SUSTAINABILITY OF HEALTH INSURANCE IN GHANA: A CASE STUDY OF SEKYERE EAST DISTRICT MUTUAL HEALTH INSURANCE SCHEME (SEDMHIS)

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A DISSERTATION SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES IN PARTIAL FULFILMENT FOR THE AWARD OF COMMONWEALTH EXECUTIVE MASTER OF BUSINESS ADMINISTRATION (CEMBA)

JANUARY, 2011
DECLARATION

I hereby declare that this thesis (Sustainability of Health Insurance in Ghana: A case study of Sekyere East District Mutual Health Insurance Scheme) is my own work towards the award of Masters Degree in Commonwealth Executive Masters of Business Administration (CEMBA) and that to the best of knowledge, it contains no material previously published by another person nor material which has been accepted for the award of any other degree of the University, except where due acknowledgment has been made in the text.

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Supervisor’s Name ................................................ Signature ................................................ Date

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Dean, IDL ................................................ Signature ................................................ Date
DEDICATION

This project is dedicated to the almighty God, my lovely wife-Gifty, my children: Yenube, Yenulom and Kinansua, my siblings and to all those who helped to make this project a success.
ACKNOWLEDGEMENT

Many hands have contributed in diverse ways to the completion of this piece of work.

I would especially like to first and foremost thank the almighty God who by his grace gave me the strength and determination to work on this thesis.

My heartfelt gratitude goes to my Supervisor, Mr. Emmanuel Buabeng, for his constructive criticism, advice, guidance and assistance offered which in no small way contributed to the success of this project.

Special thanks also go to Michael Osei, Robert Amankwaa, Louis Boakye and Kwaku Agyei for great collaboration, useful discussions and overall moral support to help me finish this thesis.

Also, a special mention is made of the Sekyere East District Office of the National Health Insurance Scheme, Health Providers and the people of Sekyere East whose contribution has brought this project to a successful conclusion.

Finally I want to thank my wife, children and siblings for making my life more pleasant.

This thesis is to my parents whose effort made it possible for me to benefit from education. I thank you very much and may the good Lord replenish all that you have lost.

May the almighty God in his own wisdom bless you all! Amen.
ABSTRACT

The introduction of the “cash and carry” system in 1992 compounded the problem of financial access to quality health care and thus led to low utilization of health services especially, by the poor. This led to deteriorating health status. To reduce this problem of financial access to healthcare, Ghana government showed its commitment by introducing, a convenient, affordable and sustainable health financing arrangement to protect the people, especially the poor, through the National Health Insurance Scheme (NHIS). This study aims at empirically investigating the sustainability of the NHIS in Ghana using the Sekyere East District as a case study. A sample consisting of 350 community members (individual respondents), 12 health providers and the scheme Manager were selected for the study.

Data was collected through quantitative means with structured questionnaire. Also, secondary data was collected from the Sekyere East District Health Administration, The District Assembly and the Health Insurance office at Effiduase. Data was analyzed using the statistical package for Social Sciences (SPSS) and prose. Key findings from the study indicated that the human resource base for health care delivery in the District is insufficiently low. This was reflected in the high Doctor Population ratio. This is also reflected in the fact that the district outsourced staff to assist in the health care delivery in the district. Logistical needs were seen to be generally adequate by the studies. Perception on knowledge and acceptability was identified as being high with all respondents indicating that the NHIS was the most acceptable humane health care financing policy that guaranteed access to quality health care especially for the poor in society. Coverage of membership in the district was seen to be impressively high with over 75% of the district population on board the NHIS. Trends in claims administration however, revealed a downward trend with claims expenditure exceeding that of revenue. This reflected in the high patronage (utilization) of the services of the scheme by members in the district. To ensure sustainability which is in doubt as revealed by the study, continuous education, co-payment to check abuse by members has been recommended.

