaction with the local communities also appeared to have a positive effect upon discussions and decisions concerning health at the district level.

The expectation is also that community participation will enhance community understanding of the proposed functioning of the CHIs and compliance with payment of membership dues. When the scheme administrators tend to be responsive to the community's preference, people's overall satisfaction with the community scheme's services is likely to increase. One example of response to a community preference is that of the Pikine primary health care project in Senegal: the community representatives

preferred wind or sun shelters in waiting places at health centres, rather than to buy more refrigerators or to give monetary incentives to heath volunteers. Also note that in the ILO Study, out of 100 schemes with information, 57 schemes included participation of the community related to the benefit package. And in 51 schemes out of 104 with information, the community was a partner in discussing the level of the premiums (WHO, 2003).



**2.5 Health Insurance Coverage**

Most health insurance schemes in Africa which covered people in the informal sector begun with low enrolment rates at the beginning of their implementation but record encouraging enrolment rates with time. An extensive WHO review was made in 1998 concerning 82 nonprofit health insurance schemes for people outside the formal sector employment in developing countries. However, according to Bennet S. Creese A. and Monasch R. (1998) very few of these schemes covered large populations or did not even cover high proportions of the eligible populations. From a subset of 44 of these schemes the median value of the percentage of the eligible population covered was 24.9%, 13 schemes had a coverage rate below 15% and 12 schemes had a coverage rate above 50%. It was realized that adverse selection was more affecting the schemes that insured against high cost low frequency events than schemes that covered low cost, high frequency events. One of the main reasons was that many people tended to sign up with the community health insurance schemes at the moment of illness.

In one health insurance scheme in Ghana and Mali, it was found out that 53% and 25% of the target population of 25,000 and 200,000 was covered respectively. In Senegal, one

health insurance scheme recorded a coverage rate of 26% after three years of operation. In the Maliando Health Organization in Guinea, subscription of membership dropped from 8% to 6% of the target population (Criel, 1998). Musau (1999) observed low percentage enrolment rates in a study on five community-based health insurance schemes in Eastern and Southern Africa. In other four schemes, percentage varied between 0.3% to 6.5% of the target population. According to Schneider et al (2001), a project was launched in Rwanda, establishing 54 schemes in three districts in July 1999. By the end of the first year of operation the enrolment rate reached in the three districts was 7.9% (88,303 members out of a total target population of 1,115,509).

All these experiences have supported the fact that quite often membership rates may be too low in the beginning but might increase as schemes improve management and design.

**2.6 Problems in the Health Insurance Market**

One particular problem of insurance market is covariant risk. This means that a person's risk of needing care is not independent of his or her neighbours' health. This is because the risks of falling ill are correlated especially in cases where natural disasters or epidemics hit a geographical area. This can present the problem of depletion of resources of insurance schemes (Jutting, 2002).

For instance, a malaria epidemic in South Western Uganda cost the Kisiizi Hospital Health Society around 8.5 million Ugandan Shillings (about $6,500) between January and December, 1998, about 64% of treatment expenditures were covered by the schemes revenue. Again, moral hazard behaviours of the insured present a potential threat to the financial sustainability of schemes. This will occur when insured members abuse the use

of health facilities than they would have under user fee system. Experience from studies in other areas have shown that to prevent insurance market failures due to adverse selection people should be made to join schemes as groups so as to ensure that both healthy and sick people are enrolled (Jutting, 2002).

### 2.7 Health Insurance in Kintampo Municipality

The Kintampo Municipal Mutual Health Insurance Scheme (KMMHIS) is one of the well established 19 District-wide Mutual Health Insurance Schemes in the Brong Ahafo Region of Ghana. The Scheme was established in response to the Government's determination to make healthcare delivery affordable and accessible to all residents of Ghana through the establishment of a District-wide Mutual Health Insurance Scheme in the year, 2004.

The Scheme held its maiden General Assembly on the 7th October 2004, to promulgate and adopt its constitution and Bye-Laws, to appoint the Board of Directors and to set Premium and Registration fees, among other things. Though a new district was calved out of the Municipality in 2004, the Scheme's activities were managed together until 1st March, 2006, when the Scheme was split.

The Scheme registered with the Registrar General Department as a Company Limited by guarantee as required by the Act (Act 650) and the Legislative Instrument (LI1809). It has secured the appropriate certificates such as the certificate of incorporation and the certificate to Commence Business with registration number G15, 574.

The Scheme's administrative office is located on the P & T road, in-between the Community Centre and the Municipal Hospital, and directly adjacent to the Pensioners Office.

The Scheme had a well established structure as set-out in the National Health Insurance Policy Guideline. Among such structures included the General Assembly, the Board of Directors, Management Staff and Community Committees. The General Assembly was the highest decision making body of the Scheme. The General Assembly was the representatives of all registered clients in each community in the Municipality.

The Scheme was governed by fifteen (15) - member Board of Directors. They were automatic members of the General Assembly. The Board is dissolved and in its place a four-member Care-Taker Committee constituted to direct the affairs of the Scheme until a new board is formed (KMMHIS, 2010).

# CHAPTER THREE

# METHODOLOGY

## 3.0 Introduction

This chapter deals with the method used for the data collection. It describes the study area, the scope of the study, sampling and sampling procedure, the administration of data and data collection instruments.



## 3.1. Study Design and Methods

The study used descriptive and cross-sectional and also employed both qualitative and quantitative methods for data collection. The qualitative methods included the use of in-depth interviews with field workers and workers of health insurance and focus group discussions with caregivers. The quantitative part involved the use of structured questionnaires on heads of institutions. Most of the questionnaires were self-administered.

The face to face interviewing method was used to collect data from respondents who could not complete the questionnaire themselves. This was to ensure that respondents understood the questions and were thus providing the type of information needed for the study. Appointments were booked with the heads of departments, Scheme Manager and other staff members of the scheme.

These design and methods were employed because the researcher wanted to have accurate and authentic information for his work. Again, the researcher wanted a fair representation of the respondents. The design and the methods enabled the researcher finish his work on schedule because right people were contacted for the information. The

complete enumeration done on all the heads of health institutions enabled the researcher obtained relevant and first hand information for his work.

### 3.2 Scope of the Study

Geographically, the study was carried out in all the health facilities in the sub districts in the Kintampo Municipality. The main focus was to assess the role played by the health facilities and field agents in the sustainability of health insurance in Kintampo Municipality.



### 3.3 Study Population

The study population included 108 health workers, 12 heads of health institutions, 90 scheme workers and field agents; all totaling 210.

**Table 3.1 Study Population**

| **Category** | **No** |
|---|---|
| Health Workers | 108 |
| Heads of Health Institutions | 12 |
| Scheme Workers | 20 |
| Field Agents | 70 |
| **Total** | **210** |

Source: Field Survey, May, 2011

### 3.4 Sampling Method and Sampling Size

A combination of sampling techniques was employed in selecting the study districts, health facilities and participants. The district was clustered into 10 sub-districts based on the MHMT's demarcation. All the sub-districts were selected for the study.

For the selection of field agents, the study used the Kintampo Health Research Centre's Demographic Surveillance Systems data on all the field agents in the Municipality. The respondents were then selected using random numbers.

Purposive sampling method was employed to select the health staff and scheme workers on the assumption that they have adequate knowledge on the topic under investigation, whiles complete enumeration was done on the heads of institutions.

Ten focus group discussions were also conducted with caregivers in all the sub-districts, one each in a sub-district. In all, the sampling size stood at forty (40) out of the two hundred and ten (210) study population.

