ASSESSING THE CLIENTELE SATISFACTION OF THE IMPLEMENTATION OF THE NATIONAL HEALTH INSURANCE POLICY IN GHANA:

A COMPARATIVE STUDY OF THE DISTRICT AND PRIVATE MUTUAL HEALTH INSURANCE SCHEMES

BY

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DECLARATION

This report has been the results of my own field research except where specific references are made which have been duly acknowledged. Except for this degree, this work has not been submitted towards any other degree or publication. I am fully responsible for the views expressed, factual accuracy of the content and any other blemishes that this report might contain.

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ABSTRACT

Over the past two decades, the focus of major reforms in Ghana's health sector has been to accelerate access to quality healthcare, especially for the poor and vulnerable. In order to achieve this objective, the health sector continues to deepen efforts towards enhancing efficiency in service delivery and ensuring sustainable healthcare financing arrangements that protect the poor. The implementation of the National Health Insurance Policy (NHIS) in 2004 has been one major stride towards the achievement of this objective. This study sought to find out the levels of awareness created about the National Health Insurance Policy and the level of acceptance by the citizenry in terms of enrolment and satisfaction of service provision.

The cross sectional research design was adopted in order to allow statistical inferences to be made from the analysis. A Comparative Case Study Approach between the District Mutual and Private Mutual Health Insurance Schemes was adopted in order to allow the use of multiple sources of data. The Likert Scale was used as the major analytical tool to determine the clientele satisfaction of service provision under the two types of schemes.

The National Health Insurance Act, 2003 (Act 650) and National Health Insurance Regulation, 2004 (LI 1809) provide guidelines for the qualification for registration and licensing to operate a health insurance scheme in Ghana. The study revealed that whilst the District Mutual Health Insurance Schemes adhere to the provisions in the Act and Regulation and thus receive state funding from the National Health Insurance Fund, the Private Mutual Health Insurance Schemes do not bother about the provisions since they do not receive any form of state funding. The results of the analysis indicated a high level of awareness about the schemes but this has not resulted in a commensurate national enrolment levels. With regards to clients' level of satisfaction with service provision and total benefit packages, the Likert Scale depicted over 90 percent satisfaction score with the District Mutual Health Insurance Schemes and 68.33 percent score with the Private Mutual Health Insurance Schemes.

Apart from the general challenges facing the implementation of the NHIS Policy in Ghana, the study identified inadequate structures for monitoring and lack of a comprehensive computerized mechanism for the administration of claims and its attendant fraudulent deals as urgent issues that need attention.

Recommendations towards improving the design and operations of the NHIS include the extension of the regulatory and supervisory roles of the National Health Insurance Authority and the establishment of equitable funding arrangements for all the types of schemes established under the National Health Insurance Act. Recommendations were also made towards improving the total benefit packages, enrolment levels, attitudes of NHIS/Health Staff and more importantly establishing comprehensive structures for monitoring and administration of claims.

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ABREVIATIONS/ACRONYMS

ANDMHIS	Atwima Nwabiagya District Mutual Health Insurance Scheme
ANDA	Atwima Nwabiagya District Assembly
CHI	Community Health Insurance
DMTDP	District Medium Term Development Plan
DMHIS	District Mutual Health Insurance Schemes
DANIDA	Danish International Development Agency
EU	European Union
GSS	Ghana Statistical Services
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
GDP	Gross Domestic Product
HMO	Health Maintenance Organization
HIPC	Highly Indebted Poor Country
IGF	Internally Generated Fund
IMF	International Monetary Fund
KMA	Kumasi Metropolitan Assembly
LI	Legislative Instrument
MDGs	Millennium Development Goals
MOH	Ministry of Health
MHIS	Mutual Health Insurance Schemes
NHIS	National Health Insurance Scheme
NHIF	National Health Insurance Fund
NHIC	National Health Insurance Council
NHS	National Health Service
PCHIS	Private Commercial Health Insurance Schemes
PMHIS	Private Mutual Health Insurance Schemes
PPME	Planning, Monitoring and Evaluation
PPO	Preferred Provider Organizations
POS	Point-of-Service
SAP	Structural Adjustment Programme

SPCCUMHS	St. Peters Co-operative Credit Union Mutual Health Scheme
SSNIT	Social Security and National Insurance Trust
SPSS	Statistical Package for Social Scientist
UN	United Nations
UNICEF	United Nation's Children Education Fund
UNCTAD	United Nations Conference for Trade and Development
UNDP	United Nations Development Programme
WHO	World Health Organisation
VAT	Value Added Tax

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CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

The National Health Insurance Law was passed in Ghana by the Parliament in September 2004. The law sought to set up a National Health Insurance Scheme (NHIS), which would enable residents in Ghana to obtain basic healthcare services without paying money at the point of delivery. This would in effect replace the "cash and carry" system which had been in operation for many years and had been identified as having a myriad of problems. In order to address these problems, the New Patriotic Party (NPP) Government made the National Health Insurance one of its cardinal policies in their election manifesto in 2000.

The National Health Insurance Law was meant to provide a policy and regulatory framework for health insurance that would enable the nation to achieve the goal of equitable access to basic health care in relation to need rather than socio-economic or socio-cultural status. The objectives of the National Health Insurance Policy were spelt out in the National Health Insurance Law, 2004; (LI 1809). The National Health Insurance Act, 2003 (Act 650) also provided guidelines for the operations of the various schemes. The Act stipulates the directives for the establishment, registration, licensing and operations of different types of health insurance schemes in the country. The types include:

(a) District Mutual Health Insurance Schemes (DMHIS)
(b) Private Commercial Health Insurance Schemes and (PCHIS)
(c) Private Mutual Health Insurance Schemes (PMHIS)

The DMHIS has enjoyed a lot of patronage since the formal launch of the policy in 2004. In the context of the national health policy framework, health insurance is seen as one option of obtaining additional resources for the financing of health care without deterring the poor and vulnerable group from seeking care when they need it. It is therefore a way of improving the quality and access to health care as well as managing resources more efficiently.

In historical perspective, health care financing in Ghana started under the leadership of Osagyefo Dr. Kwame Nkrumah, when he set up the National Health Service which was fully financed from state revenue. It provided health services for everybody at no cost, so it protected the poor from financial shock. The advantage of this scheme was that it was progressive (i.e. high income individuals paid higher taxes than low income people). However, the scheme was biased towards the urban population to the neglect of the rural poor. The quality of medical service was also poor. In 1969, the Progress Party Government led by Dr. Kofi Abrefa Busia introduced user fees to patients for hospital procedures. Although the fees were small it helped establish the principle of payment for health care utilization by patient.

In 1983, the Government was made to reduce expenditure on social services under the Structural Adjustment Programme (SAP), with education and health bearing the heaviest brunt. Full cost recovery for health service delivery was subsequently introduced. In 1985, the government revoked the Hospital Fees Regulation, 1963, (LI 1277) and replaced it with the Hospital Fees Regulation, 1985, (LI 1313) which mandated full cost recovery for health service delivery in Ghana (Atim et al, 2001). This was known as the "cash and carry" system and it involved the total withdrawal of government subsidies on health delivery. Patients were therefore asked to pay for full cost of medication and care. The concept was to afford an increase in resources to health care facilities which would allow them to expand and upgrade their services. It was also meant to improve access to health care and reduce unnecessary visits by patients who would abuse the system because it was free.

Unfortunately, evidence gathered described the "cash and carry" system as a "stinking and dehumanising" system because patients who did not have the ability to pay for medical service were turned away from hospital only to die at home (Atim et al, 2001). The disabled, poor and accident victims were even asked to pay on the spot before receiving medical attention. The utilization of health care among the poor, women and children, especially those in the rural areas decreased. Finally, there is no empirical evidence to show that the significant amount that were generated by the introduction of the user fees helped to improve health facilities. This was the background and the need to achieve the Millennium Development Goals (MDGs) that rekindle the Government's efforts for social equity by the National Health Insurance Scheme. The scheme

has been welcomed in principle by all and sundry. However, the politics, funding and its implementation have left much to be desired.

1.2 **Problem Statement**

Good health status is an indicator of development. However access to health care in most low income countries is limited due to poverty. According to the Ghana Poverty Reduction Strategy II document, about 45 percent of Ghanaians live below the poverty line thus limiting access to health care by the core poor and the vulnerable. In order to accelerate access to quality health services, the health sector continues to deepen efforts and focus on three policy objectives. These are:

- To bridge the equity gap in access to quality health and nutrition services;
- To enhance efficiency in service delivery and
- To ensure sustainable financing arrangements that protect the poor.

The National Health Insurance Policy seeks to unite all the three broad objectives as its central focus. As already stated, the Policy has been welcomed in principle by most Ghanaians. However, it has been observed that the District Mutual Health Insurance schemes have experienced some appreciable level of patronage since the formal launch of the policy in 2004, whiles enrolment onto the other types of schemes seems to be dwindling. The question is: Could this difference be attributed to the level of satisfaction derived by clients in terms of services being provided by the various schemes, or could it be attributed to other factors? This study aims at assessing the clientele satisfaction of the implementation of the national health insurance policy in Ghana using the District and Private Mutual Health Insurance Schemes as case studies. It is anticipated that in the course of the study, challenges of implementation confronting the various schemes would be identified and suggestions offered for consideration.

In a paper presented by Arhin (1995) on the Socio-Cultural Challenges of Social Health Insurance in Ghana, he identified some crucial issues of social and cultural nature that need to be considered in the design and implementation of socialized health insurance; but these have not received adequate attention in Ghana's case. He stated that in most communities in third world countries, social security arrangements have been and still are largely based on primary relationships within and between relatively small -scale units, such as kinship, parenthood and

gender, neighbourhood, friendship, patron-client ties and common village membership. The underlying principle of exchange in these arrangements is reciprocity. The National Health Insurance Scheme is however based on an entirely different principle: that of state authority. The question that needs to be answered is how traditional mechanisms of reciprocal moral obligation can be "scaled up" or extended to a more formalized state centred social insurance scheme.

1.3 Research Questions

The study aimed at investigating into the above critical issues by providing answers to the following questions:

1. Do the operations of the DMHIS and PMHIS conform to the regulations provided by the Health Insurance Policy?
2. What are the percentage levels of enrolment in the DMHIS and PMHIS?
3. What types of services/ benefits do clients derive from the two types of schemes?
4. What is the level of clients' satisfaction with respect to service provision by the two types of schemes?
5. What are the challenges that militate against the successful implementation of the National Health Insurance Policy in Ghana?
6. What proposals could be made to address these implementation challenges to ensure the sustainability of the scheme?

1.4 Objectives of the Study

The overall objective of this study was to assess the level of satisfaction of the services provided by the DMHIS and PMHIS from the clientele perspective and identify challenges facing the implementation of NHIS Policy in Ghana. Appropriate recommendations would subsequently be made to ensure sustainability of the schemes.

Specifically, the study sought to achieve the following objectives:

1. To assess whether the operations of the DMHIS and PMHIS conform to the provisions in the National Health Insurance Act, 2003 (Act 650) and the National Health Insurance Regulation, 2004 (LI 1809);
2. To assess the levels of enrolment in the DMHIS and PMHIS;
3. To identify the types of services/benefits clients derive from the schemes;

4. To assess the level of clientele satisfaction in the DMHIS and PMHIS;
5. To assess the achievements and challenges facing the implementation of the National Health Insurance policy in Ghana and
6. To make recommendations for implementation to ensure sustainability of the schemes.

1.5 Significance of the Study

The National Health Insurance Policy is in its fourth year of implementation. However, in as much as some successes have been achieved, a lot of implementation challenges have been identified. Among these are the limited sources of funding for the scheme, abuse and frivolous use of health facilities leading to delay in health care utilization, inadequate premium to sustain the operation of the scheme, insufficient administrative, managerial and technical human capacity, delays and inconsistencies in issuing health insurance cards to those who are registered, difficulties in providing effective coverage for the poor and "exempt" indigents and the uncertainty of political commitment to sustain the scheme (Jutting, 2002). There is therefore the need to subject these implementation challenges to a more detailed analysis and to suggest means of addressing the issues.

1.6 Scope of the Study

The study focused on the analysis of the National Health Insurance Act, 2003 (Act 650) and the National Health Insurance Regulation, 2004 (LI 1809) which provide guidelines and strategies for the implementation of the National Health Insurance scheme. Specifically, the level of compliance/conformity by the DMHIS and PMHIS with Sections 12, 13, 27 and 28 of the Act were assessed.

Geographically the study has been concentrated within a seventy (70) kilometre radius of the Kumasi Metropolis and the Atwima Nwabiagya District where the Private Mutual Health Insurance and the District Mutual Health Insurance Schemes have been identified to be operating. The Atwima Nwabiagya District Mutual Health Insurance Scheme (ANDMHIS) was selected based on the fact that it was one of the pilot schemes that were initiated by the then NPP

Administration in 2003. The first year was used for community sensitization and registration of clients but actual operations began in June, 2004.

Coincidentally, the St. Peters Co-operative Credit Union Mutual Health Scheme (SPCCUMHS) also started operation in the Kumasi Metropolis as a private health scheme in July, 2003. These two schemes therefore provided a better platform for an effective comparative analysis in terms of enrolment levels and other factors.

Conceptually, the study looked at the linkages of critical factors that influence clientele satisfaction of the implementation of the National Health Insurance Policy, enrolment levels, policy objectives and implementation challenges. The operations and achievements of the two schemes were also assessed and recommendations made towards their sustainability.

1.7 Limitations of the Study

The study would have been more comprehensive if a proper trend and impact assessment could be carried out. However, since both schemes had not been operated fully for five years consecutively, this objective could not be achieved. There was also an age bias since only respondents between 18-60 years were targeted. This age bracket constitutes the actual registered clients who make monetary contributions to the schemes. Those below 18 years and those above 60 are considered as dependants.

1.8 Organisation of the Report

The report from the study was made up of five main chapters. Chapter one dealt with the introductory aspect of the study and it comprised the background, statement of the problem, research questions, objectives and scope of the study. Chapter two dealt with a review of theories and related literature on the phenomenon. It also contained the conceptual framework of the study. Chapter three comprised the research methodology and a brief justification of the choice of the study areas. Chapter four dealt with findings, analysis and discussion of results whiles chapter five consisted of the summary of findings, recommendations and conclusion.

CHAPTER TWO

REVIEW OF THEORIES AND RELATED LITERATURE

2.1 Theoretical Basis of the Study

The idea of quality, efficient and affordable health care utilisation can be traced to the theory of Social Justice which came into being with the introduction of the human concept of development in 1974. In Cocoyoc, Mexico, this Concept of Human Development was adopted by the United Nations Conference for Trade and Development (UNCTAD) with the declaration that "the whole purpose of development must be redefined. Development should not be to develop things but to develop man. Human beings have basic needs such as food, shelter, clothing, health and education. Any process of growth that does not lead to their fulfilment or even worse disrupt them is a travesty of the idea of development" (UN, 1975). To the proponents of this theory, the living conditions of the population may be a better indicator of development especially in developing countries than economic indicators. The application of the principles of development theory in the discussions of health care policy formulation stands to offer a better understanding of how international health care systems could be adopted in developing countries.

Other theories that have significant bearing on the human concept of development are the "Structuralist Approach" which emphasises industrialization and capitalist development as the leading causes of welfare state formation, with welfare state referring to the government provision of services and income security (Esping-Anderson, 1990). This approach argues that once a level of industrialization is attained, the social structures from pre-industrial society such as the family and the church would no longer be capable of providing the services they once contributed to society's well-being. The state must therefore provide this function. Closely related to this theory is the "state-centered approach" which emphasises state instruments for shaping the directions of social legislation (Quadagno, 1987). In relation to healthcare, the modernization theory sees limited resources and the existence of traditional beliefs to be the key issues that need to be overcome in order to achieve significant impact in health care delivery (Quaye, 1991).

Despite the logic in these theories, some of the arguments put forward have been challenged in further research. For example, a comparative study of 59 nations by Collier and Messick (1975)

revealed that while a certain level of modernization may be a prerequisite for welfare state development, it cannot be seen as the sole determinant of welfare state formation. Instead, the study argues for a model of hierarchical diffusion in which countries imitate states that are at a higher level of development.

2.2 Status and Access to Health Services in Ghana

One major objective of Ghana's health sector reforms whose implementation started in 1997 was to increase geographical access to basic clinical and public health services. Access to clinical services is defined as living within thirty (30) minutes of any kind of modern health facility. It is also stated that access to health care services indicates the degree to which individuals are inhibited in their ability to gain entry to and receive care and services from the health care system (Ministry of Health,1996). Geographical, financial and transportation factors influence access to health care. Geographical access indicates the spatial interaction of people and health facilities. Financial access refers to the ability of the people to demand and pay for health services when the need arises. Transportation access refers to the ease with which people can get to their destinations where health facilities are located. A Core Welfare Indicator Questionnaire survey conducted by the Ghana Statistical Services (GSS) in 2003 indicated that between 1997 and 2003, the percentage of people stating that they had access to a health facility increased from 37 per cent to 58 percent.

The 2004 Ghana Demographic and Health Survey (GDHS) gave the following health status indicators: infant mortality rate: 68 per 1000 live births; under 5 mortality rate: 112 per 1000 live births; maternal mortality: 540 per 100, 000 live births and life expectancy: 57.2 years. Malaria remains the most frequently reported cause of morbidity and a major cause of childhood mortality. Other frequently reported diseases are diarrhoea, acute respiratory infections, skin diseases, pregnancy related complications, anaemia and malnutrition (GSS, 2005).

The most common chronic diseases are hypertension and diabetes. According to the 2005 Ghana Health Service Annual Report, Ghana has extremely constrained health care resources, with an estimated doctor to population ratio of 1:18,000 and nurse to population ratio of 1:1,500. The availability of staff has improved dramatically in recent years due to concerted efforts to improve

health professionals' conditions of employment. Nevertheless, Ghana has consistently been one of the countries most severely affected by international health worker migration. About 45 percent of the doctors and a quarter of nurses trained in Ghana have been lost to migration (Ghana Health Service, 2006).

Ghana has substantial public and private health sectors. There is an extensive network of about 300 mission (religious/charitable) hospitals, which receive subventions from the government, some of which serve as the District Hospitals in areas where there are no public hospitals. There are a growing number of private profit-based facilities, including an estimated 140 hospitals, 910 clinics, 108 company clinics, and nearly 400 maternity homes. According to the Ghana Health Service, 2006 Annual Report, it is estimated that approximately 2,400 nurse midwives, 1,400 state registered nurses, 570 medical specialists and 930 generalist doctors work in the private sector, although some of these health workers engage in dual government and private sector work. There are also a range of traditional healers and informal providers such as licensed chemical sellers. In contrast, the public sector employs about 1,200 doctors (generalist and specialist), 420 medical assistants, 8,500 professional nurses and midwives and 5,900 enrolled nurses. In 2005, there was an estimated shortfall of over 11,000 health workers in the public sector. Public sector health services are primarily provided through hospitals (teaching, regional and district level) and clinics. The organisation of the public health sector is decentralised, with health districts carrying considerable management responsibility and teaching hospitals functioning as autonomous institutions. In addition, the Ministry of Health is only responsible for policy formulation, monitoring and evaluation and other auxiliary functions since health service provision responsibilities were delegated to a separate organisation, the Ghana Health Service, in 1996.