Finally, health insurance is a welcoming noble health care financing policy for all of us in Ghana but its sustainability depends on the efforts of all stakeholders.
ABBREVIATIONS / ACRONYMS

ADRA: Adventist Development Relief Agency
ANC: Antenatal Care
CHAG: Christian Health Association of Ghana
CVA: Cerebrovascular Accidents
DA: District Assembly
DANIDA: Danish International Development Agency
DCE: District Chief Executive
DDHS: District Director of Health Services
DHA: District Health Administration
DHMT: District Health Management Team
5YPOW: 5 Year Programme of Work
GHS: Ghana Health Service
GSS: Ghana Statistical Service
HI: Health Insurance
HIS: Health Insurance Scheme
ICT: Information communication and technology
IR: Individual Respondents
IRC: International Rescue Committee
KNUST: Kwame Nkrumah University of Science and Technology
MDGs: Millennium Development Goals
MOH: Ministry of Health
NCCE: National Commission for Civic Education
NCWD: National Commission on Women and Development
NGOs: Non-Government Organisations
NHIA: National Health Insurance Authority
NHIS: National Health Insurance Scheme
OPD: Out Patient Department
OTTI: Optical Technician Training Institute
SEDA: Sekyere East District Assembly
SEDMHIS: Sekyere East District Mutual Health Insurance Scheme
UN: United Nations
WHO: World Health Organisation.
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CHAPTER ONE

INTRODUCTION

1.1 BACK GROUND INFORMATION

According to the World Health Organization (WHO, 2004), the good health of a nation is vital to the human development as well as economic growth of the nation and it is essential that health systems perform well to ensure that people’s health are not being compromised. Health insurance scheme is thought of improving access to health care because the individual cannot afford the cost alone especially in the case of the poor and vulnerable. In recent times, health care financing has become a world-wide problem with increasing demand for health care and relatively slow increase in its supply (McConnell, 1999). Also, health care cost can be unpredictable and very large. In such a situation people will want health insurance (Rosen, 1999).

Health insurance is defined as a method of providing members of a defined group or community with protection against the cost of medical care (Atim et al.; 1998; Burnet, 2004). It is based on the principle of pooling risks, and therefore, the redistribution of financial resources from that segment of a community that does not incur high healthcare cost to those segments of the community that do. The objective of health insurance is to cover future risks of ill health.

By regularly laying aside sums of money to schemes, the contributor who becomes ill is then guaranteed treatment of his or her illness by an appropriate health facility. By taking money from large numbers of people the scheme is able to “spread risks” over these large numbers and hence able to afford, at any one time, to cover health service fees for that proportion of people currently...
ill. (Ghana Health Insurance Review, Oct-Dec.2008). This raising of revenue at a collective level permits risks pooling. The aim is to spread the risk of incurring health care cost over a group of subscribers lowering the risk to an individual subscriber. Thus, the objective is to capture the largest population as possible.

In Ghana, development efforts by successive governments have focused partly on human resource of the economy. This is evidenced by the massive educational infrastructures that were embarked upon by Dr. Kwame Nkrumah in the 1950s and 1960s. This effort have been continued by other governments and continue to receive utmost attention under the current government all in a bid to build, expand and develop the capacities of the human resource base of the country. These governments realized that effective development depended on a healthy human resource base.

To ensure the good health of the populace and to make healthcare more affordable to the people of Ghana, successive governments have initiated and implemented several schemes. This started with “free” health care for all its citizenry at the independence of Ghana in 1957. This meant that there was no direct out-of-pocket payment at point of consumption of healthcare. Financing of health was, therefore, entirely through government tax revenue. With a decline in the economy, the sustainability of “free” health care became problematic given competing demands for the country’s scarce resources (Ministry of Health (MOH), 2002).

This was followed by the introduction of user fees in 1969 which enabled “a token fee” to be charged on health services. This policy saw a decline in the utilization of health services in the country (Waddington & Enyimayew, 1989). In spite of this, the government went ahead to institute full cost recovery for drugs as a way of generating revenue to address the shortage of drugs. The new payment mechanism put in place was termed “cash and carry” (Adams, 2002).
The “cash and carry” system which had been preceded by the introduction of the token fees in 1969 for public health services worsened the situation. It was therefore replaced with a prepayment system of “cost sharing” under the National Health Insurance Scheme (NHIS) (MOH, 2004).