**Table 3.2 Sampling Size and Data Collection Techniques**

| **Category** | **Sampling Size** | **Method of Data Collection** |
|---|---|---|
| Health Workers | 13 | Face to face interview, focus group discussion |
| Heads of Health Institutions | 12 | Questionnaires |
| Scheme Workers | 5 | Face to face interview |
| Field Agents | 10 | Face to face interview |
| **Total** | **40** | |

Source: Field Survey, May, 2011

### 3.5 Data Collection Techniques and Tools

Prior to field work, two research assistants were trained on the rudiments of research. At the training, the objectives of the study were explained and information on data collection translated to the local dialect. Focus groups discussions were held with caregivers while in-depth interviews were held with health workers, scheme workers and field agents. Besides, structured questionnaires were also administered on all the heads of health institutions. The questionnaire administered were both opened and closed structured.



### 3.6 Pretesting of Study Instruments

Pre-testing of data collection tools was done in two health facilities, one government and the other private, and two field agents. The pretesting exercise involved the principal investigator and two other field supervisors. A day was used to complete the pre-test. The experiences from the pre-testing were incorporated into finalizing on the data collection tools.

### 3.7 Ethical Consideration

Consent was sought from the Municipal Health Management Team (MHMT), the management of health insurance scheme and the Municipal Health Directorate, as well as study participants. Confidentiality of respondents was assured. The study was expected to pose no physical or psychological harm to the study participants.

### 3.8 Data Handling

The field work was scheduled to be completed in twelve weeks. Two field assistants were employed to assist in the fieldwork. Data collection was done in five days. Forms

collection was done by the two field assistants during supervisory visits. During the period, a lot of support was given to the field assistants on data collection. Sorting was done to ensure quality control of data. Other quality control measures were checks for completeness, internal consistency and accuracy of data processing (categorizing and coding of data). Data was double entered by two data entry clerks.

### 3.9 Data Analysis Technique

Data analysis started soon after data collection completed. The analysis was done by the principal investigator with the help of the two field assistants at the Kintampo Water Supply Office.

The data were organized into tables and charts based on the questionnaire given to respondents. The results were then analyzed and converted into percentages and other charts. Quantitative and qualitative methods were employed in the analysis of the data. The result was subsequently computed into percentages. Diagrammatic representations of the statistical summaries of the result were presented in the form of pie charts and frequency tables.

Computer data analysis such as Microsoft word and other relevant software such as Microsoft excel were the main tools employed to analyze the data in order to help interpreted results. This package was used to compute the percentages because it is easier to use. It can also be used to make tables needed for discussions of the results. Also Ms Excel was used to draw the graphs for the computed data. This was used by the researcher because of the ease in using Ms excel for this purpose over the other software. The other questions that were open-ended were analyzed by listing all the vital responses

given by the respondents. They were then considered based on their relevance to the research. The reason for using tables and charts is to have pictorial presentation of the data results.

### 3.10 Validity and Reliability of the Research

The validity and reliability of the data can be proven beyond all reasonable doubt due to the fact that, the source of information was traced from the grass root level of the research area. Also, a lot of research methods were employed to obtain pieces of information written down: interviews, questionnaire, observation and the literature review were also used to confirm some of the responses to test their validity.

### 3.11 Profile of the Study Area

The profile comprises the following: the geographical location and size, population growth and spatial distribution, climate and vegetation, relief and drainage, major economic activities, transportation system, telecommunication, ethnicity and religion, health service delivery, common diseases in the district and issues of public health importance.

#### 3.11.1 Geographical Location and Size

The then Kintampo District was established in 1988 under LI 1480. However, in 2004 the Kintampo South District was carved out from it, and it was renamed the Kintampo North District by Legislative Instrument of the Local government Act, Act 462, LI 1762, now Kintampo Municipal by Legislative Instrument of the Local government Act, Act 462, LI

1871. The Kintampo Municipal is one of the Twenty-two (22) Municipals/Districts in the Brong Ahafo Region (BAR) of Ghana.

It is located between latitudes 8º45'N and 7º45'N and Longitudes 1º20'W and 2°1'E and shares boundaries with five other districts in the Country:, namely; Central Gonja District to the North; Bole District to the West; East Gonja District to the North-East (all in the Northern Region); Kintampo South District to the South; and Pru District to the South-East (all in the Brong Ahafo Region). The Municipal Capital, Kintampo, is about 130KM away by road from the regional capital and lies east of the BAR Capital, Sunyani. The Municipal has a surface area of about 5,108km², thus occupying a land area of about 12.9% of the total land area of BAR (39,557km²) (MPCU, 2010).

In terms of location and size, the Municipal is strategically located at the centre of Ghana and serves as a transit point between the northern and southern sectors of the country. It is hoped that the construction of the Kunsu- Ntankro, Prang – Kintampo - Wa roads will further open and enhance vehicular traffic on these roads as well as interaction between the southern and northern parts of Ghana.

The vast nature of the Municipal (about 5,108km$^2$), with an estimated population of 111,122, gives a low density of 21.75 persons per square kilometre. The implication in terms of agriculture is that there could be abundant land for farming and other socio-economic activities. This is further buttressed by the comparatively easy acquisition of agricultural land in the area. Figures 3.1 and 3.2 depict Kintampo Municipal in the national and regional context respectively.