Prior to independence, financial access to modern health care was predominantly by out-of-pocket payments at point of service use (Arhinful, 2003). Following independence, the government switched to tax-based financing of public sector health services and all such services were made free. Private sector health services continued to be paid for by out-of-pocket fees at point of service use. By the early 1970s, general tax revenue in Ghana, with its stagnating economy, could not support a tax-based health financing system. In 1972, very low out-of-pocket

fees at point of service use were introduced in the public sector to discourage frivolous use of health facilities (Arhinful, 2003).

The stagnation of Ghana's economy was followed by a decline and in the health sector there were widespread shortages of essential medicines, supplies and equipment, and poor quality of care. In 1983, the People's National Defense Council (PNDC) government adopted a traditional International Monetary Fund (IMF) and World Bank economic recovery programme. In 1985, public sector user fees for health care were raised significantly as part of structural adjustment policies and became known as the 'cash and carry system'. The aim of the 1985 user fees was to recover at least 15 percent of recurrent expenditure for quality improvements. The financial aims were achieved and shortages of essential medicines and some supplies improved. However, these achievements were accompanied by inequities in financial access to basic and essential clinical services (Waddington and Enyimayew 1989).

2.3 The Concept of Health Care Financing

Healthcare financing the world over has been of great concern to both developed and developing countries. Thus, policies on how to finance and provide healthcare to an entire nation to include both the formal and informal sectors, rural and urban areas in low and middle income countries is a huge challenge for most developing countries. However, in sub-Saharan African countries, health care financing policies have been in crisis mainly because of the frequent occurrence of political instability coupled with severe economic constraint and lack of good governance (World Bank, 2004).

Over the last three decades, the perspective of health care financing has dramatically changed in developing countries. During the sixties, health care policies focused on fighting major epidemics; thus, health care programmes were dedicated to reducing the threat to population. In the eighties, the economic approach became a major part of all health care policies. At that time, most of health care financing was related to cost recovery strategies. All attention was then drawn on how it worked: fee policies, distribution of revenues and efficient use of resources. In the late nineties, cost recovery was relegated to the back scene and health care financing policy then become a major matter for discussions (World Bank, 2004).

A wide range of mechanisms are used for financing both public and personal health care services. Whereas public health care services are usually financed by governments through taxation, foreign donors and development partners, personal health care financing involves community financing, health insurance (both social and private insurance schemes) with varying degrees of involvement by governments and non-governmental organisations. Such community-based financing covers different mechanisms of mobilizing resources such as micro-insurance, community health fund, mutual health organizations, revolving drug funds, and community involvement in user fee management.

2.3.1 Sources of Funds for Health Care in Developing Countries

Among the many variables that influence the outcome of national health status in both developed and developing countries are the availability and efficiency of health care financing. Annual public and private expenditures from domestic sources were estimated to be approximately $100 billion (1983) for 148 developing countries. For the United States alone, annual public and private costs for medical care are almost five times larger - about $478 billion in 1988 (World Bank, 1993).

In contrast to domestic expenditures, the total flow of donor assistance for health in 1986 was estimated to be $4 billion, approximately 5% of total current domestic expenditures by developing countries. Approximately 10% of all United States development assistance is allocated for health, nutrition, and population planning purposes. While the total health sector contribution is about $500 million annually, the United States' contribution represents about 13% of health contributions by all external donors. In sub-Saharan Africa, all donor health allocations only reach 3.4% of total development assistance. Available data suggest that private and voluntary organizations contribute approximately 20 percent of total global health assistance (Preker, 2002).

Today, global spending on health is about 8 percent of global GDP (US$2.5 trillion) or 4 percent of the GDP of developing countries (US$280 billion). Among low income countries, the African region is particularly disadvantaged. Although the African region and other low income

countries bear the largest burden of illness (90 per cent), only 11 per cent of total global spending occurs in these countries (Preker, 2002).

Clearly, developing countries as a whole are dependent on the efficient use of their own resources because external financing remains a small fraction of total domestic financing. Nevertheless, improvement in health sector performance often depends on the sharing of western experience and technology, services available through external donor cooperation. In this effort, the available supply of donor financing for health is not restricted entirely by donor policy, but also by the official demand for external financing as submitted by developing countries. The supply of financing for health greatly exceeds the receipt of well-articulated and officially approved proposals from developing countries. The major constraints that produce this imbalance are unfamiliarity of ministries of health with potential donor sources; passive approaches to external financing; unfamiliarity with proposal preparation; increasing competition within developing countries by competing sectors, such as industry and agriculture; and absence of an international system which is able to support developing countries in mobilizing external financing (Thomas and Gilson, 2004).

Ghana has had a chequered history of health care financing options. There had been certain times that health services were provided free of charge and other times that user fees were charged. Since the 1980s user fees for government services have become an accepted financing option for the health and social sectors in Ghana and many other developing countries. In July 1985, the government of Ghana enacted the Hospital Fees Regulation as a cost-sharing measure for the use of Ministry of Health facilities. Proponents of user fees argued that equity and efficiency could be achieved through the implementation of a cost-recovery policy package. This was known as the “cash and carry” and it involved the wholesale withdrawal of government subsidies on health delivery. This attempt to recover health care expenses through the user charges produced less revenue than expected and national health insurance was seen as an attractive alternative (Quaye, 1991).

In recognition of the potential of the health insurance scheme to eliminate user fees and increase access to health care in Ghana, the National Health Insurance Act was enacted in 2003, mandating the establishment of district-wide mutual health insurance schemes. In other

developing countries like Senegal, Guinea Bissau and South Africa, community health care financing has played a significant role in health care delivery (Thomas and Gilson, 2004).

2.3.2 The "Cash and Carry" System

This system is where the receiver of health services pays for the services rendered by the health personnel/institution. In 1971, the user fee for hospital procedures was introduced in Ghana. Initially, the fee was small but, the principle was established. By the early 1980s, Ghana experienced balance of payments crisis which was soon generalized into an economic crisis that affected all the sectors of the economy leading to a weak taxation to finance health services.

The Structural Adjustment Programme in 1983 was very much concerned about balancing budgets and servicing both domestic and external debts. In so doing, there were budget cuts on social spending with education and health bearing the heaviest brunt. In 1985, the PNDC Government embarked on full cost recovery of health services. This became popularly known as the 'cash and carry system'. This system stemmed from the Structural Adjustment Programme which the IMF and the World Bank had prescribed and was readily adopted in Ghana. The fundamental principle involved the wholesale withdrawal of Government subsidies on health delivery.

Under the 'cash and carry system', patients were required to pay for the full cost of medication and care. The rationale was that, there would be an increase in resources to finance health care facilities, improve access to health care, and improve patients' care and better efficiency due to the increased revenue from charges. It was also based on the presumption that the cost recovery would help reduce unnecessary visits to hospital by patients who were abusing the system because it was free. However, evidence gathered so far suggests that, none of the above assumptions was realised. The 'Cash and carry' system appeared to have carried away health services from the people of Ghana (Quaye, 1991).

Patients who did not have the ability to pay for medical services were turned away from hospitals only to die at home. The disabled, poor and accident victims were required to pay on the spot before getting medical attention. What worsened the conditions was that, this cost recovery

system was introduced at a time when many people had been laid off from the public sector and income levels were extremely low. The poor were simply priced out of hospital care and a two-tier health care system came into operation with better facilities for those who could afford to pay. Some people especially the poor had to borrow money, took out loans, sold their animals or furniture, dissolved their little savings, cut down on buying food and even stopped sending their children to school in order to pay for health care. The process of borrowing money from the extended family or neighbourhood delayed treatment and in many cases, caused deterioration of the illness or even death (Osei, 2007).

2.3.3 Community Solidarity in Health Care Financing

The term 'community' as used by both sociologists and geographers, refers to any set of social relationships operating within certain boundaries, locations and territories. The term has both descriptive and prescriptive connotation in both popular and academic usage (Jutting, 2002). Community health care financing can be referred to as any scheme that is broadly characterized by the following three features:

1. It is voluntary in nature;
2. Payment for health care is made by the community members, and
3. Community control of resources and their management.

The community gets together and finds ways of financing its unmet health needs. Such financing arrangements can significantly differ from each other in terms of their objectives, structure, management, organization, and institutional characteristics (Jutting, 2002). Community financing of health has evolved from different contexts essentially in response to prevailing circumstances which in turn depend upon the existing stage of development. For example, the Democratic Republic of Congo's Bwamanda scheme and Guinea-Bissau's Abota scheme were developed in response to the near collapse of government-funded health care (Jutting, 2002).

Traditionally, community enrolment onto a health insurance scheme is essentially based on ones membership of a social group where contributions are occasionally made in the spirit of solidarity. In the Thien Region in Senegal, traditional solidarity in the community setting plays a

major role in the success of their community health insurance. These social groupings are usually farmers groups but in other areas work based and church groups are identified (Jutting, 2002).

2.3.4 Health Insurance

The term health insurance is basically used to describe that form of insurance which pays for almost all medical expenses. It is many times used much more broadly to include insurance covering long term nursing or disability care needs (Quaye, 1991). It is technically defined as a mechanism in which the risks of incurring health care costs are spread over a group of individuals or households (Arhin – Tenkorang, 2001).

It may be provided through a private insurance company, agency or provider or from a government-sponsored social insurance program. It may also be on a group basis (e.g., by a company to cover its employees) or bought by individual consumers. In each of the above cases, the covered individuals or groups pay taxes or premiums to help protect them from an unexpected or a very high healthcare expense. Similar benefits paying for healthcare expenses may also be provided through social welfare programs that are generally funded by the government. By calculating the total risk of the expenses of healthcare, a structure of routine finance (like annual tax or a monthly premium) can be made, ensuring that money is really available to pay for the benefits of healthcare specified in the agreement of the insurance. The benefit is administered by a central organization, most often either by a private or government agency or non-profit organisation that operates a health plan.

The rationale for adopting the National Health Insurance policy in Ghana was based on the huge cost involved in the provision of health care services. Previous Governments have persistently tried to devote substantial portions of the nation's resources for the provision of health care services to the citizenry but this is usually inadequate. For example, the Health of Nation Report by the Ministry of Health (MOH) in 1999 indicated that 8.4 per cent of government budget was spent on health. The total public expenditure was about US$129 million USD and the public per capita expenditure on health was about $6.83 (MOH, 2001).

These amounts came mainly from the Government of Ghana (GOG) internally generated fund (IGF), development partners and donors. The report also indicated that individual households in Ghana spend about 4.6 per cent of their total expenditure on health. In order to reduce

government spending, while at the same time improving resource mobilisation for the health sector, a policy of cost recovery by charging user fees was introduced by the Ghana Government in 1985. Unfortunately, the policy was plagued with far more problems than was envisaged. For example, it failed to address the problem of the inability of majority of people to access health services, and could not sustain health delivery services (Arhinful, 2003).

Regardless of whether or not government alone can carry the burden of health delivery, there are those who argue that access to health services is a fundamental right of the citizens of any country and should be the responsibility of government. Arhinful observed that the payment of hospital fees was not only a health hazard but also a psychological barrier to health care. He contended that hospital fees were roadblocks to good health and made a mockery of the idea of health care being a right, rather than a privilege. Perhaps what was conspicuously left out in the argument was a pragmatic proposal on exactly how governments, without the means, could support the provision of effective non-cost recovery health care for their people. This has been the situation in which many African countries, including Ghana, found themselves throughout the 19th century. There had been a growing public concern about the inequities inherent in the cash and carry system and therefore, an urgent need to replace it with a more humane alternative. The National Health Insurance policy was thought of as the best alternative choice and attempt was made within the public sector to introduce the scheme as far back as 1995. By way of experimentation, some public pilot schemes were initiated in four districts in the Eastern Region. These experiments failed to get off the ground even in its planned form (Arhinful, 2003).

2.4 History and Evolution of Health Insurance

The concept of health insurance was proposed in 1694 by the Peter Chamberlen family. In line with this, accident insurance was first offered in the United States of America (USA) by the Franklin Health Assurance Company of Massachusetts. This firm, founded in 1850, offered insurance against injuries arising from railroad and steamboat accidents.

The National Health Insurance systems were first introduced in Europe in 1883 by the Germans while there were earlier experiments in USA. Thus, it is on record that the first country to provide health insurance on a national scale was Germany in 1883. Before the development of medical expense insurance, patients were expected to pay all other health care costs out of their own pockets known as the fee-for-service business model. Hospital and

medical expense policies were introduced during the first half of the 20th century when hospitals began offering services to individuals on a pre-paid basis, eventually leading to the development of Blue Cross Organizations (Microsoft Wikipedi, 2007).

The first community health insurance scheme in Ghana was the Nkoranza Health Insurance Scheme started by the St. Theresa's Catholic Mission Hospital in 1992 (Atim and Madjiguene, 2000). In the mid 1990s, a unit was created in the Ministry of Health (MOH) to establish national health insurance as an alternative to 'cash and carry'. The unit focused its efforts and resources on consultancies and feasibility studies for a pilot social health insurance scheme for the formal sector and other organized groups (Arhinful, 2003).

Giving a historical background of health insurance in Ghana in a paper Agyepong and Adjei (2008), indicated that UNICEF began funding for exploratory research on the feasibility of district-wide community health insurance for the non-formal sector in 1993 and it was specifically centred in the Dangme West (a purely rural district with a subsistence economy and widespread poverty). The study had strong support from the Ministry of Health. The study showed enthusiasm among community members for the concept of Community Health Insurance (CHI). A pilot district-wide CHI was planned in the same district with support for design, implementation and finance from the Ministry of Health (MOH) and the European Union (EU). After the MOH and EU support had ceased, the Dangme West District Assembly and community members continued their collaboration and completed the design of the pilot district scheme. The District Assembly contributed part of its United Nations Development Programme (UNDP) poverty reduction fund to support community mobilization and household registration. The World Health Organisation (WHO) and the Danish International Development Agency (DANIDA) provided the start-up funding. Registration of beneficiaries and delivery of benefits started in October, 2000 (Agyepong et al, 2006).

When the New Patriotic Party (NPP) Government took over power in 2001, the new Minister for Health inaugurated a seven member ministerial health financing task force under the chairmanship of the Director for Policy, Planning, Monitoring and Evaluation (PPME) in the MOH. Members were chosen based on their technical knowledge and experience on the subject and they were from the MOH, Ghana Health Service (GHS), Dangme West District Health

Directorate & Research Centre, Trades Union Congress and the Ghana Health Care company. The terms of reference of the task force were to support and advise the MOH on the development of a NHIS, the building up of systems and capacity for regulation of health insurance in Ghana, the development of appropriate health insurance legislation, and the mobilization of extra resources to support national health insurance (Agyepong and Adjei, 2008).

2.5 Typology of Health Insurance

Health insurance can be put into two broad categories: The Traditional Care and the Managed Care. No one type of health care plan is better than the other. It really depends on one's needs and preferences. The traditional health insurance is the one in which one pays a certain amount of one's medical expenses up-front in the form of a deductible and afterward the insurance company pays the majority of the bill. This is a public health insurance which is practiced by many countries in the world. Under this type, one has complete autonomy when it comes to choosing doctors, hospitals and other health care providers. Fee-for-service plans include a ceiling for out-of-pocket expenses, after which the insurance company will pay 100 per cent of any cost. It offers flexibility in exchange for higher out-of-pocket expenses.

The Managed Care plans involve an arrangement between the insurer and a selected network of health care providers, and they offer policyholders significant financial incentives to use the providers in that network. Managed care has been in existence since the 1930s. As it grew, three basic types have evolved. These are: the Preferred Provider Organizations ***(PPOs)*** which make arrangements for lower fees with a network of health care providers. PPOs give their policyholders a financial incentive to stay within that network. The second type that has evolved under Managed Care is the Point-of-Service (***POS***) plans that cover more preventive care services and offer health improvement programs like workshops on nutrition and smoking cessation, and discounts at health clubs. Point-of-service plans are similar to PPOs, but they introduce the gatekeeper, or primary care physician.

The third type is the Health Maintenance Organization ***(HMO)*** which is the least expensive among the three, but the least flexible type of health plan. HMOs tend to be geared more toward members of group plans than individuals. In exchange for a low co-payment and low premiums, it requires that a policy holder has to consult a primary care physician before one can get a referral to see a specialist.

The NHIS policy in Ghana makes available three types of the scheme: District Mutual Health Insurance Schemes, Private Mutual Health Insurance Schemes and Private Commercial Health Insurance Schemes. Every Ghanaian citizen is required to join one of these types of health insurance schemes, and each of the schemes is required to provide basic healthcare benefits as determined by the National Health Insurance Council. Mutual Health Organizations (MHOs) are autonomous, non-profit organizations based on solidarity among members. They are commonly used for but not limited to the non-formal sector. The Private Mutual Health Schemes are owned by Insurance Companies which operate for profit based on the calculated risks of particular individuals incurring health care costs.

2.6 The Policy Framework of Ghana's Health Insurance Scheme

Ghana took the decision to access the Highly Indebted Poor Country (HIPC) initiative in March, 2001 and reached decision and completion points in February, 2002 and July 2004 respectively. Areas of expenditure under HIPC included funding of projects for poverty reduction and economic growth. In February 2003, the budgetary allocation for the Ministry of Health under the HIPC funding was used to support the creation of government sponsored mutual health insurance schemes in all districts where they did not already exist (Agyepong and Adjei, 2008).

In July, 2003 the final draft of the National Health Insurance Bill was laid before Parliament. Adverts were placed in the national dailies requesting comments from the general public on the bill. Organized labour comprising the Civil Servants Association, the Ghana National Association of Teachers, the Ghana Registered Nurses Association, the Judicial Services Workers Union, and the Trades Union Congress all submitted comments and formal resolutions to parliament and protested about some aspects of the bill. The Parliamentarians on the Minority Divide, especially members from the National Democratic Congress (NDC) also raised a lot concerns. After some of the concerns and protests had been addressed, the bill was debated and finally passed in August, 2003.

The bill required both the formal and the informal sectors to enroll in government-sponsored mutual health insurance schemes. Government sponsorship for the district MHO was automatic and not tied to efficiency and policy effectiveness or responsiveness criteria. All mutual health insurance schemes that were not district-wide government-sponsored were classified as private.

The private mutual health insurance schemes, though recognized as non-profit solidarity organizations, were legally entitled to operate, but would not receive any financial support from the national health insurance fund or any of the subsidies to cover groups exempted from premium payments such as the elderly and the poor (Agyepong et al, 2006).