Also, it is against the background of efficiently funding health care delivery in Ghana and subsequently improving its accessibility and sustainability, that the government of Ghana introduced the NHIS.

In 2003, parliament passed a law, Act 650 governing the establishment of a single national health insurance scheme (MOH, 2004). In this scheme, all residents of Ghana who work in either the formal and informal, private or public sector contribute money regularly (pays premiums) to the fund regardless of whether they are sick or not, thus making a payment against the possibility of ill health.

The vision is to assure equitable universal access to quality basic package of health to all residents in Ghana without being required to pay out of pocket at the point of service use. The long-term objective for the scheme is for every resident of Ghana to belong to a health insurance scheme that adequately covers him or her (Sharp, et al, 1990).

The National Health Insurance Act, established three types of health insurance schemes in the country namely, the District Mutual Health Insurance Schemes (DMHIS), Private Mutual Health Insurance Schemes (PMHIS), and Private Commercial Health Insurance Schemes (PCHIS).

The National Health Insurance Authority (NHIA) as established by Act 650 is the regulator of all forms of health insurance business in Ghana, as well as the implementer of the National Health Insurance Scheme in the Country. It is mandated by law to secure the sustainability of the NHIS through prudent financial administration at all levels. It is also mandated by section 68 of the
National Health Insurance Act to assure the provision of good quality of service to members of the NHIS. To be able to deliver on these mandates the authority has a head office set up in Accra the capital of Ghana, with its extension in each of the ten regional capitals and the establishment of the District schemes in the various Metropolitan, Municipal and Districts in the country. In all about one hundred and forty-six (146) schemes are established and functioning in the country. In simple terms, their major functions are to register members, take premiums, process and pay claims from health providers.

Under these mandates, Regional Offices of NHIA have been monitoring NHIS activities at provider sites and the district schemes. Based on the monitoring reports, auditing teams of the NHIA follow up with visits to provider sites and schemes to delve deeper into potential lapses, abuse and wrongdoing that the monitoring unearths. The audit teams comprise professionals with the required expertise and experience in finance, claims and clinical work.

Funding for healthcare financing under the National Health Insurance Scheme as established by Act 650, comes from a Fund created by the Act, with income from two main sources. These are the National Health Insurance Levy (NHIL), a 2.5 percentage top up of the Value Added Tax (VAT), and a 2.5 percentage transfer from the existing Social Security and National Insurance Trust (SSNIT) alongside the contributions (premiums) made by the informal sector groups not contributing to the SSNIT. (NHIA, 2010)

It is emphasized that the focus of this study is to delve into the operations of the Sekyere East District Mutual Health Insurance Scheme (SEDMHIS) to establish whether the scheme is sustainable or otherwise. This will be carried out by sampling the views and position of Managers of the NHIS, health providers in the District and the general public.
1.2. PROBLEM STATEMENT

Healthy life is worthy of living but as has already been noted, financial barrier is a major obstacle to health care delivery and accessibility. It is in confirmation of this that Ministry of Health (MOH) in 2004, under the policy framework of the national health insurance scheme states: “The implementation of the “cash and carry” system compounded the utilization problem by creating a financial barrier to health care access especially for the poor. It is estimated that out of the 18% of the population who require health care at any given time, only 20% of them are able to access it”.

It is obvious that most of the 80% of patients who do not have access to health care are the core poor. This result in patients absconding from health facilities, seeking treatment late, loss of innocent lives among others (Leo and Davids ,1990) . In the quest for attaining middle income levels by the year 2020, as enshrined in Ghana Poverty Reduction Strategy document (GPRS, 2003), these health outcomes are not only disturbing but unacceptable for middle income status. A number of good health financing policies have already been tried in our health delivery systems in Ghana, ranging from ‘free health care’, ’token fees’ to the ‘cash and carry’ systems but have all either failed or proven to be unsustainable with dire consequences on the people, especially the core poor in society. Therefore it is imperative to support effort aimed at ensuring or guaranteeing easy access to quality health care and sustaining it. Furthermore, research on the sustainability of health insurance in Ghana has not attracted much attention or has been totally neglected.