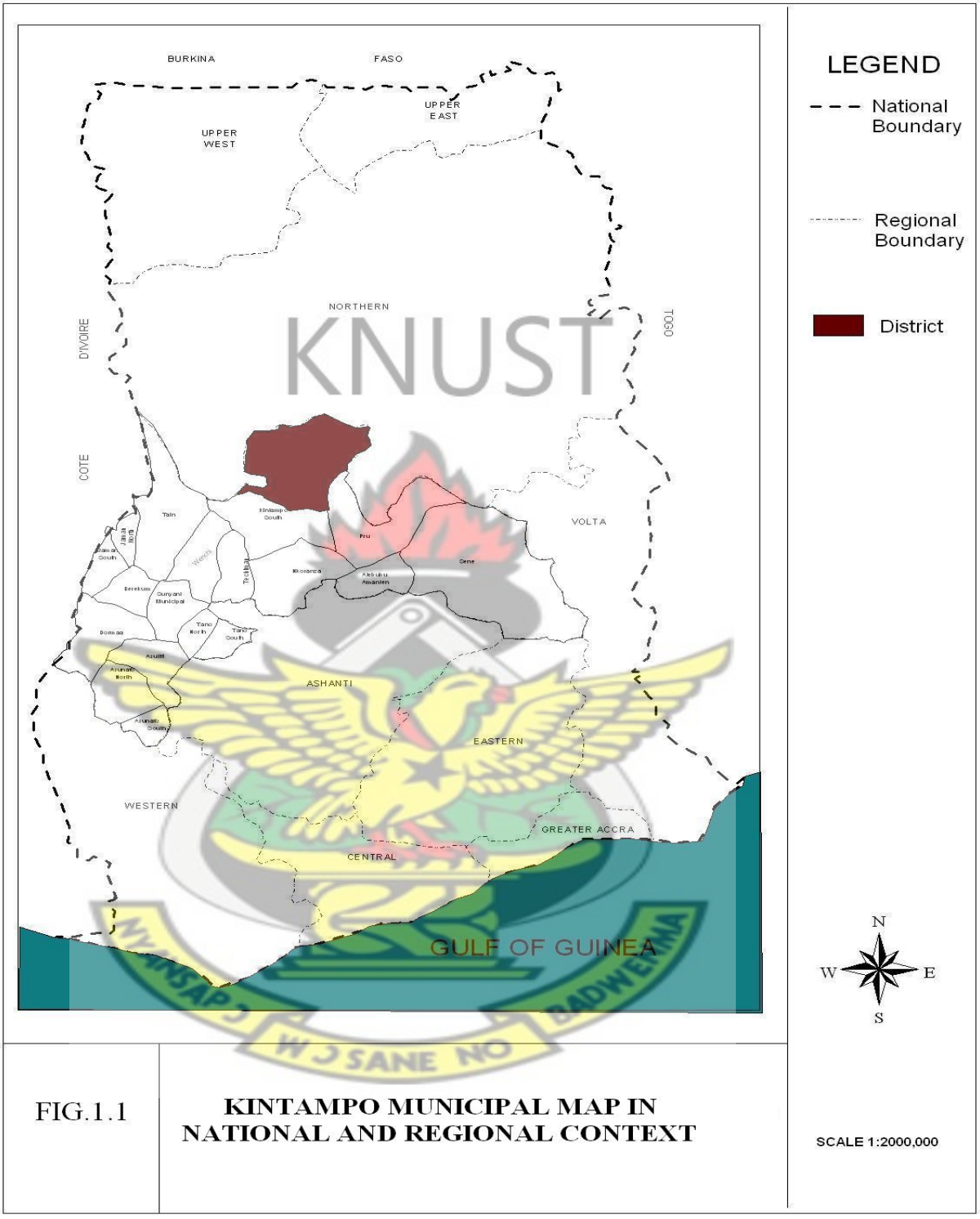


**Figure 3.1 Ghana Map Showing Kintampo Municipality (MPCU, 2010)**

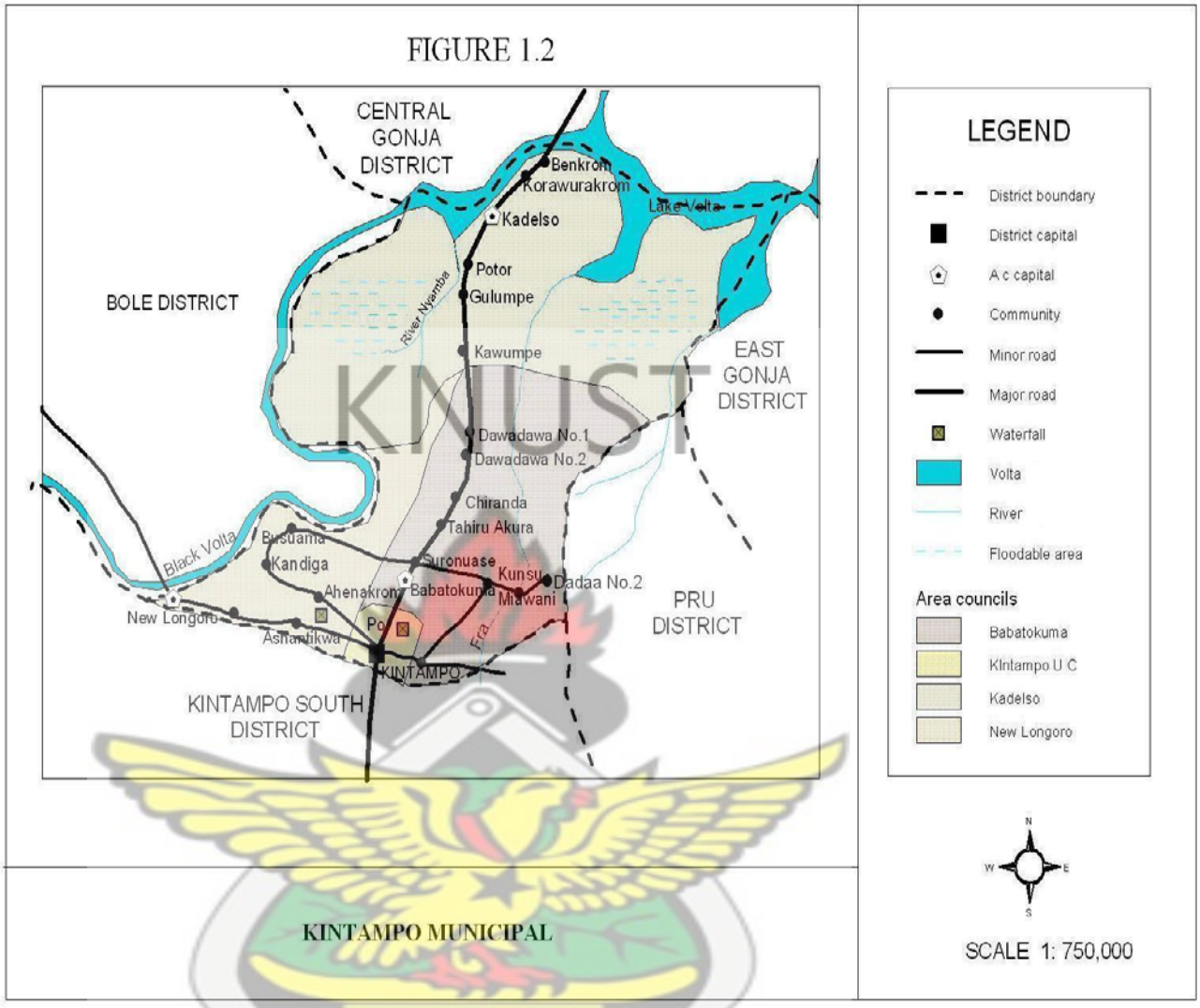


**Figure 3.2: Kintampo Municipal Map (MPCU, 2010)**

### 3.11.2 Population Growth and Spatial Distribution

Kintampo Municipal has an estimated population of 111,263 comprising 48.48% male and 51.52% female, with a growth rate of 2.6%. The area has a potential of population explosion due to the fertile nature of the land. Migrant farmers from the north move to

settle on arable lands where they can get enough farm produce. There is therefore the need to put strategic measures to manage the population in the area (MPCU, 2010).

Table 1 contains the spatial distribution of the population in the major towns in the Municipality

**Table 3.3: Distribution of Population**

| Area/Community | Sex | | |
|---|---|---|---|
| | Male | Female | Total |
| Kintampo | 17,264 | 19,462 | 36,726 |
| Babatokuma | 3,842 | 3,825 | 7,667 |
| Busuama | 1,162 | 1,205 | 2,367 |
| Dawadawa No.1 & 2 | 4,266 | 4,422 | 8,688 |
| Gulumpe | 10,763 | 11,158 | 21,921 |
| Kadelso | 4,416 | 4,575 | 8,991 |
| Kunsu | 5,976 | 6,199 | 12,175 |
| New Longoro | 2,145 | 2,228 | 4,373 |
| Portor | 4,102 | 4,253 | 8,355 |
| **TOTAL** | **53,936** | **57,327** | **111,263** |

Source: MPCU Projections, December, 2010

From table 1, it may be concluded that most of the major settlements have population over 5,000. At a glance, one may say that these settlements are urban, based on the national standard. The population figures however include other smaller settlements around these major settlements. Only Kintampo, Babatorkuma, Gulumpe and Kunsu are of urban status. These communities, except Kintampo, are more rural than urban settlements.



### 3.11.3 Climate and Vegetation

The municipal experiences the tropical continental or interior savannah type of climate, which is a modified form of the tropical continental or the wet-semi equatorial type of climate. This is due largely to the fact that the municipal is in the transitional zone between the two major climatic regions in Ghana. The mean annual rainfall is between 1,400mm-1,800mm and occurs in two seasons; from May to July and from September to October with the minor season (May – July) sometimes being obscured. However, because of the transitional nature of the area, the distinction between the two peaks is often not so marked. The mean monthly temperature ranging from 30°c in March to 24°c in August with mean annual temperatures between 26.5°c and 27.2°c. These conditions give rise to sunny conditions for most parts of the year. Relative humidity are light varying from 90%-95% in the rainy season to 75% - 80% in the dry season. The climate of the municipal has the tendency to change and be inclined more to the drier tropical continental conditions or to the wet semi-equatorial conditions (MPCU, 2010).