2.6.1 Implementation of Ghana's Health Insurance Policy

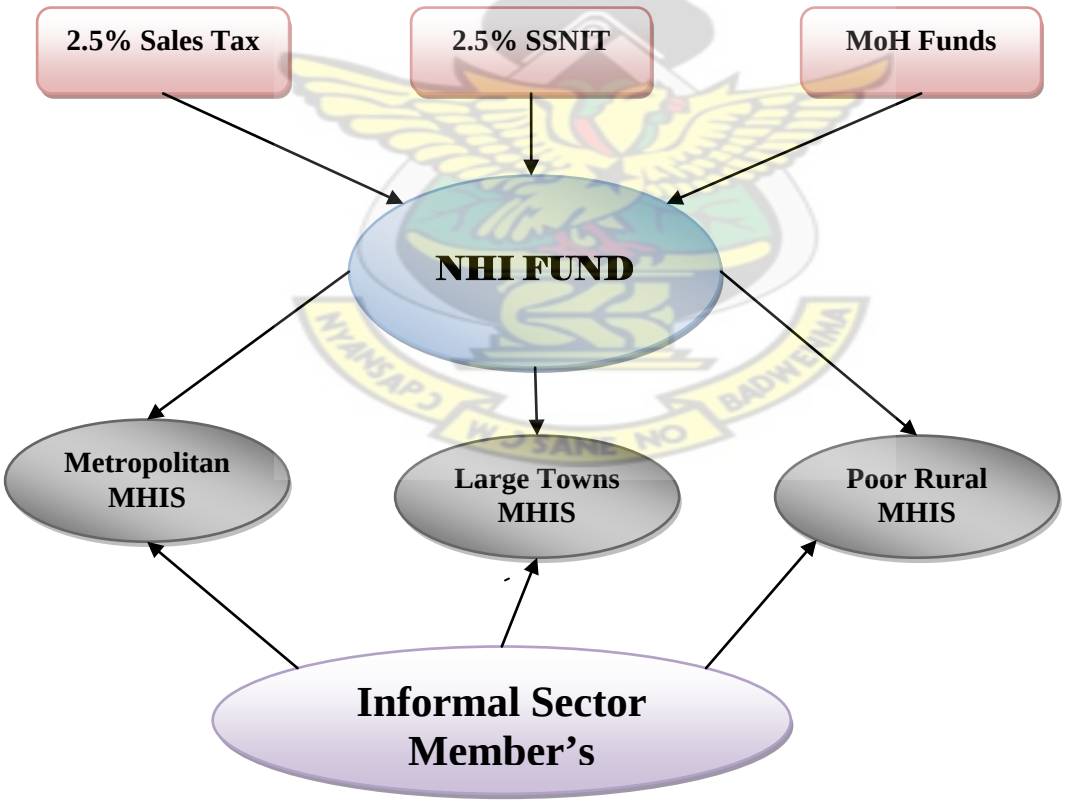
After the passage of National Health Insurance Act, (Act 650) in 2003, the Ministry of Health organized series of stakeholder meetings and set up task forces, with membership from both technical and political actors to provide recommendations and implementation guidelines for the policy. The basic aim of the policy was to move away from the user fees towards a pre-payment financing mechanism and it was designed to incorporate those in the formal and informal employment sectors in a single insurance system. The government was committed to a universal coverage under the national health insurance, but recognized that coverage would have to be gradually extended to achieve enrolment levels of about sixty per cent (60%) of residents in Ghana within ten (10) years of implementation (NHI Act, 650).

The basic blocks of the national health insurance policy were district-wide Mutual Health Insurance Schemes (MHIS) in each district and the Act requires every Ghanaian citizen to join and belong to a district MHIS or a private mutual or commercial insurance scheme. However, government subsidies were to be provided for those belonging to the district MHIS thus creating an incentive for more people to join (Ministry of Health, 2004).

Financing of the NHIS was to be by individual premium payments and a 2.5 percent National Health Insurance Levy to be collected using the same mechanisms as the already existing 12.5 percent Value Added Tax (VAT). A National Health Insurance Fund (NHIF) was created by the Act and is mainly funded by the NHI levy of 2.5 percent sales tax on almost all goods and services. Two and a half percent (2.5%) of formal sector worker contributions to the Social Security and National Insurance Trust (SSNIT) towards retirement benefits were to be automatically transferred to the national health insurance fund on a monthly basis. Each adult in a household is expected to become a MHIS member in their own right and pay the necessary contribution, which covers themselves and dependent children under the age of 18.

The NHIF subsidises the contributions of the indigent and the elderly (Agyepong et al, 2006). Figure 1 below indicates the flow of funds into the NHIF.

Figure 1: Flow of Funds into the National Health Insurance Fund



Source: Agyepong et al, 2006. (Adapted)

A National Health Insurance Council was established to govern the operations of the NHIS. The basic objective of the Council was to secure the implementation of a national health insurance policy that ensures access to basic health care services to all residents in Ghana. Its responsibilities included registration, licensing, regulation and supervision of the operations of all types of health insurance schemes. It was also responsible for granting accreditation to health care providers, monitoring their performance, and ensuring that health care services rendered to beneficiaries were of good quality. A chief executive officer was appointed and supporting secretariat was set up to support the National Health Insurance Council in the execution of its functions (Agyepong and Adjei, 2008).

The scheme covers a minimum benefit package for almost all out - patient care, diagnosis, drugs, dental, optical and maternity services as well as most in - patient care services. Services excluded include appliances and prostheses, cosmetic surgery, anti-retroviral treatment, fertility treatment, dialysis for chronic renal failure, organ transplants, and medicines which are not included on the essential drug list prepared by the National Health Insurance Council.

2.7 The Practice of Health Insurance in Other Countries

2.7.1 Health Insurance in Germany

The German Health Care system is financed predominantly through social security insurance schemes. Membership of one of the social health insurances (GKV) is mandatory for all employees (below a certain income), while their spouses and their children under the age of 18 are able to hold free membership. About 90 percent of Germans are members of a social health insurance scheme, while the remainder of the population are insured by private health insurance companies. Only 0.9 per cent of all Germans have no health insurances at all (Christian, 2001).

The GKV social health insurance finances the bulk of all expenditure in health care and it determines the scope of medical services which include prevention, diagnostics, and treatment of diseases, maternity service, sick benefits as well as health promotion. Health promotion covers special disease prevention programmes such as nutrition counselling, anti-smoking counselling and relaxation. Members over the age of 34 years are entitled to a medical check-up every two years for screening of heart, circulation, kidney problems and diabetes. Women and men over 25

and 45 respectively, are entitled to special cancer screening every year. Regular check-ups for children are also part of the medical cover provided by the GKV.

In spite of the strong financial incentives for preventive services for doctors, the overall participation rates in screening and check-up programmes are moderate with lower participation rates among patients with low socio-economic status. Health promotion is a big issue in the discussion about the health care system. Politicians, health care providers and doctors association usually express their strong commitment to the re-orientation of the health care system towards preventive health care (Christian, 2001).

2.7.2 Health Insurance in the United States of America

The USA health care system relies heavily on private and not-profit health insurance, which is the primary source of coverage for most Americans. According to the United States Census Bureau, approximately 84.0 percent of Americans have health insurance; 60.0 percent obtain it through an employer, while about 9.0 percent purchase it directly and various Government Agencies provide coverage to about 15.0 percent of Americans. Public programs provide the primary source of coverage for the elderly and low-income children and families who meet certain eligibility requirements (Collier et al, 1975). The primary public programs are:

- Medicare, which is a Federal Social Insurance Program for the elderly and certain disabled individuals,
- Medicaid, which is funded jointly by the federal government and states but administered at the state level. It provides insurance covers for very low income children and their families, and also
- A Federal-State Partnership that serves certain children and families who do not qualify for Medicaid but who cannot afford private coverage.

2.7.3 Health Insurance in the United Kingdom

The United Kingdom National Health Service (NHS) Act 1946 came into effect in July, 1948. The UK Government Department responsible for the NHS is the Department of Health, headed by a Secretary of State for Health, who sits in the British Cabinet. The NHS is the world's largest health service and the world's third largest employee after the Chinese army and the Indian railways. Great Britain's NHS is a publicly funded healthcare system that provides coverage to everyone normally resident in the UK. The NHS provides the majority of health care in England, including primary care, in-patient care, long-term health care, ophthalmology and dentistry. Private health insurance continues to run parallel to the NHS, but it is used by less than 8 percent of the population, and generally as a top-up to NHS services (Preker, 2004).

Recently, the private sector has been increasingly used to increase NHS capacity despite a large proportion of the British public opposing such involvement. Government funding covered 86.0 percent of overall health care expenditures in the UK in 2004, with private expenditures covering the remaining 14.0 percent (WHO, 2005). The costs of running the NHS are met directly from general taxation. It is argued that the implementation of the National Health Insurance Policy in Ghana takes its roots, lessons and experiences from the U.K's Health Insurance (Agyepong, 2006).

2.8 National Health Insurance Scheme and National Development

The economic development of a country is closely interrelated with the health status of its population. The health status of a country's citizens is a significant indication of the poverty situation in the country. An efficient and equitable health care system is therefore an important instrument in breaking the vicious cycle of poverty and ill health. Poor health is now recognised as the biggest barrier to economic growth in developing countries. The Human Concept of Development draws a direct linkage between improved health status of the population and increased productivity in all sectors of the economy (UN, 1975)

The contribution of the National Health Insurance (NHIS) Policy in national development is seen in the areas of increasing access to health care services, employment creation, labour productivity, higher educational attainment and improved income levels which are the cardinal points for poverty reduction. The focus of the policy in Ghana has been on financial access to

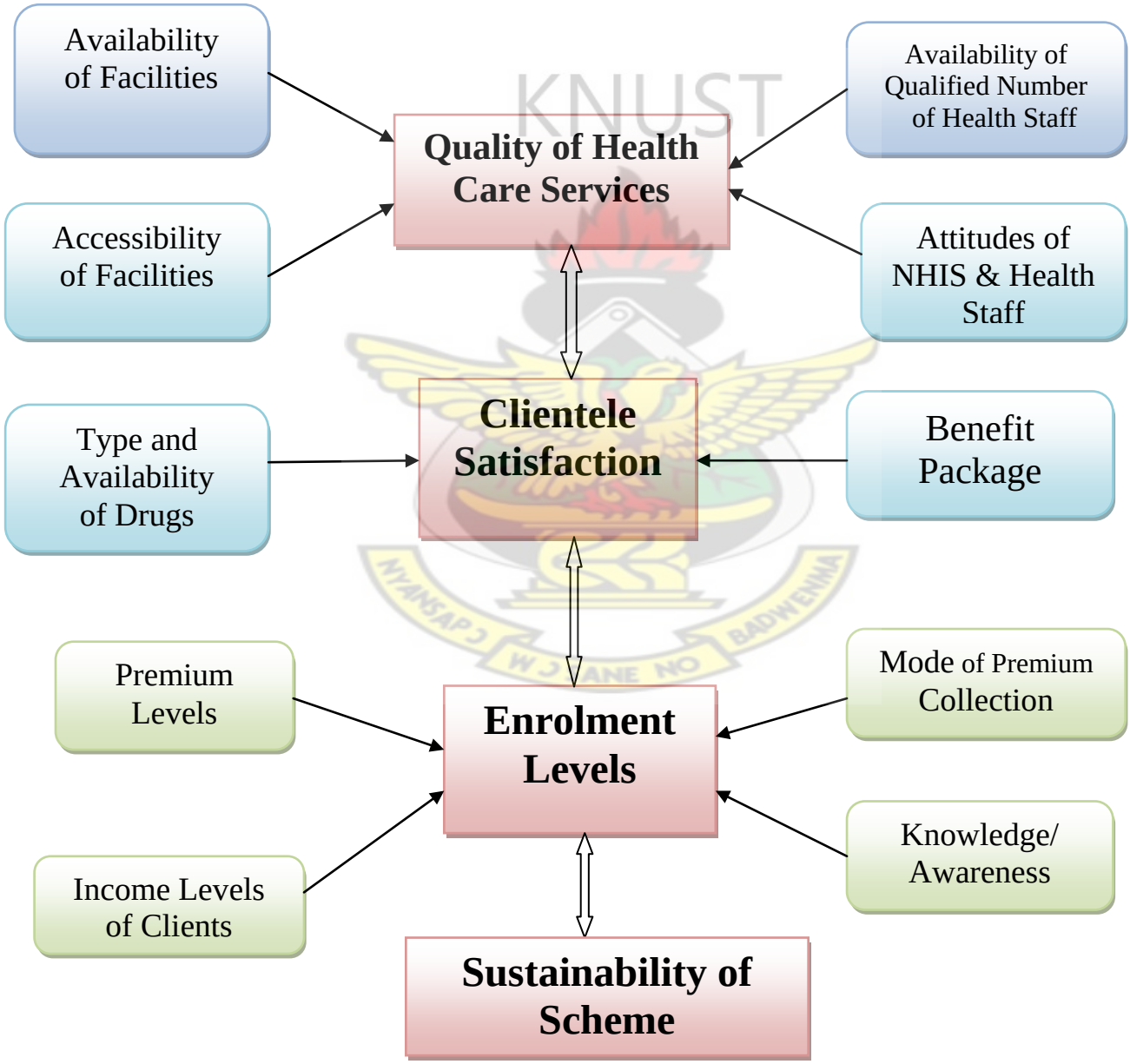
health care coupled with increased Government expenditure on health infrastructure, manpower and logistics. These objectives are expressed in the Millennium Development Goals (MDGs) in terms of reduction in infant mortality rate, maternal mortality rate and combating HIV/AIDS and malaria (Republic of Ghana, 2002).

The UNDP Human Development Report (2007) indicates that, over the period of piloting and implementing the NHIS Policy in Ghana (i.e. 1998 – 2008), there has been a consistent increase in access to health care services, especially to the poor. This has led to a tremendous reduction in general poverty situation from 52 percent to 29 percent (GSS, 2007).

2.9 Conceptual Framework of the Study

After reviewing available literature on the various theories, concepts and ideologies about the implementation and practice of health insurance the world over, this research work is conceptualised as presented in figure 2 below. It depicts the linkages on critical factors that may influence clientele satisfaction of the implementation of the National Health Insurance Policy, enrolment levels and sustainability of the scheme.

Figure 2: Conceptual Framework for the Study



Source: Author's Construct, May, 2009

The clientele satisfaction is influenced by factors like the quality of health care provided under the National Health Insurance Scheme. It is presumed that if clients are satisfied with the quality of health care provision, it will lead to higher enrolment into the health insurance schemes. If, on the other hand, clients are not satisfied with the service provision, a lot of them may want to withdraw their membership. The quality of health care provision is determined by certain factors such as availability and accessibility of health facilities, availability of qualified number of health staff, attitudes of the NHIS staff as well as health care providers among others. Client satisfaction can also be determined by the type and availability of drugs administered by the health care providers as well as other benefit packages specified under the operational guidelines of the particular scheme.

Clients' enrolment onto a particular scheme may also be determined by knowledge and awareness of the scheme, income and premium levels as well as the mode of premium collection. High enrolment is expected if the target population is aware of the existence of the schemes and if they have adequate knowledge about their principles and operations. The reverse holds if knowledge and awareness levels are low. An income level of the target population which is a determining factor of ability to pay is quite critical to enrolment. Widespread poverty and low income among potential members can be a serious hindrance to enrolment in health insurance.

Premium levels and their mode of collection largely determine the financing arrangements of the scheme. These two factors are critical in determining enrolment levels in an insurance scheme. It is a common knowledge that members of some professional bodies or working groups enroll automatically onto the District Mutual Health Insurance Schemes and deductions are made from their SSNIT contributions to pay for their premiums. Members of these groups thus become automatic members of a particular scheme without any choice. Flexibility in the premium collection where potential members are allowed to contribute in installments may encourage high enrolment levels.

It is anticipated that since insurance operates on the principle of solidarity where members pull resources together to cater for needy members at a particular time, high enrolment levels would lead to a broad financial base and ensure the sustainability of the scheme.

CHAPTER THREE
THE RESEARCH METHODOLOGY

3.0 Introduction

This chapter focuses on the design and method adopted for the research as well as the conceptual framework for the analysis. It is intended to explain the variables and their units of measurements and analysis, data collection tools/techniques and sources as well as the expected output of this research paper. The profiles of the study areas and basis for choosing these areas would also be discussed.

3.1 Research Design and Method

The study adopted the cross sectional research design which allowed the research to be carried out in natural settings without the control and manipulation of the variables by the researcher. The advantage with this design is that it allows statistical inferences to a broader population so that results can be extrapolated (Babbie,1983). It also increases external validity through generalisation. The Case Study Method was employed alongside the Comparative Research Approach since they allow the researcher to investigate and understand the dynamics of a particular system and the use of multiple sources of data. These design and method have been employed based on the fact that there are over a hundred and forty (140) operational District Mutual Health Insurance Schemes but few Private Mutual Health Insurance Schemes that are still operating as private. One each of these schemes was selected for the case studies. It is therefore imperative that the results of the study be subjected to statistical manipulations in order to make inferences which could be generalised.

3.2 Sources of Data and Collection Techniques

Both primary and secondary sources of data will be used for the study. Primary data will be collected using simple random sampling technique to select clients for one–on–one interview through the administration of structured and semi- structured questionnaires. This will afford every person in the study areas an equal chance of being selected. The Management Teams of

the two insurance schemes and other field officers as well as health care providers will be interviewed to assess the performance and achievements of the schemes in the study areas.

With regards to secondary data, a thorough study and analysis will be done on the main policy document of the National Health Insurance, Health Insurance Act , 2003 (Act 650) and the Legislative Instrument that establishes the schemes (LI 1809). The other secondary source of data will involve review of literature from documentary sources such as health journals, magazines, periodicals and relevant materials from the internet. Relevant health issues that have already been published and those that will appear in the national dailies in the course of the study will be consulted. Records from the offices of the Atwima Nwabiagya District Health Insurance Scheme and St. Peters Private Health Insurance Scheme as well as other health facilities in the areas were analysed to determine the enrolment rate and other relevant parameters of focus.

3.3 Determination of Sample Size and Technique

The study adopts a mathematical approach in the determination of the sample size. This approach makes room for a margin of error and provides a scientific means for sampling. A sample represents a subset of a larger population and if it is properly and scientifically determined, it provides bases for the researcher to extrapolate and make inferences on the larger population. The following mathematical model is employed in determining the sample size:

$$\mathbf{n = N/1 + N (\alpha)^2}$$

Where:

n = sample size

N = sample frame

α = margin of error

The sample frame (N) represents the compilation of the list of all card bearing clients in both schemes which is drawn from the entire population of the study areas. After the sample frame has been determined, the above formula was applied to determine the sample size (n) for the interview in each scheme.