The above assertion has therefore necessitated the effort to support this claim with empirical evidence on pragmatic and sustainable health financing mechanism, hence this study.
1.3. RATIONALE OF THE STUDY

The research is investigating the sustainability of health insurance in Ghana. Health Insurance improves access to health care for the poor and vulnerable in society and thus reduces morbidity and mortality levels, reduces health expenditure, and thus increase disposable income for its members (to spend on equally important areas other than health).

This study has important implications for health care financing for Ghana and beyond. From academic point of view, this study will present additional evidence concerning the search for an optimal healthcare financing in Ghana. In practice, it will help to document the performance of nations that employ heath insurance in their health delivery systems as compared to non-users. Moreover, the study will afford policy makers knowledge on which options on health financing is appropriate under certain circumstances.

1.4 CONCEPTUAL FRAMEWORK

Figure 1.1 below describes the interplay of variables that influence the thinking of stakeholders and their impact on the sustainability of the National Health Insurance Scheme from stakeholders’ perspective.

![Figure 1.1 Conceptual Framework](source)

**Figure 1.1 Conceptual Framework**

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<th>Training on NHIS</th>
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<th>Motivation of industry workers</th>
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<th>Involvement in planning &amp; management</th>
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Source: Author’s survey 2010
The independent variables are the perception of stakeholders: their human resource base, membership drive of the schemes, claims administration, logistics and equipment (infrastructure for proper financing of schemes), training on NHIS, Motivation of personnel in the health sector and involvement (of stakeholders) in planning and management.

These factors to a very large extent determine the level of resource availability and its continuous provision to sustain the health insurance schemes in the country.

Level of availability and continuous improvement on resource provision as perceived by stakeholders is the intervening variable because it connects the independent variables to the outcomes of interest leading to sustainability.

1.5 OBJECTIVES

The main objective of the study is to assess the sustainability of the NHIS in Ghana with specific reference to the Sekyere East District Mutual Health Insurance Scheme (SEDMHIS). To achieve this, the following specific objectives are set:

- To determine the adequacy of human resource and logistical needs of both the health workers and the scheme based on the World Health Organisation (W.H.O) standards.
- To assess the extent to which members are joining and renewing their membership with schemes.
- To study the pattern of premiums/revenues and claims (expenditure) generated over the period.
- To study people’s perception and acceptance of the scheme
1.6 RESEARCH QUESTIONS

This study aims to address the following questions:

1. Is the premium adequate to provide financial access to health service for all?
2. Do health providers have the skills for claims administration?
3. Is there adequate human resource base (manpower) for the various health providers and scheme?
4. Are members registering and renewing their membership to be permanent members of the scheme?
5. Do the pattern of revenue and expenditure portray favourable results over the period under consideration?

1.7. SCOPE OF STUDY

The study was carried out in the Sekyere east District. In view of the fact that health insurance is a broad concept, this study looked particularly at the sustainability of the NHIS with specific reference to the Sekyere East District Mutual Health Insurance Scheme (SEDMHIS). This would be carried out over the period of April-December 2010 by sampling the views and positions of the scheme managers, health providers and the general public.

1.8. ORGANIZATION OF STUDY

The study is organized into five chapters. Chapter one, provides the background of the study, looks at the problem statement and continues to state the research objectives and questions. This chapter also includes the significance, scope and organization of the study. Chapter two focuses
on the review of relevant literature concerning the study. Chapter three is devoted to the research design and methodology employed for this study including the analytical method used for the study. Chapter four covers a detailed analysis of the results as well as discussion of findings. Chapter five presents a summary of findings of the study. It will also include conclusions and recommendations of the study.
CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction
This chapter reviews the works of several authors of textbooks, journals, articles, and newspapers, unpublished researches and annual reports on insurance. This chapter is made up of eight sections. Section one deals with the Historical Development of Insurance, section two discusses the principles of insurance. Theories of Insurance and Empirical Literature are discussed in the third and forth sections respectively. Section five touches on the Philosophy of Health Insurance, section six talks about Health Care Financing while sections seven and eight discusses Health Insurance In Ghana and Sustainability respectively.