The municipal comes under the interior wooded savannah or tree savannah. However, owing to its transitional nature, the area does not totally exhibit typical savannah

conditions. Thus the savannah here is heavily wooded, though most of the trees are not as tall and gigantic as those in the most deciduous forest. It is believed that the transitional zone was once forested and that the savannah conditions currently prevailing have been the result of man's activities. This may be evidenced by the existence of "fringe forest" found along the banks of major rivers and streams and other areas where the impact of man's activities are minimal. Only trees such as the Mahogany, Wawa, Odum, Onyina, Boabab, Dawadawa, Acacia, and the Sheanut trees, which have adapted to this environment are found in the vegetation zone. They are few and scattered except along the margins of the moist deciduous forest where the trees often grow quite close together. Grass grows in tussocks and can reach a height of about 10 ft (MPCU, 2010).



### 3.11.4 Relief and Drainage

The Kintampo Municipal which falls within the voltain Basin and the southern plateau physiographic regions is a plain with rolling and undulating land surface with a general elevation between 60-150m above sea level. The southern voltain plateau occupying the southern part of the Municipal is characterized by series of escarpments. The municipal which falls within the voltain basin is endowed with a lot of water resources. The major water bodies include the Fra, Urukwain, and the Nyamba rivers. Others are rivers Oyoko, Pumpum and Tanfi. These water bodies flow through the west of the municipal and join the Black Volta at Buipe. The slopes through which the rivers flow have given rise to waterfalls. The major ones include the Fular Falls on the Oyoko River and the Kintampo water falls on the Pumpum River. Most of these rivers are intermittent and the

large ones like Urukwain and Pumpum fluctuate in volume. This makes them unreliable for irrigation purpose.

In terms of relief and drainage, the vast expanse of flat land especially the Northern part makes it suitable for large scale mechanized farming. Road construction and other activities are also relatively cheap. The vast water resources in the western part of the municipal could be harnessed for irrigation purposes especially rice cultivation and dry season gardening as well as domestic supply of potable water. Fishing which is already an important activity on the Black Volta can be promoted if measures are put in place to ensure sustainable operations by the fishermen (MPCU, 2010).



### 3.11.5 Major Economic Activities

The Kintampo Municipal economy can be described as purely agrarian in that almost every resident in the area is a farmer. About 71.1% of the population is engaged in agriculture and its related activities as their main economic activity. The remaining 28.9% are distributed among commerce, industry and services. Agriculture being the major economic activity constitutes the main source of household income in the area. The major food crops produced in the area are yam, maize, cowpea, cassava, rice, plantain, egushie, groundnut and beans. Cashew, mango, tomatoes, onions, water mellon, garden eggs and soya beans have potential to increase the incomes of farmers. Despite the efforts of the farmers, frequent bush-fires, high cost of inputs, inadequate extension services, prevalence of pests and diseases, in-access to credit and poor market prices and market facilities account for the low yield of farm produce in the area (MPCU, 2010).

### 3.11.6 Transportation System

There is one second class road running from the southern boundary through the district capital to the northern boundary at Central Gonja District. The roads linking the district capital and other communities in the district are of the third class category. With the onset of rains the conditions of these roads deteriorate. Various communities are however linked by foot paths. Vehicles plying between the sub-districts and the district capital are mostly old and ill-maintained. This makes accessibility to the district hospital and the other health centres and clinics a problem especially, in times of emergencies (MPCU, 2010).



### 3.11.7 Telecommunication

There are presently the Vodafone, Tigo, Mobile Telecommunication Network (MTN) and Expresso GSM networks in the area. These however cover about 60% of the Municipal area. There is also few fixed line by Ghana telecommunication available in the Municipal. Presently, there is only one Post Office in the Municipal located at Kintampo (MPCU, 2010).

### 3.11.8 Ethnicity and Religion

The ethnic composition of the municipal is heterogeneous with the Mos and Nkoranzas being the indigenous custodians of the land. There are however, a large proportion of northern tribes which forms the third force in the Municipal not forgetting other Akan tribes, Ewes, Gas and others. In terms of religion, Christians dominate, comprising 62.2% of the total population and the Muslim Community 29.6%. This may be due to

immigration of settler farmers from the north who are mostly Muslims. Traditional religion still has a place in the district and is practiced by 8.2% of the population (MPCU, 2010).

### 3.11.9 Health Services Delivery

For administrative convenience of health services delivery, the Kintampo municipal has been demarcated into 10 sub-districts. Each sub-district has a health facility that supports the provision of health care to the rural populations. Other service providers such as private midwives, private medical practitioners, chemical sellers, traditional healers, community-based surveillance volunteers and traditional birth attendants are also involved in health service provision, particularly in remote communities throughout the district. The Kintampo municipal hospital serves as the referral point for the smaller facilities in the sub-districts whilst at the same time playing the role of a teaching hospital for the Rural Health Training School located at Kintampo. There are seven government health facilities and the Kintampo municipal hospital while there are five private health facilities in the district. The Kintampo Health Research Centre also undertakes studies on micro nutrients supplementation especially VITAMIN A and other drug trials annually (KMHD, 2010).

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**Table 3.4 Distribution of Health Facilities in the Kintampo Municipality**

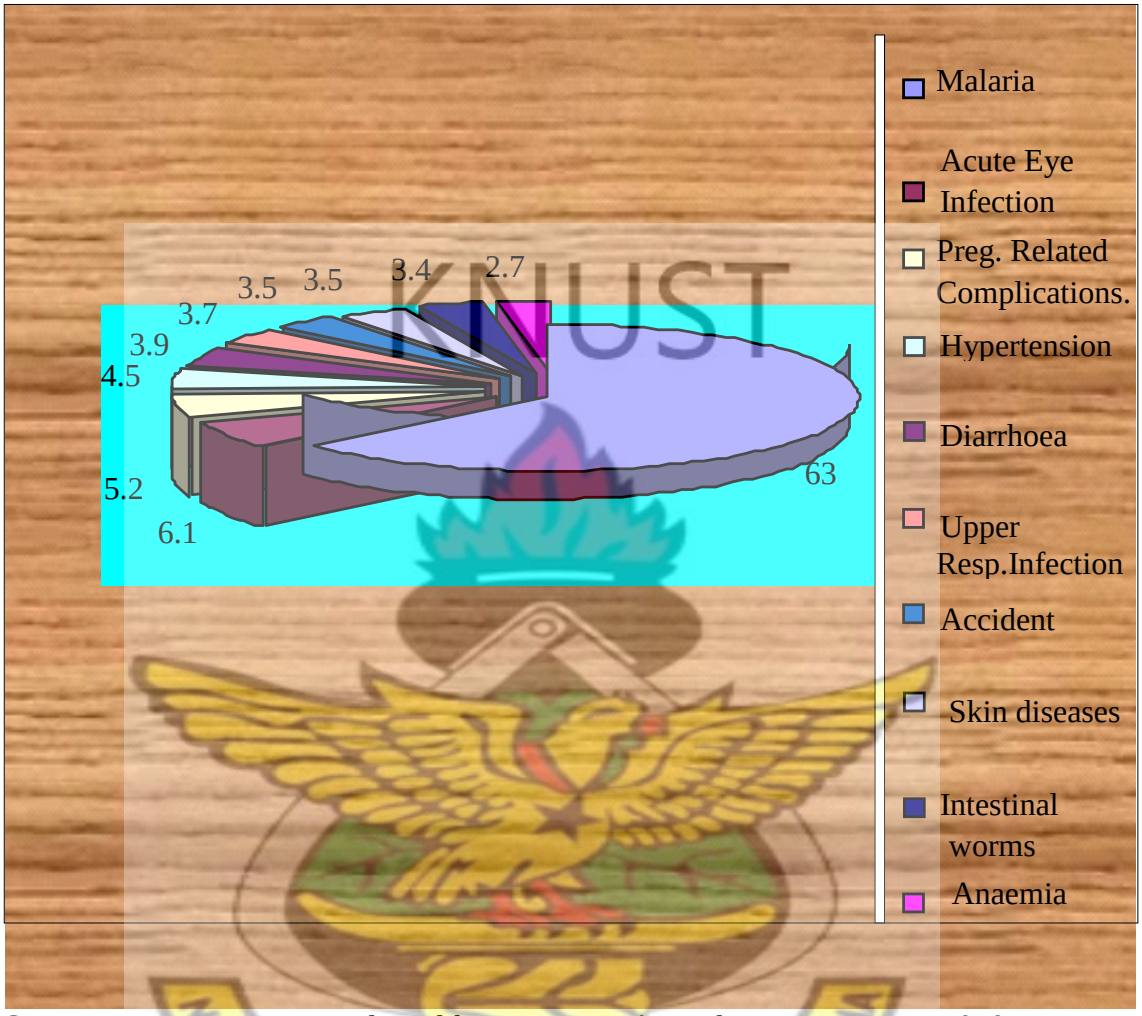
| HEALTH FACILITY | NUMBER | OWNERSHIP |
|---|---|---|
| Kintampo Municipal Hospital | 1 | Government. |
| Annor Asare Memorial Clinic | 1 | Private |
| Kintampo Dental Clinic | 1 | Government |
| Ayamba Initiative Diagnostic Centre | 1 | Private |
| Kunsu Health Centre | 1 | Government |
| Kadelso Health Centre | 1 | Government |
| Dawadawa Health Centre | 1 | Government |
| Newlongoro Health Centre | 1 | Government |
| Busuama Rural Clinic | 1 | Government |
| Prince of Peace Maternity Home | 1 | Private |
| Sunkwa Clinic | 1 | Private |
| Yuzela Hospital | 1 | Private |