Regarding the sampling techniques, the study adopted the use of a variety of them at different stages of the sampling process. It involved both Probability and Non – Probability sampling techniques. Purposive Sampling (Non – Probability) was employed to select the two types of schemes for the comparative study based on the fact that the Atwima Nwabiagya District Mutual Health Insurance Scheme is one of the pilot schemes that have been operational for four consecutive years. Similarly, for the purpose of effective comparative study, the St. Peters Private Mutual Health Insurance Scheme which has been operational for more than four years and is still running as a private scheme was chosen for the study. The systematic sampling technique was adopted in selecting clients for the interviews. In this technique, clients were grouped into odd and even numbers and those with odd numbers (called the K^{th} number) were selected for the interview after the first client had been randomly selected.

Using the mathematical model defined above, the following sample sizes (n) for the clients were determined allowing 10 per cent margin of error (α) or 90 per cent confidence level.

ANDMHIS

If N = 133,722 at 10%, then $n = 133,722/1 + 133,722(0.1)^2$

= 99.9 (Approximately 100)

SPCUMHS If N = 9,000 at 10%, then $n = 9,000/1 + 9,000(0.1)^2$

= 98.9 (Approximately 100)

Thus, client sample sizes of one hundred (100) each from each health scheme making a total of two hundred was used for the interview. Structured institutional interviews were also conducted at the Districts Health Administration, Scheme Managers offices and some health care providers.

3.4 Key Variables of the Study

A variable is an empirical property that can take two or more values (Berg, 2007). This means that if a property can change either in quantity or in quality, it can be regarded as a variable. Bruce indicates that every research must be driven by some key variables since they are the key elements of the research problem. Some of the key variables that were measured in this research include: age, sex, economic status (type of job), health seeking behaviour of clients, Awareness

(of the existence of schemes), quality of health care, premium size, enrolment levels, benefit package, client satisfaction, among others.

3.5 Units of Enquiry/Analysis

These are the basic units of the research around which data was collected and they represent the most elementary part of the phenomenon under investigation. The units of enquiry in this research are the management members of the health insurance schemes, operators of health care facilities such as pharmacists/chemical sellers, medical doctors, nurses and the various clients/individuals of the two schemes.

3.6 Data Analysis

The study adopted a combination of quantitative and qualitative analytical approaches. The quantitative aspect focused on the empirical data which are numerical in nature such as enrolment levels, premium sizes, etc. It involved trend analysis using the Statistical Package for Social Scientist (SPSS). The qualitative analysis involved descriptions, interpretations and implications of the results using bar charts for pictorial presentations. A nominal scale developed by an American Social Science Professor, Rensis Likert was adopted in the determination of clientele satisfaction with the services and benefit packages provided under the National Health Insurance Scheme. The Likert Scale is usually used in Social Science researches to measure attitudes, preferences and subjective reactions.

3.7 Choice of Study Areas

The Atwima Nwabiagya District and the Kumasi Metropolis were selected as the areas of concern for the research because they serve as the main operational areas of the two types of health schemes under investigation. The Atwima Nwabiagya District Mutual Health Insurance Scheme was purposively selected as one component of the research since it was one of the pilot schemes that was established immediately after the passage of the National Health Insurance Act, 2003 (Act 650).

The St. Peters Co-operative Credit Union Mutual Health Scheme which operates within the Kumasi Metropolis was also purposively selected because it is one of the few private health schemes which has operated for more than four years and is still operating as such. These two schemes provide basis for an effective comparative study.

CHAPTER FOUR

ANALYSIS AND DISCUSSION OF FINDINGS

4.0 Introduction

This chapter focuses on the analysis and discussion of the data that have been collected from the field. It is divided into four sections. The first section deals with a brief presentation of the profile of the study areas with emphasis on the available social services such as health and education as well as the economic activities of the people in the area.

The second section deals with the analysis of the results from the institutional questionnaire concerning the design and operational issues of the two health insurance schemes under investigation. The section basically looks at the operations of the two schemes to find out whether they conform to the provisions of the National Health Insurance Regulations, 2004 (LI 1809). Enrolment levels as well as the types of services/benefit packages provided for clients are also discussed in the section. The discussions are geared towards providing answers to the first three research questions. The third section deals with both qualitative and quantitative analysis of the socio – economic backgrounds of the clients and how they influence clients' satisfaction on the services provided by the schemes and health care providers. Here, indications of clients' satisfaction are disaggregated and related to specific factors which influence enrolment levels and sustainability of the schemes as shown in the conceptual framework of the study.

The final section of this chapter looks at the analysis of the identified challenges that militate against the successful implementation of the National Health Insurance Policy in Ghana. The discussions will also involve significant success stories that have been achieved by the two schemes since their establishment.

4.1 Profile of the Study Areas

4.1.1 Location and Size

(i) Atwima Nwabiagya District

The Atwima Nwabiagya District was carved out of the former Atwima District in 2004 by the legislative Instrument 1738. The District lies approximately on latitude 6^o 75'N and between longitude 1^o 45' and 2^o 00' West. It is one of the 27 political and administrative Districts in Ashanti Region. It is situated in the Western part of the region and shares common boundaries with Ahafo Ano South and Atwima Mponua Districts (to the West), Offinso District (to the North), Amansie–West and Atwima Kwanwoma Districts (to the South), Kumasi Metropolis and Kwabre Districts (to the East). It covers an estimated area of 294.84 sq km. The district capital is Nkawie.

(ii) Kumasi Metropolis

The Kumasi Metropolis is located in the transitional forest zone and is about 270km north of the national capital, Accra. It lies between latitude 6.35^o – 6.40^o and longitude 1.30^o – 1.35^o with an area of about 254 square kilometres. It shares boundaries with Kwabre District (to the North), Atwima Bosomtwe (to the South), Atwima Nwabiagya (to the East) and Ejisu-Juaben (to the West). The unique centrality of the Metropolis as a traversing point from all parts of the country makes it a special destination for migrants. Structural maps of the study areas are attached as appendices I and II

4.1.2 Climate, Vegetation and Soil Characteristics

(i) Atwima Nwabiagya District

The Atwima Nwabiagya District lies within the wet semi-equatorial zone marked by double maximum rainfall ranging between 170 centimeters and 185 centimeters per annum. The major rainfall season is from Mid-March to July and minor season is between September and mid-November. Rainfall in the district is not very reliable. It is therefore not safe to entirely practice rain fed agriculture. Temperature is fairly uniform ranging between 27 degrees celcious (in August) and 31 degrees celcious (in March). Mean relative humidity of about 87 to 91 percent is experienced. The vegetation is predominantly the semi-deciduous type. There are two large forest reserves in the district and these serve as water shed protection for the Ofin and Owabi

rivers. These two rivers are the main water sources for the Barekese and Owabi dams which provide drinking water for the whole of the Kumasi Metropolis and its adjoining districts.

The predominant soils in the district are the Kumasi-Asuansi/Nta-Ofin Compound Associations and the Bekwai- Nzema/Oda Complex Associations. The soils are good for agriculture. They are suitable for tree and arable crops such as cocoa, citrus, oil palm, mangoes, guava, avocado, maize, cassava, yams, cocoyam, plantain, pawpaw, groundnuts pineapple and ginger. The valley bottom soils are good for the cultivation of rice, sugarcane and vegetable. There are large deposits of rocks in the district. It is anticipated that full-scale exploitation of these rocks can create jobs in the district and also provide the much-needed revenue for the district's development.

(ii) Kumasi Metropolis

The Kumasi Metropolis falls within the wet sub-equatorial type. The average minimum temperature is about 21.5 degrees celcious and a maximum average temperature of 30.7 degrees celcious. Average humidity ranges between 60 and 84 percent. The moderate temperature and humidity and the double maxima rainfall regime (214.3 millimeters in June and 165.2 millimeters in September) have a direct effect on population growth and the environment as it has precipitated the influx of people from every part of the country and beyond its frontiers to the metropolis. This is chiefly because the climatic conditions are not harsh.

The vegetation of the city falls within the moist semi-deciduous South-East Ecological Zone. A patch of vegetation reserve within the city has led to the development of the Kumasi Zoological Gardens, adjacent to the Ghana National Cultural Centre and opposite the Kejetia Lorry Terminal. Apart from the zoological gardens, there are other patches of vegetation cover scattered over the peri-urban areas of the metropolis. This vast vegetation cover led to the description of the Metropolis as the "Garden City of West Africa". However, the rapid spate of urbanization has caused the depletion of most of these nature reserves.

The major soil type in the metropolis is the Forest Ochrosol. Agriculture in the metropolis has seen a dramatic change in the last two decades due to rapid urbanization. The demand for residential, industrial and commercial land uses has become much greater than that of agricultural land use. The Town and Country Planning Department estimates 48 percent of the Metropolis as urban, 46 percent as peri-urban and 6 percent as rural, confirming the fast rate of urbanization.

4.1.3 **Demographic Characteristics**

(i) Atwima Nwabiagya District

According to the 2000 Population and Housing Census, the total population of Atwima Nwabiagya District, was 129,375, with an annual growth rate of 3 per cent per annum and a sex ratio of 101 males (51%) to 100 females (49%). The population of the district is projected at 163,888 in 2008 (using the geometric method). The district has a population density of 439 persons per sq. Km which is third in the region, after Kumasi Metropolis and Kwabre District (5,419 and 659 persons per sq. km respectively).The district is predominantly urban with 64 per cent of the population living in the urban/peri-urban areas and 36 per cent living in the rural areas of the district. The proximity of the district to the Kumasi Metropolis greatly accounts for this situation. Kumasi is already choked so people are now moving toward the peri -urban towns. It is therefore important for the district to put in place strategies that will help the proper management of the urban situation of development and also provide the needed infrastructure and services for the rural settlements. The average household size in the district is 5.7 persons. This is higher than the regional average of 5.3 persons. Heads of household are mainly male (67.8%). Where a female is head of household; it may be a single person or single parent household.

The age structure of the population in the district is skewed towards the youth. The highest proportions are in the age groups 0-4 years (15.5%) and 5-9 years (15.8%). Cumulatively, 43.2 per cent of the population in the District is below 15 years and 6.2 per cent is above 64 years. This high dependency ratio places a high potential demand for social facilities and services.

(ii) Kumasi Metropolis

The Kumasi metropolis is the most densely populated district in the Ashanti Region. During the 2000 Population Census it recorded a figure of 1,170,270 and a growth rate of 5.4 per cent per annum. This accounted for about a third (32.4%) of the region's population. It has been projected to have a population of 1,782,424, by end of 2008 (using the geometric method). Kumasi has attracted such a large population partly because it is the regional capital, and also the most commercialized centre in the region. It has a population density of 5,419 persons per sq. km. (2000 Population Census) compared with the regional figure of 148 per sq. Km. It has however been estimated that 48 per cent of the population live in the urban areas, 46 per cent in the peri-urban areas and 6 per cent in the relatively rural areas (Metro Agric. Directorate).

The average household size in the Metropolis is 5.1 which is lower than the regional average of 5.3 and 5.7 for Atwima Nwabiagya. The age structure of the population in the metropolis is skewed towards the youth. The highest proportions of the population are in the age cohorts 0–4 years (13.2%) and 5 – 9 years (12.4%). Cumulatively, 39.9 per cent of the population is below 15 years and 6.7 per cent is 64 years and above. There are more males (50.2%) than females (48.8%) in the metropolis. Similar to the situation in Atwima Nwabiagya, the high dependency ratio calls for concerted efforts towards the provision of social infrastructure and services in the metropolis.

4.1.4 **Economic Activities**

(i) Atwima Nwabiagya District

The economy of Atwima Nwabiagya District can be analyzed under four broad categories namely: Agriculture, Industry, Trading and Services. In spite of the peri-urban nature of the District, agriculture is the dominant sector; it employs about 50.8 percent of the labour force as shown in the table below. This is followed by the industrial sector, which employs about 17.4 percent of the labour force. Trading, that is buying and selling employs 14.4 percent whiles the service sector employs 17.4 percent of the labour force.

Table 1: Sectoral Employment of Atwima Nwabiagya District

Sector	Agriculture	Industry	Trading (Commerce)	Service
Labour Force	50.8%	17.4%	14.4%	17.4%

Source: Atwima Nwabiagya District Profile, 2008

Crop farming is the principal agricultural activity in the district. The main crops grown in the district are maize, cassava, yam, cocoyam, ginger, oil palm, rice, citrus, plantain and a wide range of vegetables. The main types of industries found in the district are small scale manufacturing enterprises. These include food processing, textiles/dressmaking, brick and tile making, distillery, pottery, clayware and ceramics. Major trading activities involve food stuffs, provisions, drinks and building materials. Apart from a few who trade in defined market places, most of the trading activities are carried out along roads and residential neighborhoods and the traders are usually small size retailers. The service sector is mainly the provision social services such as health, education and telecommunications. Most of these economic activities are carried on small scale basis and this gives an indication of the economic status of majority of the people in the district and their decision to seek health care from the formal sector. This invariably affects their ability to enroll onto a health care insurance scheme.

(ii) Kumasi Metropolis

Economic activities in the Kumasi Metropolis can be grouped into three main categories: namely: Agriculture, Industry and Commerce including the Service Sector. The economy is made up of the formal and the informal sectors. The formal sector is characterized by businesses with corporate ownership, large-scale operation, capital–intensive and the use of sophisticated technology and the good access to infrastructure and land. The informal sector is made up of thousands of tiny workshops and enterprises producing almost everything under the sun, with a complicated distribution and communication network at their disposal. The major sectors of the economy fall under trade/commerce/services which accounts for about 71 percent, manufacturing/industry which takes up of 24 percent and the primary production sector which takes only 5 percent.

The primary production sector of the metropolis is made up of urban agriculture and quarrying/sand winning. The industrial sector is made up of manufacturing (breweries, beverages) and wood processing. There is vehicular parts production and service industry located at Suame Magazine which is the second largest industrial area in the metropolis. The service sector consists of an integrated system of markets at Adum (central business district) and Kumasi central market with linkages to other satellite markets. Banking, insurance, transportation, hotels, restaurants and traditional caterers (chop bars) and other tourist sites are found in the city. Although many people in metropolis are engaged in a form of employment (employment level 86 percent) either with the private or public sector, about 60 per cent of residents still have a lower standard of living resulting from low incomes and this has a direct bearing on their ability to purchase any form of insurance.

4.1.4 Social Services

(i) Atwima Nwabiagya District

Education

There are forty-six (46) kindergarten/nursery schools, seventy-eight (78) primary schools, forty-four (44) junior secondary schools and four (4) senior high schools in the district. One of the senior high schools provides technical courses. There are also four (4) vocational schools in the District. At the pre-school level, total enrolment is 5364 with 49 per cent being males and 51 per cent females. However, at the primary, JHS and SHS levels, boys' school participation is higher than that of girls (DMTDP, 2006 - 2009).This implies that as pupils climb the educational ladder, girls' dropout turns to be higher than boys. Management attention and action is needed to resolve the issue so as to ensure the retention of girls in school throughout the ladder. The study revealed that the general school participation rate in the District is 27 per cent at the pre-school level and 74 per cent at the basic school level.

Health Care

The District has one (1) hospital, four (4) health centres, four (4) clinics and six (6) maternity homes. The hospital is located at Nkawie-Toase. The district has a doctor/population ratio of about 1:51,000 and a nurse/population ratio of about 1:3000 as the end of 2008 (ANDA District Profile, 2008). Common diseases in the include malaria, typhoid fever, skin diseases, cough and

cold, diarrhoea diseases, hypertension, rheumatic and joint pains, pneumonia and anaemia. Most of the diseases are due to poor environment. buruli ulcer is endemic in the district, though not one of the ten top diseases.

Antenatal service coverage recorded 43.3 per cent (at end of 2008) with average visit of 3 per client, which is low compared with an average of 4 per client especially with the NHIS and free antenatal care. Late teenagers recorded 12.3 percent (382) of the total antenatal attendants. HIV/AIDS prevalence rate in the District is about 4.5 percent. Voluntary counseling and testing (VCT) and prevention of mother to child transmission (PMTCT) services are available at the Nkawie hospital. The District has a District Aids Committee (DAC) and a District Responses Initiative Management Team (DRIMT). These committees are responsible for the monitoring and co-ordination of HIV/AIDS activities in the District.

(ii) Kumasi Metropolis

Education

Educational facilities in the Kumasi metropolis are provided by the public and private (individual and religious bodies) sectors. The private sector provides the bulk of these institutions at the pre-school, first and second cycle levels, whereas the public sector is the leader at teacher training colleges and tertiary levels. These are evenly distributed in space as shown in table 2 below.

Table 2: Distribution of Educational Institutions by Sector in the Kumasi Metropolis

Level	Public Sector		Private Sector		Total
	Absolute	%	Absolute	%	
Tertiary					
University	2	67	1	33	3
Polytechnic	1	100	0	-	1
Nursing Training	1	100	1	-	1
Teacher Training College	2	100	-	-	2
Second Cycle					
SSS	18	37	31	63	49
Technical/Vocational	1	6	31	93	32
First Cycle					
Primary	204	31	448	69	652
JSS	169	46	197	54	366
Pre-School	159	26	443	74	602

Source: Metropolitan Education Directorate, 2006

Available statistics indicates that the private sector accounted for 70.6 per cent of pre – school enrolment in 2006. The public sector's development of pre – school is constrained by the requirement of high and costly standards while the private sector resort to the use of flexible conditions by operating in residential and temporary structures. However, it must be pointed out that some of the structures used by the private sector are substandard. Participation rate at the basic school level (Primary and JHS) was 73.6 per cent whiles total enrolment at the second cycle stood at 36,527 in 2006 (KMA, MTDP; 2006 – 2009).

Health Care

The metropolitan health services are organized around five (5) sub metro health teams; namely, Bantama, Asokwa, Manhyia North, Manhyia South and Subin. The city has a number of health facilities in both the public and private sectors. Notable among them are the Komfo Anokye Teaching Hospital (KATH), four (4) quasi health institutions, five (5) health centres owned by the Church of Christ and the Seventh-Day Adventist Church. In addition, there are over two hundred (200) known private health institutions and 13 industrial clinics in the metropolis. There are also 54 trained traditional birth attendants (TBAs), nine (9) maternal and child health (MCH) points and 119-outreach sites. These facilities are evenly distributed in space as shown in table 3 below.