2.1 Historical Development on Insurance
According to the encyclopaedia Britinica(1990), the concept of insurance evolved with the development of the human society.

There exist two types of economies of human societies: money economies (with markets, money, financial instruments and so on) and non-money or natural economies (without money, markets, financial instruments and so on). The latter is a more ancient than the former. In such an economy, we can see insurance in the form of people helping each other. For example, when a neighbour’s property gets flooded, the members of the community mobilize resources to mitigate the loss. Should the same thing happen to one’s neighbour, the other neighbours must help. Otherwise neighbours will not receive help in the future. This type of insurance has survived to
the present day in some countries where modern money economy with its financial instruments is not widespread.

Turning to insurance in the modern sense (insurance in a modern market economy), in which insurance is part of the financial sphere, early methods of transferring or distributing risk were practiced by Babylonian and Chinese traders as long ago as the second and third millennia Before Christ (BC), respectively. Chinese merchants travelling treacherous river rapids would redistribute their wares across many vessels to limit the loss due to any single vessel’s capsizing. The Babylonians developed a system which was recorded in the famous Code of Hammurabi, 1750 BC, and practiced by early Mediterranean sailing merchants. If a merchant received a loan to fund his shipment, he would pay the lender an additional sum in exchange for the lender’s guarantee to cancel the loan should the shipment be stolen or lost at the sea. (Encyclopaedia, 1990)

Achaemenian monarchs of ancient Persia were the first to insure their people and made it official by registering the insuring process in governmental notary offices. The insurance tradition was performed each year in Norouz (beginning of the Iranian New Year); the heads of different ethnic groups as well as others willing to take part, presented gifts to the monarch. The most important gift was presented during a special ceremony. When a gift was worth more than 10,000 Derrik (Achaemenian gold coin) the issue was registered in a special office. This was advantageous to those who presented such special gifts. For others, the presents were fairly assessed by the confidant of the court. Then the assessment was registered in special office. The purpose of registering was that whenever the person who presented the gifts registered by the court was in trouble, the monarch and the court would help him. (Encyclopaedia, 1990)
Also, the Greeks and the Romans introduced the origins of health and life insurance, 600 AD when they organized guilds called “benevolent societies” which cared for the families and paid funeral expenses of members upon death. Guilds in the middle ages served a similar purpose. The Talmud deals with several aspect of insuring goods. Before insurance was established in the late seventeenth (17th) century, “friendly societies” existed in England, in which people donated amounts of money to a general sum that could be used for emergencies. Studies on life insurance consumption dates back to Heubner (1942) who postulated that human life value has certain qualitative aspect that gives rise to its economic value. But his idea was normative in nature as it suggested ‘how much’ of life insurance to be purchased and not ‘what’ would be purchased. There were no guidelines regarding the kind of life policies to be selected depending upon the consumers capacity and the amount of risk to be carried in the product. (Encyclopaedia,1990)

In England, fire insurance arose later, obtaining impetus from the great fire of London in 1666. A number of insurance companies were started after 1711, during the so called bubble era. Many of them were fraudulent, get rich quick schemes concerned mainly with selling their securities to the public. Nevertheless, two important and successful English insurance companies were formed during this period-the London Assurance Corporation and the Royal Exchange Assurance Corporation. Their operation marks the beginning of modern property and liability insurance. (Encyclopaedia,1990)

2.2 Principles of insurance

There are some underlying principles with regard to the concept of insurance. Frank A. Fetter (1964) in his book “Economics in Two volumes: Volume II. Modern Economic Problems” identified that commercially insurable risks typically share six common characteristics. Health
insurance also has its unique characteristics and for the sake of the topic under discussion these principles have been highlighted as well.