Annual Review Report. KMHD, 2010

### 3.11.10 Common Diseases in the District

The District recorded a total of 72,450 OPD cases for the year 2010. The figure below shows the ten most important health problems in the district:

**Figure 3.3: Top Ten Causes of OPD Attendance in the District.**

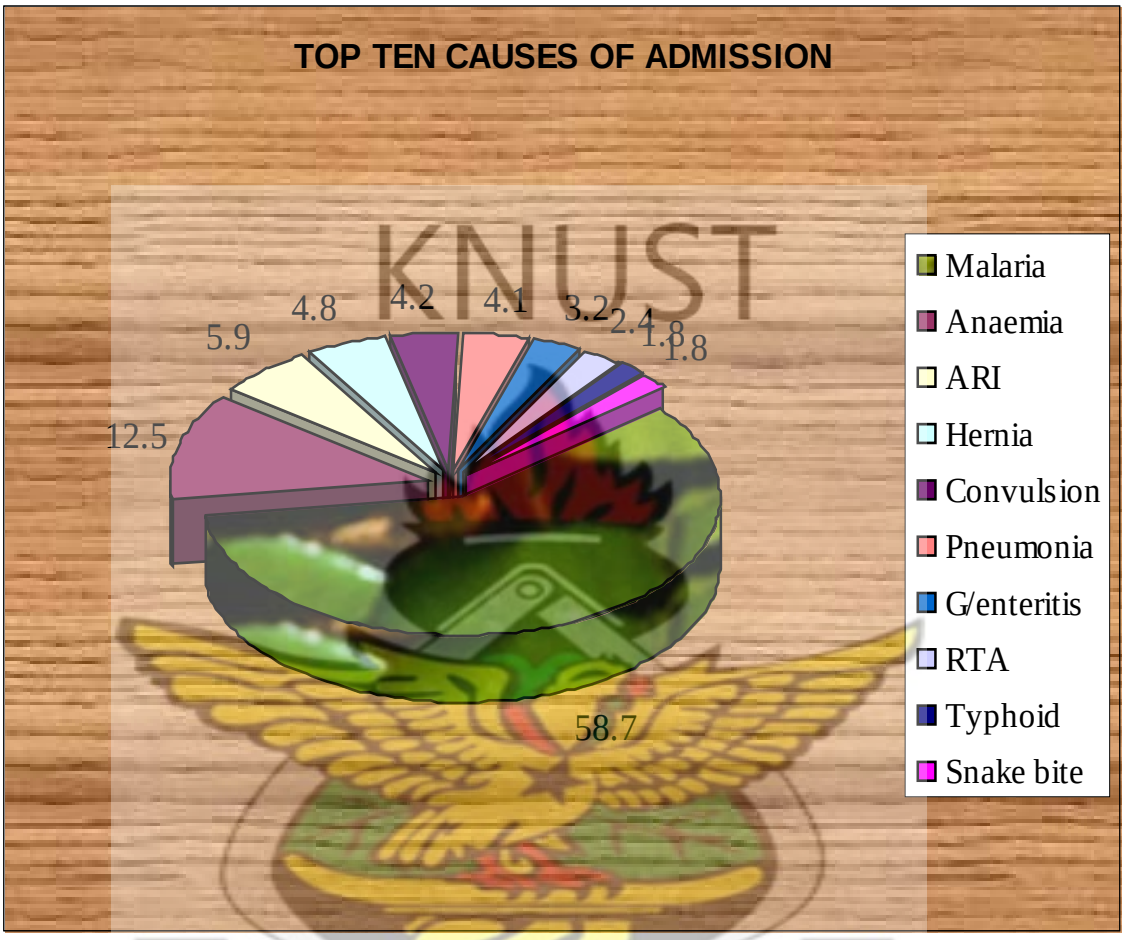



Source: Kintampo Municipal Health Directorate Annual Review Report, 2010

The data found in the figure 3.3 above implies that these diseases constitute the main causes of outpatients' attendance at the health facilities in the district.

The figure 3.4 below shows the top ten diseases of the admissions at the health facilities in the Kintampo Municipality.

**Figure 3.4: Top Ten Causes of Hospital Admissions in the Municipality.**




Source: Kintampo Municipal Health Directorate Annual Review Report, 2010

Data on the figure 3.4 above implies that these are the main diseases which will constitute the burden of health care cost for the scheme.

### 3.11.11 Issues of Public Health Importance

Over 50% of the population use streams and ponds as sources of drinking water. In addition to this, there is indiscriminate defecation and disposal of household waste.

Another problem is the large immigrant population from the Northern Region as a result of the 1994 northern conflict posing pressure on the existing health facilities. However, the hospital is not adequately equipped and staffed to take care of all these problems as well as serve as an effective referral facility for the other peripheral facilities (Annual Review Report, KMDHD, 2010).



# CHAPTER FOUR

# DISCUSSIONS OF RESULTS

## 4.0 Introduction

This chapter discusses the results of the study in the form of tables, graphs, percentages and charts. This chapter is also divided into sub-headings to throw more light on questions asked on the field.



## 4.1 Socio-Demographic Characteristics of the Respondents

The socio-demographic data of respondents were undertaken to gather information relevant to help in the analysis of the results.

The following variables constitute the socio-demographic characteristics of the study: age, sex, educational status, marital status and religion.

### 4.1.1 Age Distribution

To determine the sustainability of the scheme, the ages of the respondents would be an important input. The age is important because someone underage will not have a fair idea about the health insurance scheme. The experience that a worker acquires is linked to the number of years he/she works on the particular job. This leads to specialization and efficiency in the systems which will finally result to the sustainability of the NHIS.

**Table 4.1.1 Age of the Respondent**

| Variable | Frequency | Percent (%) |
|---|---|---|
| Below 20 years | 4 | 10 |
| 20 – 29 years | 10 | 25 |
| 30 - 39 | 16 | 40 |
| 40 - 49 | 8 | 20 |
| 50 and above | 2 | 5 |
| Total | 40 | 100.0 |

Source: Field Survey, May, 2011



As shown in table 4.1.1, 10% of the respondents were below 20 years, 25% of respondents were between 20 and 29 years while those between 30 and 39 years formed the majority of the respondents with 40%. 20% were between 40 and 49 years while the smallest group, thus, 50 and above years constituted 5% of the respondents. This means that those in the youthful age, thus, those below 40 years constituted 75% of the respondents. This signifies that they will work for a long time in the sector and therefore gain more experience in the sustainability of the health insurance scheme in the municipality.