Table 3: Health Institutions in the Kumasi Metropolis

Sub-Metro	Gov't Hospital	Quasi Gov't Hospital/ Clinic	Mission Hospital/ Clinic	Private Hospital	Private Clinics	Mat. Homes	Homeo-Pathic Clinic	Private Labs	Outreach Stations
Asokwa	1	1	1	14	22	18	4	1	47
Bantama	1	0	1	15	22	30	0	7	39
Manhyia North	1	1	2	5	10	16	13	-	14
Manhyia South	1	2	1	13	14	4	3	2	15
Subin	1	-	1	3	11	3	1	3	7
Total	**5**	**4**	**6**	**50**	**79**	**54**	**21**	**13**	**122**

Source: Metropolitan Health Directorate, 2006

Analysis of available data indicated a worsening trend in doctor/patient ratio from 1: 56,250 in 2003 before the implementation of the National Health Insurance Scheme to 1:70,552 in 2008 (KMA, MTDP 2006 – 2009). The implication is that more patients are chasing few doctors and this confirms the fact that more people are now accessing health care services due to the removal of the financial barriers to health care service through the NHIS. It also reveals a situation of a not too good health delivery system.

The common diseases in the Metropolis include; malaria, diarrhoea, HIV/AIDS, tuberculosis, hypertension, diabetes, septic abortion and road traffic accident. With the introduction of the District Mutual Health Insurance Scheme in 2004, people tend to patronize the public health facilities in the Metropolis more than the private ones. This is attributable to the fact that relatively higher fees are charged by the private health facilities coupled with the fact some of the sophisticated and essential equipment are obtained at the public health facilities. All the five sub metro health teams are implementing the DMHIS.

4.2 Design and Operations of the National Health Insurance Schemes

The National Health Insurance Act, 2003 (Act 650) and the National Health Insurance Regulation, 2004 (LI 1809) mandates the establishment of three broad categories of Health Insurance Schemes in Ghana. These are:

(a) District Mutual Health Insurance Schemes (DMHIS)

(b) Private Mutual Health Insurance Schemes(PMHIS) and

(c) Private Commercial Health Insurance Schemes (PCHIS).

The Act provides the following guidelines for the establishment and operations of the various types of schemes.

4.2.1 Registration and Licensing of the Schemes

Sections 12 and 13 of the National Health Insurance Act spell out the qualification for registration and licensing to operate a health insurance scheme in Ghana. The Act states that an application for registration shall be made to the National Health Insurance Council in a prescribed form with all the necessary documentations such as the Constitution, By – Laws or rules to govern the operations of the schemes. The documentation shall include the proposed persons to manage/administer the scheme and their qualifications; proposed health care providers and health care facilities; health care benefits available under the scheme and the proposed minimum contribution for membership.

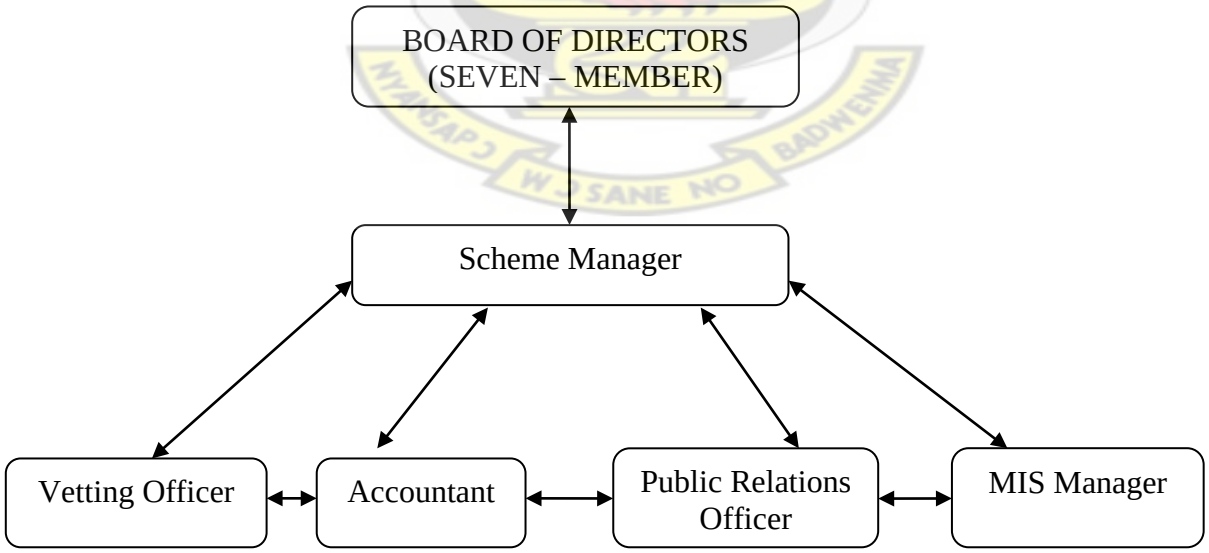
Sections 27 and 28 of the Act stipulate that upon obtaining the license for operation, the Council shall publish the name and particulars of the scheme in the Gazette and newspapers of national circulation. The licensed scheme shall then display its license in a prominent place at its offices where the license is visible to all members and prospective members. The study revealed that the St. Peters Cooperative Credit Union Mutual Health Scheme (SPCCUMHS) started operation in January, 2003. This indicates that the scheme started operation even before the National Health Act was passed by Parliament.

The Scheme Manager explained that the SPCCUMHS realised that the health needs of its members were not being adequately catered for. They therefore took advantage of the discussions and awareness that were being created about health insurance at the time and

initiated their own mutual health scheme. There were no consultations whatsoever with National Health Insurance Council. He further explained that the Union already had the license to operate under the Co-operative Societies Decree, 1968. The purpose was to improve the health status of members so that they could work and improve their incomes and their saving ability. This compares favourably with the principle of Community Solidarity in health care financing as presented by Jutting in 2002.

The study revealed that the St. Peters Cooperative Credit Union Mutual Health Scheme has not registered with the National Health Insurance Council as required by law although their operations are in line with the provisions of the National Health Insurance Regulations (LI 1809). For instance, their organisational structure presented as figure 3 below (on paper) meets the basic structure and staff requirements of the National Health Insurance Regulations. However, further investigations revealed that the actual staff strength of the Scheme is not up to the number presented in the structure. The scheme depends heavily on the other staff of the Credit Union since it is not entirely separated from the operations of the Union.

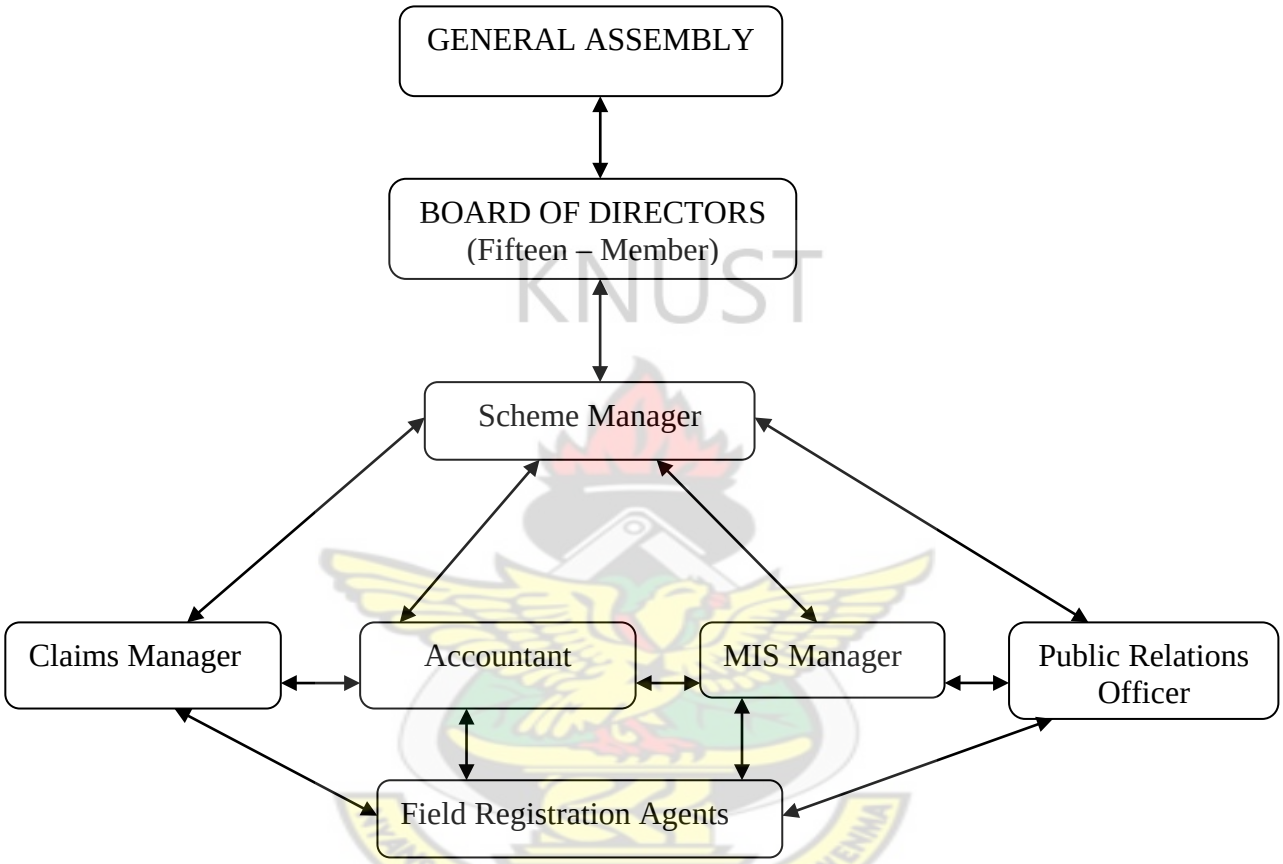
Figure 3: Organisational Structure of the St. Peters Mutual Health Scheme



Source: Author's Construct, June, 2009

The Atwima Nwabiagya District Mutual Health Insurance Scheme on the other hand submitted all the necessary documentations including the following organisational structure to the National Health Insurance Council and subsequently obtained the license for operation in November, 2004.

Figure 4: Organisational Structure of the Atwima Nwabiagya Health Scheme



Source: Author's Construct, June, 2009

Comparing the organisational structures of the two mutual health schemes, it was observed that Atwima Nwabiagya scheme satisfied the provision in section 13 of the National Health Insurance Act which requires the submission of the proposed persons to manage/administer the scheme. Also the Atwima Nwabiagya scheme has field agents who reside in the various communities and they are directly involved in the creation of awareness, registration of community members and distribution of identity cards. There is also a General Assembly whose decisions override those of the Board of Directors of the District Mutual Health Scheme. It was observed that although the St. Peters Health Scheme has the basic required structure; it has not been submitted to the National Health Insurance Council for consideration and approval.

4.2.2 Operational Objectives of the Schemes

The main objective of the National Health Insurance Policy was to set up a National Health Insurance Scheme which would enable residents in Ghana to obtain basic health care services without paying money at the point of delivery. The study revealed that the major objective of both schemes under investigation is to ensure that residents in their operational areas have easy access to quality and affordable basic health care services.

This objective is technically in line with the policy objective of the National Health Insurance Act, 2003 (Act 650). The detailed and specific objectives of both schemes are similar and they include provision of health education and prevention of diseases to the citizens, timely issuance of identity cards to registered members and prudent/effective management of contributions from members. On these scores, one can safely say that the operations of the two schemes conform to the provisions of the National Health Insurance Act. However, some basic differences were identified in terms of their sources of funding, benefit packages/ service provision and mode of premium contribution by members. Table 4 below summarizes the differences in the basic operations of the two schemes.

Table 4: Operational Differences between the Atwima and St. Peters Health Schemes

N0.	Operational Criteria	ANDMHIS	SPCCUMIS
1	Source(s) of Funding	- Government Grant from the NHI Fund for payment to Health care providers, General Administrative Support and Salaries of workers - Internally Generated Funds (IGF) from the members premium contribution and printing of ID Cards	- No financial support whatsoever from Government or any agency. Contributions from members are used in aspects of the schemes operations. - Internally Generated Funds (IGF) from members contribution only

2	Benefit Package (s)	- About 95% of all common diseases in Ghana are covered under the DMHIS. - Chronic diseases such as Renal Failures, Heart/Brain Surgery, HIV/AIDS, Dental care, Hearing and Optical Aids are not covered. - Prescriptions are made to patients based on the essential drug list provided by the National Health Insurance Council. - All Children/Dependants of members who are below 18 years are automatically covered by the scheme.	- The scheme caters for all common diseases - Chronic diseases such as HIV/AIDS and cases of infertility are exempted. - Prescriptions can be made from all type of drugs. - Children/Dependants of members are not covered under the scheme. Only contributors are covered.
3	Mode of Premium Contribution	Members pay their premiums through deductions on their SSNIT contributions or by once in a year cash payment or in installment.	Members pay their premiums through deductions on their savings in their credit union accounts. Very few members make cash payments.
4	Level of Claims paid for Health Care Provision.	The scheme pays for all expenses incurred by members at the health facilities.	The private health scheme pays up to GHC 40.00 for OPD attendance and GHC200.00 for admissions and surgery. Any cost above these has to be paid by members themselves.

Source: Author's Field Survey, June, 2009.

It was observed that these operational differences have significant impact on the enrolment levels and sustainability of the two types of schemes. Whiles the District Mutual Health Schemes enjoy funding from the Central Government for their operations and even pay for workers' salaries, the private schemes have to rely solely on members contributions which are woefully inadequate. This 'lack of funds syndrome' tends to make the private schemes less attractive in terms of the benefit packages they offer to members. They tend to pay far lower claims for health provision and in most cases, members have top up their health care expenses. The Private Scheme is not able to cater for the children/dependants of members. The net effect of these disadvantages is that a lot of their members have decided to opt out and join the District Mutual Health Schemes although they remain members of Co-operative Credit Union.

4.3 Awareness Creation and Understanding of the NHIS Concept

In order to determine how extensive the community members had heard and understood the concept of the National Health Insurance Scheme (NHIS), respondents were asked whether they had heard about the NHIS, from which source and how they understood the concept. This gave an indication of the means of awareness creation and how effective they have contributed to the levels of enrolment into the two schemes. The responses are shown in table 5 below

Table 5: Awareness Creation and Understanding of the NHIS Concept

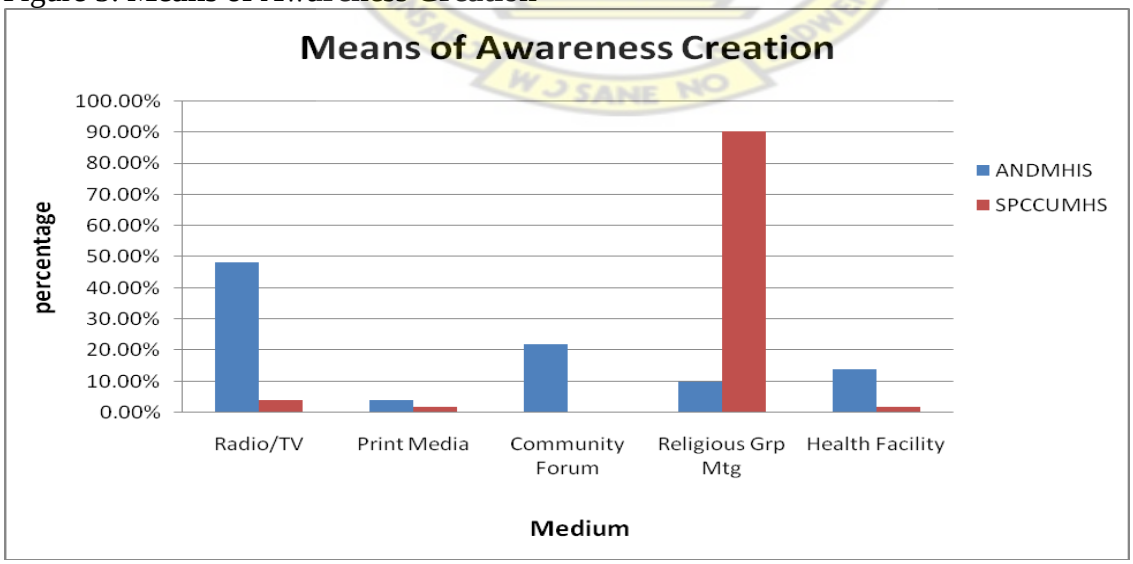
N0.	Criteria	ANDMHIS	SPCCUMHS
1	**Awareness/Understanding of the Existence of Scheme**		
	• Yes	96.9%	98.6%
	• No	3.1%	1.4%
2	**Means of Awareness Creation**		
	• Radio/TV	48.0 %	4.0 %
	• News papers/Posters	4.0 %	2.0 %
	• Community Forum	22.0 %	0.0 %
	• Church/Religious Group Meeting	10.0 %	90.0 %
	• Health Facility	14.0 %	2.0 %

Source: Author's Field Survey, June, 2009

Table 5 shows that 96.9 percent of the respondents in Atwima Nwabiagya said that they had heard and understood the concept of the NHIS as compared to 98.6 percent of the respondents from the St. Peters Health Scheme. Only 3.1 percent of the respondents from Atwima Nwabiagya and 1.4 percent from the St. Peters Scheme indicated that they did not understand the concept of the NHIS. Views that were expressed by respondents on the NHIS concept actually depicted their understanding. For instance, some respondents explained that the NHIS was introduced to replace the "Cash and Carry System" and to spread the cost of health care among community members. These views really reflect the technical definition of health insurance as offered by Arhin and Tenkorang, 2001. These views were also carried by Jutting, 2002 in his concept of "Community Solidarity in Health Care Financing" where he indicated that the community gets together and finds ways of financing its unmet health care needs.

With regards to the means of awareness creation, about half of the respondents (48%) from Atwima Nwabiagya obtained information about the scheme through the radio or television, 22 percent through community forums, 14 percent through health workers, 10 percent through church/religious group meetings and only 4 percent through the print media. Compared to the St. Peters Scheme, majority of the respondents (90%), obtained information about the scheme through church/religious group meetings. Only 4 percent heard about it through the radio and 2 percent each through the print media. The chart below (Figure 5) shows a comparative picture of the two schemes in terms of awareness creation.

Figure 5: **Means of Awareness Creation**



Source: Author's Construct, June, 2009.

The statistics shows that community radio broadcast/television advertisement and organisation of community forums have been more effective in the District Mutual Health Insurance Schemes (DMHIS) whilst in the Private Mutual Health Schemes; it is church or religious group meetings that have been more effective. Notwithstanding, both schemes need to improve upon their outreach programmes to enhance their enrolment levels.

The implication of these high levels of awareness and understanding of the NHIS concept is that where community members understand and appreciate the concept very well, it is likely to contribute to high levels of enrolment and vice versa. Jutting, 2002 supports this argument when he found out that in the case of health insurance in the Thies District (Senegal), 70 percent of those questioned had enrolled onto the scheme because they had received clear and persuasive information about the advantages concerning the existence of the scheme in the district and its attendant benefits.

4.4 Enrolment Levels

The following comparative analysis was carried out to determine whether the high levels of awareness and understanding of the NHIS concept in Ghana have actually led to corresponding increase in enrolment levels or client registration. Table 6 below shows how enrolment levels have been increasing in the two schemes over the years.