2.2.1. The existence of large number of homogenous exposure units
The vast majority of insurance policies are provided for individual members of very large classes. Existence of a large number of homogenous exposure units allows the insurers to benefit from the “law of large numbers” which in effect states that as the number of exposure units increases, proportionally the actual results are increasingly likely to become close to expected proportions. There are exceptions to this criterion. Lloyd’s of London is famous for insuring the life or health of actors, actresses and sports figures. Satellite Launch insurance covers events that are infrequent. Large commercial property policies may insure exceptional properties for which there are no ‘homogenous’ exposure units.(Fetter,1964)

2.2.2. Definite Loss
The event that gives rise to the loss that is subject to the insured, at least in principle, take place at a known time and a known place and from a known cause. The classic example is death of an insured person on a life insurance person. Fire, automobile accidents, and worker injuries may all easily meet this criterion. Other types of losses may only be definite. Occupational disease for instance, may involve prolonged exposure to injurious conditions where no specific time, place or cause is identifiable. Ideally, the time, place and cause of a loss should be clear enough that a reasonable person, with sufficient information, could objectively verify all three elements. (Fetter,1964)
2.2.3. Accidental Loss.

The event that constitutes the trigger of a claim should be fortuitous, or at least outside the control of the beneficiary of the insurance. The loss should be ‘pure’, in the sense that it results from an event for which there is only the opportunity for cost. Events that contain speculative elements, such as ordinary business risks, are generally not considered insurable. (Fetter, 1964)

2.2.4. Large loss

The size of the loss must be meaningful from the perspective of the insured. Insurance premiums need to cover both the expected cost of losses, plus the cost of issuing and administering the policy, adjusting losses, and supplying the capital needed to reasonably assure that the insurer will be able to pay claims. For small losses these latter costs may be several times the size of the expected cost of losses. There is little point in paying such costs unless the protection offered has real value to the buyer. (Fetter, 1964)

2.2.5. Affordable Premium

If the likelihood of an insured event is so high or the cost of the event so large, that the resulting premium is large relative to the amount of protection offered, it is not likely that anyone will buy insurance, even if on offer. Further, as the accounting profession formally recognizes in financial accounting standards, the premium cannot be so large that there is not a reasonable chance of a significant loss to the insurer. If there is no such chance of loss, the transaction may have the form of insurance, but not the substance. (Fetter, 1964)
2.2.6. Calculable Loss

The probability of loss, and the attendant cost must be estimable, if not formally calculable. Probability of loss is generally an empirical exercise, while cost has more to do with the ability of a reasonable person in possession of a copy of the insurance policy and a proof of loss associated with a claim presented under that policy to make a reasonably definite and objective evaluation of the amount of the loss recoverable as a result of the claim. (Fetter, 1964)

2.2.7 Equity

Equity in insurance implies that everybody has access to the minimum benefit package irrespective of people’s socio economic background. This means that everybody should have the opportunity to join a health insurance scheme. So health insurance should be available all the time so that subscribers are not denied access to health care when they need it. (MOH, 2004)

2.2.8 Risk – Equalization

By this, the scheme should ensure that disease burden and mortality patterns serve as one of the basis for allocating financial resources to geographical areas of the country. The cost of care varies depending upon the disease burden in the geographical areas. Moreover, disease burden and poverty have positive relationship. Thus, the higher the poverty levels of a geographical area, the heavier the disease burden. A formula for risk – equalization should be developed to make up the difference based on the minimum contribution levels. (MOH, 2004)
2.2.9 Cross – Subsidization

This explains that the contribution is based on ability to pay. In this case, the rich will pay more while the poor pay less. Also, it must ensure that all persons contribute and not only have those with the risk of falling ill joined the scheme.