### 4.1.2 Gender Composition

To get comprehensive view on the respondents, their gender composition was also determined. The researcher wanted a fair view of knowledge of both males and females of the topic understudy. The table below depicts the composition.

**Table 4.1.2 Gender Composition of Respondents**

| Gender | Frequency | Percent (%) |
|---|---|---|
| Male | 24 | 60 |
| Female | 16 | 40 |
| **Total** | **40** | **100** |

Source: Field Survey, May, 2011



From the table 4.1.2 above it is seen that the males represent 60% whiles their female counterparts forms 40% of the respondents. The reason was that the males form the major components of the work force of both health facilities and field agents. This implies that the males dominate in the educational sector than the females.

### 4.1.3 Educational Background of the Respondents

The educational backgrounds of the respondents were also crucial to the analysis of the data. This is because the researcher wanted to draw a sound conclusion of the study taken into consideration the educational background of the respondents. The table below shows how far the respondents have gone in terms of educational ladder.

**Table 4.1.3 Educational Background of Respondents**

| Educational level | Frequency | Percentage (%) |
|---|---|---|
| Tertiary | 16 | 40 |
| Technical/Commercial/SHS/O Level | 8 | 20 |
| Middle/JHS | 14 | 35 |
| Primary/Informal | 2 | 5 |
| **Total** | **40** | **100** |

The data portrays that, 40% of respondents had completed their tertiary education while 5% forming the minority had either primary/informal education. 20% had either technical/commercial/SHS/O Level whiles 35% had middle/JHS education. The above composition of respondents shows their ability to be able to appreciate the role of the health care providers and field agents in the sustainability of the health insurance.



### 4.1.4 Marital Status

The marital status of the respondents formed an integral part of the research. The table below shows the composition of the marital status.

**Table 4.1.4 Marital Status of the Respondents**

| Marital Status | Frequency | Percentage (%) |
|---|---|---|
| Married | 20 | 50 |
| Single | 18 | 45 |
| Divorce/Widow/Widower | 2 | 5 |
| **Total** | **40** | **100** |

Source: Field Survey, May, 2011

The marital status statistics indicates that 50% of the sampled populations were married people while only 5% were divorced/widow/widower and 45% of them were singles. This means majority of the respondents have additional responsibilities in their homes.

### 4.1.5 Religion

The religion aspect was also taken into consideration to ascertain the respondents' background in terms of their system of beliefs. This is presented in table 4.1.5 below.

**Table 4.1.5 Religion of the Respondents**

| Religion | Frequency | Percentage (%) |
|---|---|---|
| Islam | 8 | 20 |
| Christianity | 28 | 70 |
| Traditional | 2 | 5 |
| Others | 2 | 5 |
| Total | 40 | 100 |

Source: Field Survey, May, 2011

The table 4.1.5 shows that 20% of the respondents were Muslims while 70% were Christians. Those in traditional religions formed only 5% whiles another 5% constituted the respondents in other forms of religion. Because of the belief system in seeking health care by the various religious denominations, the researcher wanted a fair view on the topic understudy by taking into consideration the religion of the respondents.

### 4.2 The Role of Service Providers in Ensuring Sustainability of the Scheme

Service providers under the National Health Insurance Scheme are those who give medical treatment to insured clients when they (insured clients) fall ill.

Views from the categories of respondents were sought about the role of service providers in ensuring the sustainability of the scheme. The table below summaries the role of the service providers in ensuring the sustainability of the scheme and the respondents' stand.

**Table 4.2: The Role of Service Providers**

| Perception of the Respondents | Strongly Disagree 1 | Disagree 2 | Uncertain 3 | Agree 4 | Strongly Agree 5 | Weighted Average |
|---|---|---|---|---|---|---|
| Service providers are to authenticate the membership of the scheme before service delivery | 2<br>5% | 6<br>15% | 2<br>5% | 10<br>25% | 20<br>50% | 4 |
| Management of health care facilities are to make sure that their workers provide quality health care to the clients of the scheme | 0<br>0% | 0<br>0% | 0<br>0% | 10<br>25% | 30<br>75% | 5 |
| The health care providers are to submit accurate and genuine bills to the scheme | 0<br>0% | 1<br>2.5% | 0<br>0% | 8<br>20% | 31<br>77.5% | 5 |
| The gatekeeper system can be accurately checked at the health providers' level | 5<br>12.5% | 2<br>5% | 2<br>5% | 13<br>32.5% | 18<br>45% | 3 |

Source: Field Survey, May, 2011

A critical look at the computations in table 4.2 gives the findings below.

From the above analysis, 50% of the respondents strongly agreed to the assertion that health care providers are responsible for the authentication of the membership of the scheme before service delivery. 25% of the respondents agreed with the proposition; 15% of the respondents disagreed; 5% were uncertain whiles another 5% of the respondents strongly disagreed. The weighted average from the analysis is 4. This showed that all the respondents agreed that the health care providers are to make sure that only registered and duly qualified clients of the scheme are attended to on the ticket of health insurance to ensure sustainability of the scheme in the Kintampo Municipality. The variation in the percentages of the respondents shows their position on the role of service providers to authenticate the memberships of the clients of the scheme before service delivery.

On the issue of quality health care delivery, the responses showed that 75% strongly agree to the issue whiles 25% agree that management of health institutions are to provide quality health care to the health insurance clients to ensure trust in the system. The weighted average is 5 which show that all the respondents agree to the opinion that the management of Health Care Institutions in the Municipality is to provide health care services to all the people. Again this also affirms to the literature by WHO, 2003 that lack of quality of care was cited as the most important cause of non-enrolment in the Maliando scheme in Guinea-Conakry. The reason for the support of the idea by majority of the respondents is that if the service providers do not provide quality service to the health insurance clients, it will discourage them from registering again with the scheme; this will eventually lead to the collapse of the scheme.

77.5% of the 100% of the respondents on the issue of claims submission by health care providers strongly agreed. 20% of the respondents also agreed while 2.5% rather disagreed that health care providers are to submit claims to management of health insurance scheme. This brings the weighted average to 5. The above analysis portrays that the health care providers are to submit accurate and genuine bills to ensure sustainability of the scheme. The reason for 20% and 2.5% of the respondents' position shows that some of the respondents are of the opinion that the health care providers are not to summit their claims to the management of scheme.



Gatekeeper System: This is a process whereby the clients of health insurance scheme are encouraged to seek health care at the one closer to them (thus, primary level health care) before being referred if there is the need. On this issue the position of the respondents were as follows: 45% of the respondents strongly agreed; 32.5% agreed; 12.5% strongly disagreed whiles 5% either uncertain or disagreed to the fact that the health providers are responsible for the accurate gatekeeper system. The weighted average is 4. The information above shows that to ensure the sustainability of the scheme, the health care providers are to make sure that the gatekeeper system works accurately in the municipality. The 12.5% and 5% of the respondents are of the view that people are not to be restricted in seeking health care but rather be allowed to visit any health facility of their choice at all times.

### 4.3 The Role of Field Agents in Ensuring Sustainability of the Scheme

The field agents are workers of the insurance scheme who are stationed at the various communities. They are mostly employed from the community in which they operate and are paid on commission basis. They represent the scheme at their operational areas.