Table 6: **Enrolment Levels in Atwima and St. Peters Health Schemes**

Year	ANDMHIS			SPCCUMHS		
	Total Population of Area	**Total N0. Registered with Scheme**	**Percentage of Population Registered with Scheme**	**Total Population of Area**	**Total N0. Registered with Scheme**	**Percentage Of Population Registered with Scheme**
2003	141,372	-	-	1,370,276	2,340	0.17 %
2004	145,613	10,968	7.53 %	1,444,271	5,250	0.36%
2005	149,981	23,146	15.43 %	1,522,261	7,010	0.46%
2006	154,481	37,303	24.15 %	1,604,463	8,105	0.51%
2007	159,115	84,290	**52.97 %**	1,691,104	8,525	0.50%
2008	163,888	137, 834	**84. 10 %**	1,782,424	9,220	0.52%

Source: Author's Construct, June, 2009

Table 6 shows that the level of enrolment in the Atwima District Scheme has been increasing steadily since it began operation in 2004. In 2004, only 7.53 percent of the people in the District registered with the scheme. This increased to 15.43 percent in 2005 and 24.15 percent in 2006. This trend indicates that in the first three years of operation, less than a third of the people actually registered with the scheme. However, in 2007 enrolment levels more than doubled to 52.97 percent and 84.10 percent of the projected population in 2008 compared to the National Average of 64 percent.

This phenomenal increase in enrolment levels in the Atwima District Scheme is a result of multiplicity of factors and strategies adopted by the National Health Insurance Authority and the Management of the scheme. These include the introduction of the free registration for pregnant women which began in July, 2008. The portability of the National Health Insurance (NHI) cards was also a major contributory factor. Before August, 2007, the issuing of NHI cards used to be district-based. That means that the cards were only accepted within a particular district which issued the cards. However, in July, 2007, the National Health Insurance Authority began the issuing of cards which could be used in all health facilities across the country. The strategic location of the District also enables people from the adjoining densely populated communities to register with the Atwima Nwabiagya Scheme.

Comparing with the St. Peters Mutual Health Scheme, although enrolment levels have been increasing over the years, the trend has not been increasing as in the case of the District Scheme. The St. Peters Mutual Health Scheme has been registering an average of about 0.5 percent of the projected population in the Kumasi Metropolis. This relatively low performance is mainly due to the fact that there are five other Sub-Metro Mutual Health Schemes which offer stiff competition for membership among the people in the Metropolis. Also, enrolment onto the St. Peters Scheme is restricted to ones membership of the credit union which is predominantly religious based. This is supported by the statistics shown in table 5 on the means of awareness creation where about 90 percent of the respondents indicated that they heard about the scheme through a religious group meeting. This collaborates the fact that the means of creating awareness by the Private Schemes have not been effective. There is therefore the need to improve upon their outreach programmes so as to enhance their enrolment levels and sustainability of the schemes.

4.5 Service/Benefit Packages and Determination of Clients' Level of Satisfaction

Section 64 of the National Health Insurance Act, 2003 (Act 650) stipulates that a licensed scheme, be it Private or District Mutual, shall provide to its members the minimum healthcare benefits that the Minister of Health may prescribe, on the advice of the National Health Insurance Council. Accordingly, Section 19 of the National Health Insurance Regulations, 2004 (LI 1809) spells out a minimum benefit package of diseases which every scheme must cover. This package covers about 95 percent of diseases in Ghana. Diseases covered include malaria, diarrhoea, upper respiratory tract infection, skin diseases, hypertension, diabetics, asthma, and a lot of other diseases ranging from head to toe. Common drugs for the treatment of these diseases are spelt out in the National Health Insurance drug list. However, a scheme has the right under the law to organise its package to cover as many diseases and services as it desires, provided it is approved the National Health Insurance Council.

Certain diseases are however excluded from the benefit package. This is mainly because it is too expensive to treat those diseases. Diseases that are currently not covered by the National Health Insurance drug list are: optical aids, hearing aids, orthopaedic aids, dentures, beautification surgery, supply of HIV/AIDS drugs, treatment of chronic renal failure, heart and brain surgery. All these constitute about 5 percent of the total diseases in Ghana.

The study revealed that the Boards of Directors of both schemes decided to adhere to the guidelines provided by the National Health Insurance Council in relation to the benefit package. The only difference is that children/dependants of members of the Atwima Nwabiagya Scheme who are below 18 years are automatically covered under the scheme. However children/dependants of members of the St. Peters Scheme are not covered under the scheme. Only contributors are covered. This was identified as one major source of dissatisfaction among members of the St. Peters Scheme. They contend that after paying for their annual contribution, they still have to register with the District Mutual Health Insurance Schemes in order to cater for their dependants. This, to them, is double payment for registration and enrolment.

They also indicated that until the beginning of 2008, membership for the health scheme had been automatic once you join the Cooperative Credit Union and payment for the health insurance had been deducted from their savings. This arrangement was however reviewed in December, 2007 and membership onto the health scheme became optional. In spite of this change, members were reluctant to withdraw from the scheme so long as they remain members of the Credit Union. Yet, their level of satisfaction remains questionable.

Determination of Clients' Level of Satisfaction

In order to determine the level of satisfaction with the services and benefit packages provided by the two types of schemes, a nominal scale developed by Rensis Likert (an American Social Science Professor) was adopted. This scale, now known as the Likert Scale, offers a means of determining attitudes along a continuum of choices. It is usually used in Social Science researches to measure attitudes, preferences and subjective reactions. It helps the researcher to get at the emotional and preferential responses people have to a particular design or scheme (Likert, 1967).

In adopting the Likert Scale for this research, respondents were asked to rate their satisfaction, (using a nominal scale of 1 to 3) with respect to certain criteria which have direct influence on enrolment levels and sustainability of the schemes as presented in the conceptual framework (Figure 2). The nominal scale was defined as follows:

Definition	Nominal Scale
Highly Satisfactory	3
Satisfactory	2
Unsatisfactory	1

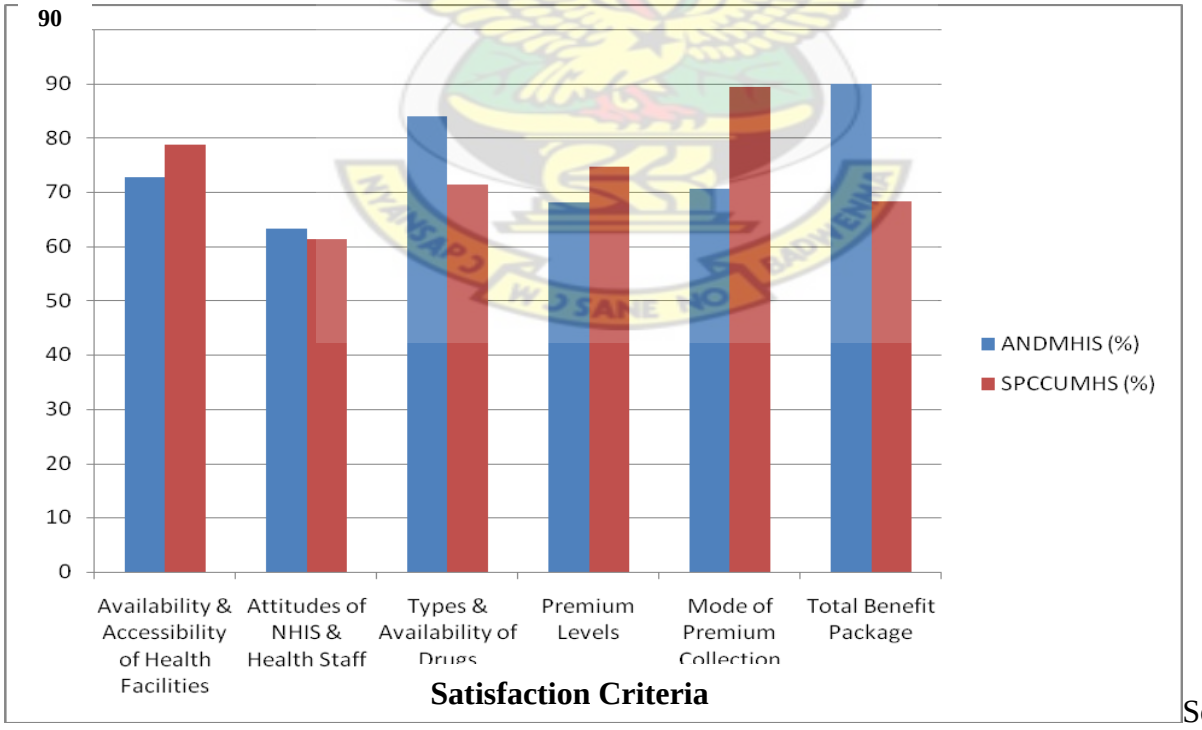
After the respondents had given their ratings with respect to the criteria, the total scores were converted into percentages and compared with the average percentage score. Any criterion which obtained a mark less than the average percentage scores was considered unsatisfactory by clients. Table 7 below and figure 6 show how the respondents rated the various criteria.

Table 7: **Determination of Clients' Level of Satisfaction with NHIS Services/Benefits**

Satisfaction Criteria	**Clients' Level of Satisfaction**			
	ANDMHIS		**SPCCUMHS**	
	Total Score By Clients	Percentage Score	Total Score By Clients	Percentage Score
Availability & Accessibility of Health Facilities	218	72.67 %	236	78.67 %
Attitudes of NHIS & Health Staff	190	63.33 %	184	61.33 %
Types & Availability of Drugs	252	84.00 %	214	71.33 %
Premium Levels	204	68.00 %	224	74.67 %
Mode of Premium Collection	212	70.67 %	268	89. 33 %
Total Benefit Package	**270**	**90.00 %**	**205**	**68.33 %**
Average Percentage Scores		**74.78 %**		**73.94 %**

Source: Author's Construct. June, 2009

F % 6: **Clients' Level of Satisfaction with NHIS S es/Benefits**



Source: Author's Construct. June, 2009

Table 7 shows that the average percentage scores were 74.78 percent for the Atwima Nwabiagya District Mutual Health Scheme and 73.94 percent for the St. Peters Health Scheme. Although, the difference in the average percentage scores was quite marginal, the actual criterion that accounted for the high scores are worth considering. Looking at clients' satisfaction with respect to the total benefit packages, the District Mutual Scheme had 90 percent score which was well above the average score as compared to only 68.33 percent in the St. Peters Scheme. This difference is accounted for by the fact that the dependants of members in the Private Schemes are not covered and also members' healthcare expenses are usually not fully borne by the scheme. Members complained that in most instances, they have had to bear extra costs (or top up) for healthcare services. These two factors explain why members from the Private Schemes still register with the District Schemes even though they remain with the private ones. This serves as a precautionary measure to fill the financing gap.

The table also shows that clients are more satisfied with the mode of premium collection in the St. Peters Scheme (89.33 percent) than in the District Health scheme (70.67 percent). Members explained that they do not usually feel the pinch when contributions are deducted from their savings instead of the direct cash payment as done in the District Schemes. The District Schemes may have to improve upon their mode of premium collection.

With regards to the types and availability of drugs, clients in the District Health Scheme scored it 84 percent which is far above the average percentage score as compared with the 71.33 percent in the Private Scheme. This is expected since the District Schemes pay for all drugs supplied to clients provided they are on the National Health Insurance Drug List. Unlike in the Private Schemes where clients sometimes have to bear additional cost for drugs supplied.

Attitudes of NHIS and health staff leave much to be desired. The table shows much lower scores for staff attitudes in both schemes; In fact, this criterion had the lowest scores among them all. This means that clients are least satisfied with the attitudes of both NHIS and health staff.
This collaborates the findings by Jutting in 2002 that the schemes lack sufficient administrative, managerial and technical human capacity to implement and sustain the momentum with which the Government wants to drive the NHIS Policy.

The 2005 Ghana Health Service Annual Report indicates constrained health care resources in Ghana with about 45 percent of health personnel trained in Ghana being lost to migration. This gives an indication of the kind of stress health personnel in Ghana go through and hence their poor attitudes towards the increasing numbers of patients in the health facilities. This is never an attempt to justify these poor attitudes but a signal towards conscious efforts at training more health personnel and building the capacities of the NHIS staff.

The above argument also holds for the availability and accessibility of health facilities, even though the percentage scores for this criterion were quite encouraging (72.67 percent for the District Mutual Scheme and 78.67 percent for the St. Peters Scheme). This indicates that availability and accessibility of health facilities are better in the urban areas where the Private Schemes operate than in the Districts. One major objective of the National Health Insurance (NHIS) Policy is to increase access to basic health care services to all residents in Ghana. However, the study revealed that the implementation of the NHIS Policy in Ghana has so far tackled the problem of accessibility partially. This is supported by the observation in a research conducted by Professor Joseph Oppong (The Interim Associate Dean for Research and Development of the University of North Texas, USA) and published in the Ghanaian Times (Thursday, July 9, 2009) that the NHIS in Ghana addresses only the financial aspect of the numerous challenges facing many Ghanaians seeking healthcare. "It is not tackling the issue of equitable geographic distribution of health facilities across the country". This leads us into the discussions on the challenges facing the implementation of the NHIS Policy.

4.6 Challenges Facing the Implementation of the NHIS Policy in Ghana

In a presentation by the then Chief Executive Officer of the National Health Insurance Scheme at the 2006 Annual Health Summit in Accra and published by the Ghana news Agency on 2nd September, 2006, a number of challenges facing the implementation of the National Health Insurance Policy in Ghana were enumerated.

Among these are the limited sources of funding for the scheme, abuse of the scheme by frequent and unnecessary visits to health facilities by clients, inadequate premium to sustain the operations of the scheme, insufficient administrative, managerial and technical human capacity, delays and inconsistencies in issuing health insurance cards to those who are registered. These

collaborate the observations made by Jutting in 2002 in his study on the implementation of Social Health Insurance in Sub-Saharan Africa.

Most of these challenges have however been overcome and significant achievements have been made especially in the areas of awareness creation and enrolment levels. The real challenges are seen in the areas of establishing structures for monitoring and consolidating the gains made as observed in a study by Mrs. Scholarstica Mensah (a member of the National Health Insurance Council) and published in the 24th January, 2007 issue of The Statesman Newspaper. It was emphasised that the greatest challenge facing the District Mutual Health Insurance Schemes in the area of monitoring is that after almost five years of implementation of the NHIS Policy in Ghana, there has not been any comprehensive development of any computerised software or mechanism for the administration of claims. The process has always adopted the manual approach where Claims Managers have to subject every single claim to a thorough manual vetting alongside thousands of prescriptions submitted by the numerous health care providers. It is really cumbersome, time consuming and evidently prone to fraud. According to Mrs. Mensah, there have been several unsubstantiated allegations involving some Scheme/Claims Managers and health care providers. This has been the major cause of undue delays in the release of funds for reimbursement from the Secretariat of the National Health Insurance Fund to the various schemes.

Consequently, health care providers usually need to make lots of follow-ups and provide "unofficial appetising means" of pushing their claims through. The study revealed that it takes an average of six (6) weeks (sometimes more than three months) for health care providers to get paid for services rendered to clients. About eighty percent (80%) of health care providers interviewed, especially pharmacists, expressed this situation as the greatest disincentive for working under the NHIS and it really borders on the sustainability of the scheme.

According to Boateng (2006), another big challenge facing the District Mutual Health Insurance Schemes in terms of enrolment is their inability to convince the larger population in the informal sector to subscribe to the schemes. As at September, 2006, only 22 percent of the people in the informal sector had enrolled into the scheme nationwide considering the fact that about 70 percent of the working population in Ghana is employed in the informal sector. The study

confirmed this situation as depicted in the occupational characteristics of respondents in table 8 below.

Table 8: Occupational Characteristics of Respondents

Occupational Characteristics	ANDMHIS	SPCCUMHS
Salaried Worker (Formal Sector)	58.0 %	36.0 %
Businessman/Trader	15.0 %	44.0 %
Farmer	13.0 %	7.0 %
Self Employed/Artisans	7.0 %	12.0 %
Unemployed	2.0 %	1.0 %
Student	5.0 %	0.0 %
Total	**100**	**100.0**

Table 8 shows that the salaried workers in the formal sector constituted 58 percent of the respondents in the Atwima Nwabiagya Health Scheme. The reason is that workers in the formal sector need not be persuaded to subscribe to the District Schemes since their premiums are deducted from their SSNIT contributions. Thus they become automatic members of the schemes. Comparatively, formal sector workers in the St. Peters Health Scheme is also quite high (36 percent of the respondents), although not as high as the businessmen/traders (44 percent).

Apart from the general challenges discussed above, other peculiar ones that were identified include the inaccessibility to some areas of the Districts especially during the rainy season and inadequate logistics such as vehicles and trained staff. The Atwima Nwabiagya Health Scheme has only one vehicle meant for outreach programmes and for that matter, they are able to cover few areas of the District. This means that there are a lot of people in the remote areas of the District who have either not heard about the Health Insurance Scheme at all or cannot be reached by the field agents for registration. As explained earlier, the high enrolment levels recorded in the last two years have been due to the influx of people from the adjoining peri-urban communities in the Kumasi Metropolis to the detriment of the indigenous people.

In terms of staff strength, the Atwima Nwabiagya Scheme has only six (6) recognised staff members on the pay-roll of the National Health Insurance Authority (compared with the fifteen-member Board of Directors). The Scheme relies heavily on the National Service Personnel and students on internship who are given some allowances from the scheme's internally generated fund (IGF). This tends to place a heavy burden on the finances of the scheme. These people also do not stay long enough to gather any meaningful experience which could be helpful to the scheme in the long term.

With the St. Peters Scheme, a myriad of challenges which border heavily on the sustainability of the scheme were identified. Apart from the low enrolment levels discussed earlier, the scheme faces serious logistical and staff challenges. In fact, there is no vehicle specifically earmarked for the scheme's activities and only two staff members are currently at post. The scheme tends to rely on the staff of the Credit Union. The limited nature of the level of reimbursement to health care providers when clients access services from them is a serious disincentive to the clients. In most cases, clients have to bear extra cost on health care provision. This is basically due to the weak financial base of the scheme because of their inability to access subsidies from the National Health Insurance Fund.

4.7 Significant Achievements of the NHI Policy in Ghana

In spite of the many challenges identified in the implementation of the NHIS Policy in Ghana, some significant successes have been achieved and these are manifested in the following areas.

- **Enrolment levels**

One of the stated targets of Ghana's National Health Insurance Policy was to achieve 50 percent coverage in its first four years of operation and universal coverage (95%) for all residents in Ghana by 2012 (Boateng, 2006).