Thus rich will cross – subsidize the poor, the healthy will cross – subsidize the sick, and the economically active adults will cross – subsidize the children.(MOH,2004)

2.2.10 Quality of care

The main tenet of quality is value for money. When clients perceive health services use as value of the money their propensity to utilize health care increases. Other things being equal, people are more likely to use health care that they perceive to be good than one perceived to be bad.(MOH,2004)

2.2.11 Solidarity

This is a major feature of social health insurance. Solidarity is the joint effort to making health care accessible by all. It is important to note that our individual health statuses are interlinked especially when dealing with communicable disease. To be free of such disease one has to help his or her neighbor, who happens to have been affected with a communicable disease in order to get rid of these diseases in most cases. The vulnerable groups and the poor, children and the elderly need the support of the rest of the population in terms of health care access.(MOH,2004)
2.2.12 Efficiency in the collection of contributions and claims administration

Collection of contributions is vital for building of sustainable fund for the social – type health insurance schemes in the country. The problem in our circumstances is that most of the potential contributors are in the informal sector of the economy where formal systems of collection of contributions do not exist. Consequently, the NHIS should adopt existing informal traditional systems of community contributions. In the case of claims administration, the issue is about how fast there the system would be able to reimburse service providers since they depend very much on internally generated funding to complement government regular budget. The Act establishing the scheme makes provision for health providers to be reimbursed within four weeks after submission of claims/bills to the schemes. (MOH, 2004)

2.2.13 Community or Subscriber ownership

Efforts have been made as part of the Primary health Care Strategy to encourage community ownership and for that matter, participation in order to ensure sustainability of the scheme for the realization of its goal. Partnership with government is key to the sustainability of the scheme based on the fact that being a pro-poor scheme government will be required to provide central funds to bridge the gap that may result from the expected contribution level and the actual contribution as well as outright payment of contribution on half of the poor, children under 18 ears and the aged. The scheme’s ownership is left in the hands of the communities within which they are established or the subscribers who form the membership of the scheme. This principle encourages each member of the scheme to treat it as a cherished asset that should be kept and sustained for the benefit of all. (MOH, 2004)
2.2.14 Reinsurance

Reinsurance is a principle in health insurance which makes funds available to distressed schemes in case of under funding due to unforeseen catastrophic events such as epidemics and natural disasters. (MOH. 2004)

2.3 Theories of Insurance

There have been many proponents of insurance theories from one epoch to another with various ideologies such as the risk theory, Nyman’s model among others.

Risk theory connotes the study usually by actuaries and insurers about the financial impact on a carrier of a portfolio insurance policy. For example, if the carrier has a 100 policies that insures against a total loss of GH¢1000, and if each policy’s chance of loss is independent and has a probability of loss of \( p \) then the loss can be described by a binomial variable. With a large enough portfolio however, we can use the Poisson function for the frequency of a loss variable where \( \lambda \) is used as the mean equal to the number of policies multiplied by \( p \). Insurance companies operate on this theory which in effect suggest that they charge premiums which is at least equal to the value of expected loss on the events they insure. If an insurance contract is offered to the public at a premium determined by the principle of equivalence (the premium should be equal to the expected claim payments and administrative costs), the expected profits in this transaction will be zero. The absence of profit is unpleasant in business. Therefore, if an insurance company consistently makes losses on its operations the company will be sooner or later unable to fulfill its part of the insurance contracts. This means that the “insurance” contracts do no longer serve the key purpose for which they were designed, that is to provide almost absolute security to the insured persons. These considerations indicate that the premium must be
set higher than dictated by the principle of equivalence. It is however subjective on how much the premium should be. (Sharp&William, 1964)

Nyman’s model was developed by John Nymanin (2003) and presents an alternative view of moral hazard in the context of private health insurance. His theory proposes that private health insurance acts as an income transfer between the sick and the healthy. As a result, the more moral hazard there is the more money available for income transfer to the people who really need it. In other words, moral hazard in the private health insurance industry makes health care more affordable. He counters the arguments that moral hazards is always welfare decreasing and that voluntary purchasing of health insurance makes people worse off. Moreover, the utility lost by the healthy via premiums is less than the utility gain by sick who receive that income transfer.