To know the extent to which the field agents contribute to the sustainability of the scheme in the municipality, the respondents' views were sought on the following roles:



**Table 4.3: The Role of Field Agents**

| Perception of the Respondents | Strongly Disagree 1 | Disagree 2 | Uncertain 3 | Agree 4 | Strongly Agree 5 | Weighted Average 6 |
|---|---|---|---|---|---|---|
| Membership registrations are done by the field agents | 0<br>0% | 2<br>5% | 0<br>0% | 8<br>20% | 30<br>75% | 5 |
| Field agents are to educate the general public on NHIS | 2<br>5% | 10<br>25% | 2<br>5% | 10<br>25% | 16<br>40% | 4 |
| Field agents are to play the role of mediation between the scheme and general public | 4<br>10% | 4<br>10% | 2<br>5% | 12<br>30% | 18<br>45% | 4 |
| Prompt payment of all monies collected | 0<br>0% | 0<br>0% | 0<br>0% | 8<br>20% | 32<br>80% | 5 |

**Source: Field Survey, May, 2011**

From Table 4.3, it is seen that 75% of the respondents strongly agreed that field agents are responsible for the registration of members into the scheme. Eight (8) of the

respondents representing 20% also agreed that membership registration is done by the field agents whiles the remaining 5% disagreed to the issue. The weighted average is 5 and this indicates that the field agents are to register members into the scheme to ensure the sustainability of the NHIS in the municipality. Some of the respondents (5%) are of the opinion that not only the field agents are responsible for the registration of clients into the scheme but rather, all the major stakeholders must be on board to achieve the sustainability of the scheme.



Table 4.3 shows that 40% of the respondents strongly agreed that the education of the general public on the National Health Insurance Scheme should be done by the field agents. 25% of the respondents also agreed whiles another 25% disagreed to the issue. 5% of the respondents were uncertain while another 5% also strongly disagreed that the education is the sole role of the field agents which brings the weighted average to be 4. From the above analysis, it is seen that even though field agents are to educate the general public on the NHIS, there are other people who are to join the education. This means all the stakeholders should be involved in the education of the general public on health insurance.

From Table 4.3 above, the position of the respondents are as follows: 45% strongly agreed, 30% agreed, 5% were uncertain whiles 10% disagreed or strongly disagreed that the field agents are to play the mediation role between the scheme and the general public. This therefore brings the weighted average to 4. From the above analysis it is seen that the field agents are to mediate between the scheme and the general public. Thus, the field agents are to liaise with the scheme to carry relevant information to their communities

where they operate. However, some of the respondents are of the view that the mediation role should not be restricted to only the field agents but all the major stakeholders.

From Table 4.3, 80% of the respondents strongly agreed that all monies collected by the field agent should be promptly paid into the scheme's accounts while 20% of the respondents also agreed to the issue which brings the weighted average to 5. This means that to ensure the sustainability of the scheme, the field agents should collect the appropriate fees from the general public and promptly paid into the scheme's accounts as none of the respondents had any divergent view.



### 4.4 Challenges that can affect the Sustainability of NHIS

The following are some of the challenges identified in the cause of the study:

There are inadequate health facilities and health personnel to cater for all the people in the municipality resulting in a lot of congestions and delay at the facilities level.

Delay in receiving reimbursement from the National Health Insurance Scheme. This affects the smooth health care delivery in the municipality.

There is political interference in the management of the health insurance scheme in the municipality. This directly and indirectly affect the performance of the staff of the scheme.

Lack of requisite logistics such as bicycles, motor bikes, revenue collection bags, calculators and many others for the field agents for the discharge of their duties. These impacts negatively on their performance.

Manual processing of claims at the scheme office. There are a lot of complications in the claims that are processed electronically, thus, slowness of the processing and unseen diagnosis that can be checked against drugs after entries have been made.

The high claims bills payment is attributable partly to high Ghana Diagnostic Related Grouping Tariffs. Thus, all related sicknesses are put under one umbrella with a fixed charge by all the health facilities concerned.



Another challenge identified in the cause of the study was delays in submission of claims by health facilities to the scheme as a lot of processes should be carried out before claims can be submitted.

Lack of motivation of health insurance staff, field agents and health facilities staffs resulting in low performance at both scheme and health facilities level. The salaries and commissions paid to all the workers at the category are not encouraging, which is resulting to high labour turnover at the municipality.

# CHAPTER FIVE

# SUMMARY, CONCLUSION AND RECOMMENDATIONS

This chapter has three sections; the first is devoted to the summary. The conclusion (major findings) is presented in the second section whiles section three deals with the recommendations to address the issues raised in the study.



## 5.1 Summary of the Study

The study was undertaken with the view of assessing the role of health service providers and the field agents in the sustainability of National Health Insurance Scheme in the Kintampo Municipality. With this aim, all the health facilities and health insurance scheme in the municipality were chosen. Samples of forty (40) out of the study population of two hundred and ten (210) were either interviewed or questionnaires send to them for appropriate data for this thesis.

For data collection, both probability and non-probability methods were employed. Under the probability method, simple random sampling was used to select health workers, field agents and workers of health insurance scheme, whilst purposive sampling was used to select the heads of health institutions.

The methods used for the analysis and interpretation of the data were frequency distribution, simple percentages, tables, diagrams and charts.

## 5.2 Conclusions (Findings)

The following are the major findings from the study:

### 5.2.1 The Role of Service Providers in Ensuring the Sustainability of the Scheme

**Membership authentication**

It was revealed from the study that for efficient and sustainability of the scheme in the Kintampo Municipality, the service providers take care of only clients with valid and active I.D Cards on the ticket of health insurance as most of the people become unaware when their cards expire. Thus, due to the nature of the cards given to the health insurance clients by the scheme, most people, especially the illiterates do not see when their membership are to be renewed.

**Provision of quality health care to the health insurance clients**

It was revealed that for members to appreciate the importance of health insurance, they should be given quality health care when they visit the health care providers with their health insurance cards.

**Submission of claims**

From the findings, it was revealed that health providers are to submit genuine and accurate claims to the management of health insurance scheme. They should also be cautious in providing fictitious claims to the scheme so that all claims that will be paid shall be the true claims. They should not condone and connive with any worker at the scheme to submit fictitious bills.

**Gatekeeper system control**

The study revealed that, the health care providers are to make sure that the health insurance clients attend the primary health care facilities like CHPS Compounds, Rural Clinics, Health Centers, Maternity Homes and Hospitals that are closer to them

before being referred to the higher facility if there is the need for that referral. If the gatekeeper system is not controlled, people will leave facilities closer to them and attend the one of their choice. Again, there will be a lot of congestions at some health facilities to the detriment of others. The management of health care facilities should educate the clients on the need to attend primary health care facilities that are closer to them.



### 5.2.2 The Role of Field Agents in Ensuring the Sustainability of the Scheme

The following roles were identified and discussed during the study:

**Membership registration**

In the cause of the study, it was also revealed that the field agents are to make sure that the members in their various communities are registered into the scheme. Since the workers of the scheme cannot be at all the communities at the same time, field agents are being recruited in every community in the municipality to register people on behalf of the scheme. This means the growth and sustainability of the scheme depend much on the field agents. This major task of the field agents should not be downplayed as it can jeopardize the sustainability of the scheme.

**Education of the general public**

The study further revealed that the field agents are also given the role of educating general public on some pertinent issues like the need to register with the health insurance scheme, where and when to register, the appropriate fee to be paid, the expiration of health insurance cards and other issues relating to health insurance. Educating clients to sustain their membership to enable them benefit anytime they are

sick and when clients agree to keep their membership the scheme sustainability is ensured.

**Mediators between the scheme and the general public**

With reference to the above, the study showed that the field agents also play the role of mediation between the scheme and the people they deal with at their various communities by submitting the members registration forms to the scheme, collecting and distributing members ID Cards to them and relay any information relevant to any of the parties. Feeding the scheme always with the problems facing clients so that the scheme could address them to enhance members' interest for joining the scheme and that will sustain the scheme.