The study revealed that in its first four years of operation (i.e. by end of 2007), the Atwima Nwabiagya Scheme recorded 52.97 percent of the population in the District and this was slightly higher than the national average of 45 percent. The St. Peters Scheme recorded only 0.50 percent of the population in the Kumasi Metropolis. By end of 2008, the Atwima Nwabiagya Scheme had recorded 84.10 percent compared to the national average of 60 percent (reasons for these

trends are as explained in section 4.4 of this report). These trends in the subscription rates indicate that the District Mutual Health Insurance Schemes can achieve the targets set although same cannot be said about the Private Mutual Health Schemes.

- **Increased Accessibility to Health Care Services**

One of the cardinal objectives of Ghana's health sector reforms that started implementation in 1997 was to increase access to basic clinical and public health services. A Core Welfare Indicator Questionnaire Survey conducted by the Ghana Statistical Services (GSS) in 2003 indicated that before the introduction of the NHIS, the percentage of people stating that they had access to health facilities (as defined by the Ministry of Health using geographical, financial and transportation factors) was 58 percent. According to a research conducted by Professor Joseph Oppong and published in the Ghanaian Times (Thursday, July 9, 2009), the percentage of people stating that they had access to health facilities had increased to 76 percent by end of 2008, although the increase is mainly due to financial accessibility.

The results from the questionnaire administered at the Atwima Nwabiagya District and Kumasi Metropolitan Health Directorate revealed that the Doctor-Patient ratio in Atwima Nwabiagya District increased from 1:20359 in 2003 before the implementation of the NHIS to 1:51,000 in 2008 compared to the UN Standard of 1:20,000. Similarly, Nurse-Patient ratio increased from 1:1787 in 2003 to 1: 3000 in 2008 compared with UN standard of 1:500. Comparing this statistics with that of the Kumasi Metropolis, the doctor-patient ratio increased from1: 56,250 in 2003 to 1:70,552 in 2008. Nurse-patient ratio also increased from 1:3845 to 1:6830 over the same period (Field Survey, July, 2008). This confirms the fact that more people are now accessing health care services with the implementation of the National Health Insurance Scheme and its subsequent removal of the financial barriers to health services accessibility.

- **Employment Creation**

Since the introduction of the NHIS in 2003, over 2,200 people have been officially employed by the National Health Insurance Authority in various sections of the scheme in different regions of the country (Boateng, 2006). These are made up of the Scheme Managers, Claims Managers, Accountants, Information System Managers and Public Relations Officers at the District and

Regional levels. Additionally, over 5,200 people have been engaged as field agents for the District Mutual Health Insurance Schemes and more than 3,000 people as office assistants.

Observation at the District office of the Atwima Nwabiagya Scheme showed that more than 200 subscribers visit the premise every working day for various kinds of services including renewal and collection of Health Insurance Cards. This makes the office premise like a market centre where food vendors and other business operators render various kinds of services. This ripple effect has also created jobs for more than 30 people in the locality. This is unlike the office premise of the St. Peters Health Scheme where less than 20 subscribers visit the place.

- **Construction of Office Complex**

One major specific achievement of the Atwima Nwabiagya District and St. Peters Cooperative Health Schemes which is worth noting is their ability to construct their own office complexes. In fact, the office complex of the Atwima Nwabiagya Scheme is just one of its kind in the whole country and what makes it unique is that the Scheme was able to put up such a magnificent, well furnished structure (shown as figure 7) at an estimated cost of **One Hundred and Ninety-Five Thousand Ghana Cedis (GHC195,000.00)** through its own internally generated funds (IGF) over a period of two years.

Similarly, the St. Peter's Cooperative Credit Union has been able to put up its own office complex (shown as figure 8) at an estimated cost of **Two Hundred and Forty Thousand Ghana Cedis (GHC240,000.00)** over a three year period.

Figure 7: Office Complex of the Atwima Nwabiagya District Health Insurance Scheme

Source: Field Survey. 2009

Figure 8: Office Complex of the St. Peters Cooperative Credit Union

Source: Field Survey. 2009

CHAPTER FIVE

SUMMARY OF FINDINGS, RECOMMENDATIONS AND CONCLUSIONS

5.0 Introduction

This chapter summarizes the findings and analysis of the results of the field survey. The link between the set objectives of the research work and the outcomes of the analysis is established in this chapter. Based on these outcomes, recommendations to address the implementation challenges of the National Health Insurance Schemes are made to ensure their sustainability.

5.1 Summary of Findings

5.1.1 Design and Operations of the National Health Insurance Schemes

The National Health Insurance Act, 2003 (Act 650) was presented to Parliament for deliberations in June, 2003 and passed into law in September, 2004. In November, 2004, the National Health Insurance Regulation, 2004 (LI 1809) was promulgated to guide the operations of the various types of schemes established under the Law. Sections 12, 13, 27 and 28 of the Law spell out the qualification for registration and licensing to operate a health insurance in Ghana.

The study revealed that the St. Peters Co-operative Credit Union Mutual Health Scheme (SPCCUMHS) started operation in January, 2003 even before the National Health Insurance Act was laid before Parliament for deliberations. The Co-operative Union took advantage of the discussions and awareness that were being created about health insurance at the time and initiated their own mutual health scheme. They started operating under the Co-operative Societies Decree, 1968 and the purpose was to improve the health status of its members so that they could work and improve their incomes and their saving ability. It was also observed that the SPCCUMHS has not registered with the National Health Insurance Council as required by law. The Atwima Nwabiagya District Health Scheme on the other hand submitted all the necessary documents to the National Health Insurance Council and obtained the license for operation in November, 2004.

5.1.2 **Operational Objectives of the SPCCUMHS and ANDMHIS**

The major objective of the SPCCUMHS and ANDMHIS is to ensure that residents in their operational areas have easy access to quality and affordable basic health care services. This objective is technically in line with the policy objective of the National Health Insurance Act, 2003 (Act 650). The detailed and specific objectives of both schemes are similar and they include provision of health education and prevention of diseases to the citizens, timely issuance of identity cards to registered members and prudent/effective management of contributions from members. One can therefore conclude that the operations of the two schemes conform to the provisions of the National Health Insurance Act. However, some basic differences were identified in terms of their sources of funding, benefit packages/ service provision and mode of premium contribution by members.

5.1.3 **Awareness Creation and Understanding of the NHIS Concept**

Questionnaires were designed to determine how extensive people in the communities have become aware of the existence of the NHIS and how they have understood the concept. This gave an indication of the means of awareness creation and how effective they have contributed to the levels of enrolment into the schemes.

The results indicated that 96.9 percent of the respondents in Atwima Nwabiagya had heard and understood the concept of the NHIS as compared to 98.6 percent of the respondents from the St. Peters Health Scheme. Only 3.1 percent of the respondents from Atwima Nwabiagya and 1.4 percent from the St. Peters Scheme indicated that they did not understand the concept of the NHIS. Views that were expressed by respondents on the NHIS concept actually depicted their understanding of the NHIS concept as carried by Arhin and Tenkorang, 2001

The implication of these high levels of awareness and understanding of the NHIS concept is that where community members understand and appreciate the concept very well, it contributed to high levels of enrolment as cited by Jutting, 2002 in the case of health insurance in the Thies District (Senegal). Regarding the means of awareness creation, radio/television advertisements and organisation of community forums were found to be more effective in the Atwima Nwabiagya District whilst in the St. Peters Health Scheme church/religious group meetings were found to be more effective.

5.1.4 **Enrolment Levels**

Analysis of the results indicated that in the first three years of operations, the high levels of awareness and understanding of the National Health Insurance concept did not actually lead to a corresponding increase in enrolment levels or client registration. However, enrolment levels in the Atwima Nwabiagya Scheme in 2007 and 2008 were above the national average of 50 percent and 60 percent respectively. In the case of the St. Peters Health Scheme, although enrolment levels increased over the years, the trend was not impressive. The Scheme registered an average of 0.5 percent of the projected population in the Kumasi Metropolis. This performance was mainly due to the fact that there are five other Sub-Metro Mutual Health Schemes which offer stiff competition for membership among the people in the Metropolis coupled with the fact that enrolment onto the St. Peters Scheme is restricted to ones membership of the Credit Union which is predominantly religious based.

5.1.4 **Service/Benefit Packages**

Section 19 of the National Health Insurance Regulations, 2004 (LI 1809) spells out a minimum benefit package of diseases which every scheme must cover. This package covers about 95 percent of diseases in Ghana. Diseases covered include malaria, diarrhoea, upper respiratory tract infection, skin diseases, hypertension, diabetics, asthma, and a lot of other diseases ranging from head to toe. Common drugs for the treatment of these diseases are spelt out in the National Health Insurance drug list. Diseases that are currently not covered by the National Health Insurance drug list are: optical aids, hearing aids, orthopaedic aids, dentures, beautification surgery, supply of HIV/AIDS drugs, treatment of chronic renal failure, heart and brain surgery. All these constitute about 5 percent of the total diseases in Ghana. It was observed that the Boards of Directors of both schemes decided to adhere to the guidelines provided by the National Health Insurance Council in relation to the benefit package.

5.1.5 **Clients' Level of Satisfaction with Service Provision**

Adopting the Likert Scale in the determination of the level of clients' satisfaction with the services provided by the two health insurance schemes, it was observed that the average percentage scores were 74.78 percent for the Atwima Nwabiagya Scheme and 73.94 percent for

the St. Peters Health Scheme. Clients' satisfaction with respect to the total benefit packages for the District Mutual Scheme was 90 percent which was well above the average score as compared to the 68.33 percent in the St. Peters Scheme. This difference is accounted for by the fact that the dependants of members in the Private Schemes are not covered and also members' healthcare expenses are usually not fully borne by the scheme. It was also observed that clients are more satisfied with the mode of premium collection in the St. Peters Scheme (89.33 percent) than in the District Health scheme (70.67 percent).

With regards to the types and availability of drugs, clients in the District Health Scheme scored it 84 percent compared with the 71.33 percent score in the Private Scheme. Attitudes of NHIS and health staff had the lowest scores among all the criteria in both schemes indicating that clients are least satisfied with the attitudes of both NHIS and health staff. Scores for availability and accessibility to health facilities were quite encouraging; 72.67 percent for the District Mutual Scheme and 78.67 percent for the St. Peters Scheme indicating that availability and accessibility of health facilities are better in the urban areas where the Private Schemes operate than in the Districts.

5.1.6 **Challenges Facing the Implementation of the NHIS Policy in Ghana**

Among the general challenges facing the implementation of the NHIS Policy in Ghana include limited sources of funding for the scheme, abuse of the scheme by frequent and unnecessary visits to health facilities by clients, inadequate premium to sustain the operations of the scheme, insufficient administrative, managerial and technical human capacity, delays and inconsistencies in issuing health insurance cards to those who are registered.

One big distinct challenge facing the implementation of the scheme is the establishment of structures for monitoring and development of a comprehensive computerised software or mechanism for the administration of claims and its attendant fraud and delay in reimbursements to the schemes. In terms of enrolment, the District Mutual Health Insurance Schemes have not been very effective in registering the larger population in the informal sector. Inadequate trained staff and logistics for general operations were identified as specific challenges facing the two schemes under investigation.

5.2 Recommendations

5.2.1 Improving the Design and Operations of the National Health Insurance Schemes

The National Health Insurance Act, 2003 (Act 650) mandates the establishment of the three broad categories of Health Insurance Schemes in Ghana as listed in section 4.2. The Act specifies that only the District Mutual Health Insurance Schemes (DMHIS) qualify to receive state funding from the National Health Insurance Fund (NHIF). It is argued that the major sources of revenue into the NHIF are taxes from both private and public workers as depicted in figure 1. Therefore, the decision to fund only the DMHIS as against the other types of schemes is arguably discriminating since the Ghanaian Constitution allows freedom of association. Consequently, it is recommended that the other types of schemes should also receive some level of state support from the NHIF to enable them compete favourably with the DMHIS. This should however be done on condition that the operations of the other types of schemes conform to the provisions of the National Health Insurance Regulation, 2004 (LI 1809).

As revealed by the study, most of the private schemes have not registered with the National Health Insurance Council (NHIC) and therefore their operations are not regularised or supervised by the Council. It is strongly recommended that the National Health Insurance Authority extend their regulatory and supervisory roles to the other types of schemes. Specifically, it is recommended that the management of the St. Peters Mutual Health Scheme take immediate steps to register with the NHIC and begin to operate under the National Health Insurance Regulation, 2004 (LI 1809) instead of the Co-oparative Societies Decree, 1968. This will put them in a properly recognised stead to push their case towards state support from the NHIF and ensure their sustainability.

5.3.2 Improving Enrolment Levels

The study revealed very high levels of awareness and understanding of the NHIS concept among community members. This implied that where members understand and appreciate the concept very well, it should contribute to high levels of enrolment. The results however, depicted quite a different situation where enrolment levels were not very encouraging, especially in the case of the St. Peters Health Scheme. This situation is blamed on multiplicity of factors which border on the focus of this research (i.e. the level of clients' satisfaction with service provision and benefit packages of the schemes). It is therefore imperative that improvements in all the criteria used in

the determination of clients' satisfaction can lead to high levels of enrolments. The following should be the areas of focus for improvement:

- **Total Benefit Package**

Section 19 of the National Health Insurance Regulations, 2004 (LI 1809) spells out the minimum benefit package of diseases that every scheme must cover. This constitutes about 95 percent of diseases in Ghana and it is regulated by a drug list provided by the National Health Insurance Council (NHIC). The study revealed that this drug list is not comprehensive enough to actually deal with the 95 percent disease coverage stated in the LI. It is also argued that the cost of treating most of these common diseases is quite affordable by the average Ghanaian worker. So where lies special benefit in joining a health scheme? It is therefore recommended that the drug list should be reviewed by the NHIC to cover at least about 98 percent of common diseases in Ghana. More importantly, it should cover most of the diseases that the average Ghanaian worker finds quite expensive to treat. This could be the most critical motivating factor for people to enrol into the schemes.

Another critical issue relating to the drug list is the complaint by healthcare providers especially, pharmacists and licensed chemical sellers that the price quotations provided by the NHIC for the drug list are unrealistic considering economic and market trends. They also complain that it takes too long a time for the NHIC to consider price adjustments. Most of them are therefore operating at a loss; or better still, they are forced to make clients pay for the difference in the price quotations. It is therefore recommended that the NHIC should meet quite frequently with representatives of Healthcare Providers, ideally, every quarter, to consider market trends and take on board emerging issues in healthcare provision.

One specific recommendation for the private schemes in terms of benefits is that they should consider the feasibility of allowing the dependants/children of their members to be covered under the scheme. This could however be translated into higher premiums being charged.

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- **Improving Attitudes of NHIS/Health Staff and Accessibility to Health Care**

The study revealed that attitudes of NHIS and health staff had the lowest scores among all the criteria in both schemes indicating that clients are least satisfied with the attitudes of both NHIS and health staff. This was attributed mainly to inadequate administrative, managerial and technical human capacity to implement and sustain the NHIS Policy. It also came out that health care resources in Ghana are so much constrained giving an indication of the kind of stress health personnel go through and hence their poor attitudes towards the increasing numbers of patients in the health facilities. One obvious recommendation to deal with this problem is a conscious effort by Government at training more health personnel and building the capacities of the NHIS staff. More private sector participation in general health care delivery and training of health personnel is a welcome strategy. In this regard, the Ministry of Health needs to create the enabling environment and necessary incentives (such as tax holidays) for private sector investments in the health care delivery system. Public Private Partnerships (PPPs) are also encouraged. All these efforts could lead to significant improvement in the accessibility of health care in the country.

- **Establishing Comprehensive Structures for Monitoring and Administration of Claims**

As observed by Mrs. Scholarstica Mensah (a member of the National Health Insurance Council), the greatest challenge facing the implementation of the NHI Policy in Ghana is the lack of a comprehensive monitoring system for the administration of claims. This borders so critically on the sustainability of the schemes since a lot of fraudulent deals that can easily collapse the schemes could pass unnoticed. One wonders why at this computer age and the long period of operating health insurance throughout the world, such software has been so hard to come by in Ghana. The simple answer offered by Mrs. Mensah that the available software is not comprehensive enough and that fraudsters are always out-pacing it, is untenable. It is strongly recommended that, no matter how much it will cost, a team of experts in computer software development should be assembled by the Government to come up with a solution to this problem. It is also recommended that Internal Auditors should be employed for all the schemes and efficient monitoring and evaluation mechanisms put in place to ensure accountability and administration of funds.

5.3 **Conclusion**

Provision of healthcare for the citizenry of any country is very important. It is therefore very necessary for Governments to develop a national health programme which will furnish adequate public health services and ample medical care facilities for all areas of the country and all groups of people, thus creating adequate physical and financial access to health care in the country. As noted by Harry Truman (1976) "a healthy citizenry is the most important element in a nation's strength". Provision of quality health care services through the National Health Insurance has been one particular policy that has been pursued by successive Governments of the United States of America for many years without much success (Truman, 1976). The success of Ghana's National Health Insurance Policy could therefore be construed as an attainment of a feat that a materially rich country as the United States of America has not been able to attain, but a materially poor country as Ghana could achieve.

APPENDIX 1**:** **List of References**

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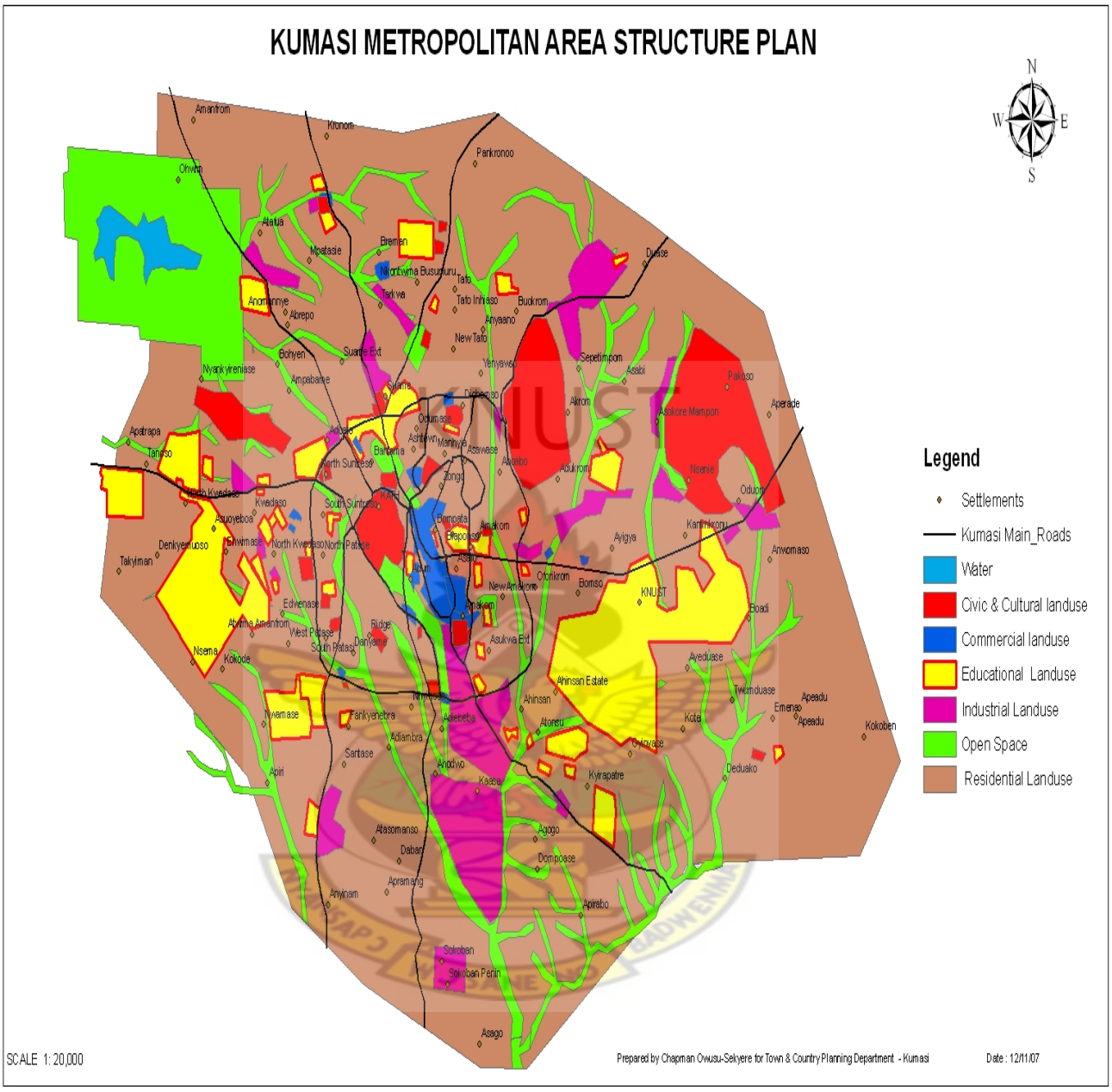
Appendix 2:


KUMASI METROPOLITAN AREA STRUCTURE PLAN
N
W
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Legend
Settlements
Kumasi Main_Roads
Water
Civic & Cultural landuse
Commercial landuse
Educational Landuse
Industrial Landuse
Open Space
Residential Landuse
SCALE 1: 20,000
Prepared by Chapman Owusu-Sekyere for Town & Country Planning Department - Kumasi
Date : 12/11/07

Appendix 4:

INTERVIEW GUIDE/QUESTIONAIRE

QUESTIONNAIRE FOR THE STAFF OF ATWIMA NWABIAGYA DMHIS

A. Operational Issues

1. When did the DMHIS start operating in the District?

……

2. Do you have a copy of the National Health Insurance Policy Document?

Yes ☐ No ☐

3. If "no" why?

……

……

4. What are the aims and objectives of the DMHIS?

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5. Are there any additions or differences between the objectives of the DMHIS and National ones? Yes ☐ No ☐

6. If yes, state them

……

……

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7. What is the administrative structure of the DMHIS?

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8. What is the operational structure of the DMHIS?

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9. What are the major sources of revenue to the scheme?

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10. What has been the trend of revenue generation and expenditure over the last five years?

Year	Amount Received		Expenditure			
	From National Health Insurance Fund (GH₵)	Internally Generated Fund (GH₵)	Service Providers (GH₵)	Provision of Office Equip't & Stationery (GH₵)	Payment of Salaries (GH₵)	Others (Pls. Specify) (GH₵)
2004						
2005						
2006						
2007						
2008						

B. Enrolment levels

11. How would you rate community awareness of the existence of the scheme?

☐ (70% +) of the population

☐ (60% +) of the population

☐ (50 %+) of the population

☐ (40% +) of the population

☐ Below 40% of the population

12. What are some of the strategies that have been adopted to create more awareness of the existence of the scheme?

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13. How many registration centres are in the District?

……

14. What are the procedures for subscribing to the scheme?

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……

15. What is the range of premiums paid by subscribers?

……

16. How do you determine the premiums to be paid by subscribers?

……

……

……

17. What are the methods available for premium contributions?

Year	Number Registered	Through SSNIT Contribution	Direct Cash Payment	Cash Payment In Installment	Others (Please Specify)
2004					
2005					
2006					
2007					
2008					

18. How many people have been registered in the different categories under the scheme?

Category	**Male**						**Female**					
	2004	2005	2006	2007	2007	2008	2004	2005	2006	2007	2007	2008
Children Below 18 yrs												
Adult (18-69)												
Aged (70+)												

19. What do you think can be done to increase subscription to the scheme?

……

……

……

……

C. **Services/Benefit Packages and Satisfaction**

20. What are the types of diseases covered by the Scheme? Please mention them.

……..

…… ……..

……

21. What types of diseases are excluded? Please mention them.

……

……

……

22. How many people in the different categories are currently benefiting under the scheme?

Category	**Male**						**Female**					
	2004	2005	2006	2007	2007	2008	2004	2005	2006	2007	2007	2008
Children Below 18 yrs												
Adult (18-69)												
Aged (70+)												

23. How long do clients have to wait to benefit after the initial subscription?

……

24. Do you think community members are satisfied with the quality of services they receive from health care providers? Yes ☐ No ☐

25. How would you rate clients' satisfaction in relation to the following factors of the scheme? (Nominal Scale: 1⟹Unsatisfactory 2⟹Satisfactory 3⟹ Highly Satisfactory)

Availability and Accessibility of Health Facilities ……. ☐

Attitudes of NHIS and Health Staff ……. ☐

Types and availability of Drugs ……..…….. ☐

Premium Levels …… ☐

Mode of Premium Collection …… ☐

26. How would you rate the overall satisfaction of clients to the services provided by the Scheme?

- ☐ Highly satisfactory
- ☐ Satisfactory
- ☐ Unsatisfactory

D. **Achievements/Implementation Challenges**

27. What are the significant achievements of the scheme in the last five years?

……

……

……

28. How long does it take for health facilities to receive payments for services provided?

……

29. What are the problems associated with the implementation of the DMHIS?

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30. What solutions can you suggest to these problems?

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31. What measures have been put in place to ensure sustainability of the scheme?

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32. What has been the District Assembly's contribution to the implementation of the DMHIS?

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33. How has the DMHIS contributed in the healthcare delivery in the district?

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34. Is there any other information you want to provide?

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THANK YOU.

QUESTIONNAIRE FOR THE STAFF OF ST. PETERS CO-OPERATIVE CREDIT UNION MUTUAL HEALTH SCHEME (SPCCUMHS)

A. Operational Issues

1. When did the scheme (SPCCUMHS) start operating?

   ……

2. Do you have a copy of the National Health Insurance Policy Document?

   Yes ☐ No ☐

3. If "no" why?

   ……

   ……

4. What are the aims and objectives of the SPCCUMHS?

   ……

   ……

   ……

   ……

   ……

5. Are there any additions or differences between the objectives of the SPCCUMHS and National ones? Yes ☐ No ☐

6. If yes, state them

   ……

   ……

   ……

7. What is the administrative structure of the SPCCUMHS?

   ……

8. What is the operational structure of the SPCCUMHS?

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9. What are the major sources of revenue to the scheme?

……

……

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10. What has been the trend of revenue generation and expenditure over the last five years?

Year	Amount Received		Expenditure			
	From National Health Insurance Fund (GH₵)	Internally Generated Fund (GH₵)	Service Providers (GH₵)	Provision of Office Equip't & Stationery (GH₵)	Payment of Salaries (GH₵)	Others (Pls. Specify) (GH₵)
2004						
2005						
2006						
2007						
2008						

B. Enrolment Levels

11. How would you rate community awareness of the existence of the scheme?

- ☐ (70% +) of the population
- ☐ (60% +) of the population
- ☐ (50 %+) of the population
- ☐ (40% +) of the population
- ☐ Below 40% of the population

12. What are some of the strategies that have been adopted to create more awareness of the existence of the scheme?

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13. How many registration centres does scheme have in its operational area?

……

14. What are the procedures for subscribing to the scheme?

……

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15. What is the range of premiums paid by subscribers?

……

……

16. How do you determine the premiums to be paid by subscribers?

……

……

……..

17. What are the methods available for premium contributions?

Year	Number Registered	Through SSNIT Contribution	Direct Cash Payment	Cash Payment In Installment	Others (Please Specify)
2004					
2005					
2006					
2007					
2008					

18. How many people have been registered in the different categories under the scheme?

Category	**Male**						**Female**					
	2004	2005	2006	2007	2007	2008	2004	2005	2006	2007	2007	2008
Children Below 18 yrs												
Adult (18-69)												
Aged (70+)												

19. What do you think can be done to increase subscription to the scheme?

……

……

……

……

C. **Services/Benefit Packages and Satisfaction**

20. What are the types of diseases covered by the Scheme? Please mention them.

……..

…… ……..

……

……

21. What types of diseases are excluded in the scheme? Please mention them.

……

……

……

22. How many people in the different categories are currently benefiting under the scheme?

Category	**Male**						**Female**					
	2004	2005	2006	2007	2007	2008	2004	2005	2006	2007	2007	2008
Children Below 18 yrs												
Adult (18-69)												
Aged (70+)												

23. How long do clients have to wait to benefit after the initial subscription?

……..

……

24. Do you think community members are satisfied with the quality of services they receive from health care providers? Yes ☐ No ☐

25. How would you rate clients' satisfaction in relation to the following factors of the scheme? (Nominal Scale: 1⇨Unsatisfactory 2⇨Satisfactory 3⇨ Highly Satisfactory)

Availability and Accessibility of Health Facilities ……. ☐

Attitudes of NHIS and Health Staff ……. ☐

Types and availability of Drugs ……..…….. ☐

Premium Levels …… ☐

Mode of Premium Collection …… ☐

26. How would you rate the overall satisfaction of clients to the services provided by the Scheme?

☐ Highly satisfactory

☐ Satisfactory

☐ Unsatisfactory

D. **Achievements/Implementation Challenges**

27. What are the significant achievements of the scheme in the last five years?

……

……

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……

28. How long does it take for health facilities to receive payments for services provided?

……

29. What are the problems associated with the implementation of the PMHIS?

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30. What solutions can you suggest to these problems?

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31. What measures have been put in place to ensure sustainability of the scheme?

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32. Does the scheme receive any support from any NGO or Government?

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33. How has the scheme contributed in the healthcare delivery in the metropolis?

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34. Is there any other information you want to provide?

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……..

THANK YOU.

QUESTIONNAIRE FOR HEALTHCARE PROVIDERS

(ANDMHIS)

A. **Operational Issues**

1. Type of Healthcare Provider

☐ Hospital ☐ Health Centre ☐ Clinic ☐ Maternity Home

☐ CHIP Compound ☐ Pharmacy ☐ Chemical Store

☐ Others (Please Specify).....

2. Ownership: ☐ Government ☐ Private ☐ Church ☐ Islamic

☐ Others (Please Specify).....

3. Does the facility operate under the National Health Insurance Scheme?

☐ Yes ☐ No

4. If yes, which of the schemes does the facility operate with?

☐ District Mutual Health Insurance Scheme

☐ Private Mutual Health Insurance Scheme

☐ Private Commercial Health Insurance Scheme

☐ Others (Please Specify).....

5. When did the facility obtain accreditation under NHIS? .....

6. Do you have a copy of the National Health Insurance Policy Document?

YES ☐ NO ☐

7. If NO, why?

……...……

.....……

.....

8. Please provide information about the number of health facilities in the area/district (if applicable) before and after the introduction of the NHIS

Facilities	Number								
	2000	2001	2002	2003	2004	2005	2006	2007	2008
1. Hospitals									
2. Health Centres									
3. Clinics									
4. Maternity Homes									
5. CHIP Compounds									
6. Pharmacies									
7. Chemical Stores									
8. Others(Specify)									

9. How many of these facilities provide services under the NHIS?

Facilities	Number					Location
	2004	2005	2006	2007	2008	
1. Hospitals						
2. Health Centres						
3. Clinics						
4. Maternity Homes						
5. CHIP Compounds						
6. Pharmacies						
7. Chemical Stores						
8. Others(Specify)						

B. Enrolment Levels

10. How would you rate community awareness of the existence of the NHIS?

- ☐ (70% +) of the population
- ☐ (60% +) of the population
- ☐ (50 %+) of the population
- ☐ (40% +) of the population

11. What has been the annual total OPD and In – Patient attendance to the facility?

Year	OPD	In - Patients	Year	OPD	In - Patients
2001			2005		
2002			2006		
2003			2007		
2004			2008		

12. What have been the trends of Doctor-Patient and Nurse-Patient Ratios in the area/district? (if applicable)

Year	2001	2002	2003	2004	2005	2006	2007	2008
Doctor-Patient Ratio								
Nurse-Patient Ratio								

13. How many clients do you serve from the DMHIS and SPCCUMHS?

Type of Scheme	**2004**	**2005**	**2006**	**2007**	**2008**
DMHIS					
SPCCUMHS					

14. What do you think can be done to increase subscription to the schemes?

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……

C. **Services/Benefit Packages and Satisfaction**

15. What are the prevalent diseases in the area/district? Please list them in order of prevalence.

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……

16. Which of these diseases are covered under the **DMHIS or SPCCUMHS** (Please indicate which is applicable)

……

……

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17. Are the charges for the DMHIS or SPCCUMHS card bearers different from non – card bearers? Yes ☐ No ☐

18. If yes, why?

……

……

……

19. What is the average cost of attendance to the health facility?

Year	**Average Cost Per Attendance**		**Year**	**Average Cost Per Attendance**	
	OPD	**In - Patients**		**OPD**	**In - Patients**
2001			2005		
2002			2006		
2003			2007		
2004			2008		

20. What problems do Patients face in accessing health care in the area/district?

……

…….....……..…….....

……...

……

21. Do you think clients are satisfied with the quality of services they receive from health care providers under the scheme? Yes ☐ No ☐

22. How would you rate clients' satisfaction in relation to the following factors of the scheme? (Nominal Scale: 1⇨Unsatisfactory 2⇨Satisfactory 3⇨ Highly Satisfactory)

Availability and Accessibility of Health Facilities ……. ☐

Attitudes of NHIS and Health Staff ……. ☐

Types and availability of Drugs ……..…….. ☐

Premium Levels …… ☐

Mode of Premium Collection …… ☐

23. How would you rate the overall satisfaction of clients to the services provided by the Scheme?

☐ Highly satisfactory

☐ Satisfactory

☐ Unsatisfactory

D. **Achievements/Implementation Challenges**

24. What are the procedures involved in processing claims from the schemes?

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……

……

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25. How long does it take for the health facility to receive payments for services provided?

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26. What problems does the facility face in the implementation of the MHIS?

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27. What suggestions can you give to improve upon the implementation of the MHIS?

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28. How has the scheme contributed in the healthcare delivery in the area/district?

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29. Is there any other information you want to provide?

……

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……

THANK YOU.

QUESTIONNAIRE FOR CLIENTS

(Card Bearing Members)

A. Background of Client

1. Are you a registered member of the NHIS? Please. Yes ☐ No ☐

   If yes, continue with questionnaire. If No, don't administer the questionnaire

2. Have you received your NHIS Card? Yes ☐ No ☐

   If yes, continue with questionnaire. If No, don't administer the questionnaire.

3. District/Area..... Town/Village.....

4. Sex: Male ☐ Female ☐ Age ☐☐

5. Marital Status: Single ☐ Married ☐ Divorced/Separated ☐

   Widowed ☐

6. Educational Level.....

7. Number of Children/Dependants.....

8. Occupation: Salaried Worker ☐ Businessman/Trader ☐ Farmer ☐

   Self Employed ☐ Unemployed ☐ Student ☐

   Other (Please Specify).....

B. **Awareness/Enrolment Levels**

8. How did you hear about the NHIS?

   Radio/TV ☐ News Papers/Posters ☐ Community Forum ☐

Health Education ☐ Church/Religious Body ☐

Others (Please Specify) …….

9. When did you register with the NHIS? (Month/Year) …….

10. How many of your children/dependants have registered for the NHIS? …….

11. What do you understand by the NHIS?

……

……

……

……

C. Services/Benefit Packages and Satisfaction

12. How long did you have to wait before you received your first NHIS card?

……

13. How do you pay your premium?

By Cash ☐ Through SSNIT ☐ By Cash (Installment) ☐

Others (Please Specify)……..

14. If by cash, how much premium do pay annually? GH₵.....

15. Is it expensive? YES ☐ NO ☐

16. If yes, how much premium can you afford to pay annually? GH₵...……

17. Would you want to pay the premium once in a life time? Yes ☐ No ☐

18. If yes, how much premium can you afford as one time payment? GH₵..…….

19. How many times do you or your dependants visit a health facility in a year? (Averagely)

Once ☐ Twice ☐ Three times ☐ Four Times ☐

Other (Please Specify)……..

21. What type(s) of diseases usually take you or your dependants to a health facility?

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……

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22 What are the prevalent diseases in the area/district? Please list them in order of prevalence.

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23. Which of these diseases are covered by the health insurance scheme?

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24. Do you find it difficult getting access to any of the health facilities in the area/district?

Yes ☐ No ☐

25. If "yes" what are the problems?

(a) Difficulty in getting transport (b) High of cost of drug (c) Unavailability of drugs

(d) Long distance to facilities (e) Others (Specify) .....

26. What measures do you think can be used to address the problems (if any)?

(a)……

(b)…….

(c) …….

(d) ……..

(e) ……..

27. Is it easy to access health service with the health insurance card?

Yes ☐ No ☐

28. If "No" what problems do you face in accessing health care with the health insurance card?

……

…….....……..…….....

……...

……

29. Are you satisfied with the quality of services you receive from health care providers under the scheme? Yes ☐ No ☐

30. How would you rate your satisfaction in relation to the following factors of the scheme?

(Nominal Scale: 1⟹Unsatisfactory 2⟹ Satisfactory 3⟹ Highly Satisfactory)

Availability and Accessibility of Health Facilities ……. ☐

Attitudes of NHIS and Health Staff ……. ☐

Types and availability of Drugs ……..…….. ☐

Premium Levels …… ☐

Mode of Premium Collection …… ☐

31. How would you rate your overall satisfaction of the implementation of the NHIS?

- ☐ Highly satisfactory
- ☐ Satisfactory
- ☐ Unsatisfactory

D. **Achievements/Implementation Challenges**

32. How useful has the health insurance been to you?

……

……

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……

33. Do you make personal claims from the health insurance office?

Yes ☐ No ☐

34. If "yes" what are the procedures involved in processing claims from the schemes?

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35. How long does it take for you to receive your claims?

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36. What do you think are the problems that militate against the implementation of the NHIS?

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37. What suggestions can you give to improve upon the implementation of the NHIS?

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38. How has the scheme contributed in the healthcare delivery in the area/district?

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39. Is there any other information you want to provide?

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……

THANK YOU.