**Prompt payment of all monies collected.**

It was also revealed that for efficient running and the sustainability of the scheme, the field agents should bank all monies collected from the general public be it processing fee, premium or reactivation fee. The field agents should be honest enough by taking the appropriate fee from the general public and desist from embezzlement of the scheme's funds.

### 5.2.3 Challenges Identified:

The following challenges were also revealed during the study:

There are delays in submission of claims by health facilities to the scheme as a lot of processes should be carried out before claims can be submitted.

There is high politicization of the scheme as some offices are closed down by some supporters of one political party after the change of government.

The field agents are not given requisite logistics in the discharge of their duties.

The health facilities are not enough to cater for all the people in the municipality which results in a lot of congestions at the facilities level.

Claims are processed manually. There are a lot of complications in the claims that are processed electronically, thus, slowness of the processing and unseen diagnosis that can be checked against drugs after entries have been made.



There are undue delays in claims payment by scheme to the health facilities. It takes at times about six months before claims bills are paid. This impede against smooth health care delivery in the district.

There is delay in receiving reinsurance funds from NHIA.

The high claims bills payment is attributable partly to high Ghana Diagnostic Related Grouping Tariffs.

There are excessive workload at both scheme and facilities level. Thus, few people are there to cater for the growing population.

Lack of motivation of health insurance staff, field agents and health facilities staffs resulting in low performance at both scheme and health facilities level.

## 5.3 Recommendations

From the study the following recommendations are made based on personal observation and those suggestions by respondents for the sustainability of the scheme.

More health facilities should be opened in the various communities to reduce the incidence of travelling long distance to access health care as a means of ensuring the sustainability of the scheme. Government and perhaps the private sector must as a matter of necessity embark on serious facility planning by making significant investments in the construction of new hospitals while expanding existing ones and providing them with basic equipments. Regardless of how much Insurance there is, if our hospitals do not have the basic equipment to accommodate the increase in numbers, then the core objective for introducing the system is defeated.

The expiring dates written at the back of the National Health Insurance Cards should be visible enough for the members to see when their cards are expiring. Since the inability of the card bearing members to be able to know that their membership cards have expired is affecting the smooth operation of the scheme. Again, it is the duty of the service providers to check that members with invalid cards are not attended to on the ticket of health insurance.

The field agents should be given requisite logistics like motor bikes, bicycles, bags and other relevant materials for the discharge of their duties. And appropriate commission should be paid to them on timely basis to motivate them to work extra hard towards the sustainability of the scheme.

There should be accurate and timely submission of claims by the health care providers. Again, for smooth and faster claims processing, all the health facilities in the district should be hooked to the national network and be made to send claims electronically.

The premium paid by the informal sector should either be increased or government sends enough money to meet the claims pay by the scheme.

To ensure sustainability of the scheme and the health facilities, funds should be released early enough by the National Health Insurance Authority. The NHIA and the various schemes must pay service providers on time for service rendered. It must be noted that the Health Insurance is still at the experimental period, and if the scheme cannot pay for services provided now that the coverage is within reasonable levels, then what will be the fate of the schemes when the saturation point is reached. The government must through the proposed legislation, require all schemes to pay 50% of claims submitted within one month and all other claims that are not disputed within two months to avoid a backlog of unpaid bills for services rendered. If this problem is not resolved, the service providers and the public at large will lose confidence in the scheme and this will affect the viability of the scheme.

The health insurance clients should not be made to suffer when they attend health facilities with their cards. This is because if clients are treated well in the name of health insurance in terms of sickness, then that will encourage them to always renew their membership and others upon hearing that will also join the scheme and by this the schemes sustainability is rest assured.

Intensive education should be carried out in the municipality about the gatekeeper system and other concepts of health insurance and health care delivery to the people of Kintampo Municipality for the sustainability of the scheme.

The operations of the scheme should be devoid of political interferences to ensure trust in the system. Since unqualified personnel may be employed on political line which in long run may lead to the collapse of the scheme.

More health personnel should be trained and posted to the district for efficient and effective health service delivery. This in the long run will lead to the sustainability of the scheme.



Regular training should be organized for the field agents to enhance the performance of their duties.

There is also need to emphasize the role of continuing education and refresher courses for all staff, especially those who have been working for many years in relative isolation in rural health centers and hospitals if acceptable standards of clinical care are to be maintained.

On the whole, the health care providers and the field agents are doing their best to ensure the sustainability of the scheme in the municipality. Therefore, all people in the municipality must have the opportunity to learn more and understand its importance. This is the only way they can support the scheme.

Finally, the people in the municipality must be made to know that they own the health insurance scheme. By so doing, they can help formulate policies that will enhance the achievement of the goals of the health insurance system and strive to work towards achieving these goals.

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## APPENDIX

THE SUSTAINABILITY OF THE NATIONAL HEALTH INSURANCE SCHEME IN THE KINTAMPO MUNICIPALITY: THE ROLE OF SERVICE PROVIDERS AND FIELD AGENTS.

The researcher is a Master of Business Administration student of the Kwame Nkrumah University of Science And Technology, Kumasi who is undertaking a research into **"The Sustainability of the National Health Insurance Scheme in the Kintampo Municipality: The Role of Service Providers and Field Agents"** for purely academic purposes. All information furnished will therefore be treated with strict confidentiality.

Kindly answer or tick [ ] one of the options to each.

5- Strongly Agree

4- Agree

3- Uncertain

2– Disagree

1 – Strongly Disagree

**Section A: Socio-Demographic Characteristics**

1. Age:

(a) Below 20 years [ ]

(b) 20 – 29 years [ ]

(c) 30 – 39 years [ ]

(d) 40 – 49 years [ ]

(e) 50 and above years [ ]

2. Gender:

(b) Male [ ]

(b) Female [ ]

3. What is your educational background?

(a) Tertiary [ ]

(b) Technical/Commercial /SHS/ 'O' Level [ ]

(c) Middle/JHS [ ]

(d) Primary school /Informal [ ]

4. Marital Status

(a) Married [ ]

(b) Single [ ]

(c) Divorce/Widow/Widower [ ]

5. Religion

(a) Islamic [ ]

(b) Christianity [ ]

(c) Traditional [ ]

(d) Others Specify [ ]



**Section B: The Role of Service Providers**

6. Service providers are to authenticate the membership of the scheme before service delivery.

1 2 3 4 5

7. Health service providers are to provide quality health care to NHIS clients.

1 2 3 4 5

8. Accurate and genuine claims submission.

1 2 3 4 5

9. Ensure the enforcement of gatekeeper system.

1 2 3 4 5



10. Are there any other roles that the health service providers are to play to ensure the sustainability of the scheme?

(a) Yes [ ]

(b) No [ ]

(11) If yes to question 10, kindly state them

a)……b)……

c)……d)……

e)……f)……

12) What suggestion(s) do you have for the scheme management, health service providers and policy makers to ensure the sustainability of the scheme?

a)----------b)----------

c) ----------d)----------

d)----------e)----------

**Section C: The Role of Field Agents**

13. The field agents are to register members into the scheme.

1 2 3 4 5

14. Field Agents are to educate the general public on the NHIS.

1 2 3 4 5

15. Field agents are the play the role of mediation between the scheme and the general public.

1 2 3 4 5

16. The field agents are to make prompt payment of all monies collected into the scheme's accounts.

1 2 3 4 5

17. Are there any other roles that the field agents are to play to ensure the sustainability of the scheme?

(a) Yes [ ]

(c) No [ ]

18. If yes to question 17, kindly state them

a)……...……b)……

c)……d)……

e)……f)……

19. What suggestion(s) do you have for the scheme management and the government on the role of field agents to ensure the sustainability of the scheme?

a)----------b)----------

c) ----------d)----------

d)----------e)----------



20. Suggest how best to improve the efficient and effective of the operations of the scheme.

a)----------b)----------

c) ----------d)----------

d)----------e)----------