The Theory of Decreasing Responsibility is a life insurance philosophy promoted by proponents of life insurance (as opposed to cash-value insurance). The theory assumes that the financial responsibilities of the insured are temporary and should be purchased to offset those responsibilities. These responsibilities include paying consumer debts, mortgages, funding children’s education and income replacement.

With a proper plan, the theory holds that each of these responsibilities is temporary. A person can pay off their debt and mortgage, owing their home outright. Children do grow up and leave home becoming independent of their parents support. The theory also assumes that having investments on hand that produce income, and/or can be converted to cash is preferable to having insurance with a monthly premium. As an example $1,000,000 worth of investments or even just cash in a savings account is preferable to $1000,000 worth of insurance. The only challenge in this approach is that the insured must take responsibility and consciously plan to become
financially independent. If they do not, or are not able, they may not have the assets they need to self insure. (Lintner, 1965)

2.4 Empirical Literature

Many authors have come out with several prominent works on insurance and risk. The reviewed works talks about demand for insurance product directly and portrays ideas that are of importance to the topic under consideration. Such renowned authors include Min-Sun Horng (2006), Yung Wang Chang (2006) and Browne et al (1993) among others.

Min-Sun Hung and Yung Wang Chang (2006) conducted a study to examine the determinant of non-life insurance consumption in Taiwan between 1970 and 2005, using econometric regression model. The analysis indicates that economic conditions affect the demand for the insurance differently across lines of coverage (i.e., fire insurance and automobile insurance). The results suggest that income has a far greater effect on automobile insurance demand, than on fire insurance demand. Moreover, the results show the purchase of non-life insurance is significantly and positively related to income and risk aversion, as well as providing weaker evidence of a negative relationship with price.

The work of Browne et al (1993) developed further on the discussion of life insurance demand by adding newer variables namely, average life expectancy and enrolment ratio of third level education. The study based on 45 countries for two separate time periods (1980 and 1987) concluded that income and social security expenditures are significant determinants of insurance demand, however inflation has a negative correlation. Dependency ratio, education and life expectancy were not significant but incorporation of religion, a dummy variable, indicates that Muslim countries have negative affinity toward life insurance.
A study by Tobin (1958) discussed the growth pattern of life insurance consumption in Mexico and United States in a comparative framework, during the period 1964 to 1984. They assumed that at an abstract level demand depends upon the price of insurance, income levels of individual, available of substitute and other individual and environment specific characteristics. Further, they experimented with demographic variables like age of individual insured and population within the age group 25 to 64 and also considered education level to have some bearing on insurance consumption decision. They concluded the existence of higher income inelasticity of demand for the life insurance in Mexico with low income levels. Age, education and income were significant factors affecting demand for life insurance in both countries.

2.5 Philosophy of Health Insurance (Health Care Financing)

The basis of modern health care financing in various nations is on the philosophy and politics of social solidarity rather than on the strategies of the private insurance, despite of the broad use of the term health insurance. The details of insurance systems vary from one country to another. Nonetheless, a common feature known as redistributive financing is evident among all insurance systems. This feature is based on the notion that a large number of individuals are charged to be able to cover up the costs of their medical health services, despite the actuality that high payers are often low users of health care and the high users are likely to be those low payers. Accordingly, health insurance was instigated from the mutual aid societies created centuries ago by urban workmen and craftsmen. Here, each member paid into a fund and the benefits includes replacement earnings in times of sickness, burial expenses and assistance to widows and also orphans. Each person paid to secure their friends or families each could claim the benefits if one suffered. In the nineteenth and twentieth centuries, the mutual protection societies have been able
to expand from their local and collegial origins, which consider most workers of various ranks in the covered firms and companies, and grew throughout each country as in the case of Ghana. Government solved issues of income security and health care access by obliging universal membership and imposing payroll taxes on workers as well as employers. Social solidarity and redistributive financing began on a small scale among friends but became universal and nationwide. Health insurance became an integral part of social security (Glaser, 1991).

2.6 Health care Financing

Financing health care is a major international concern as many governments are struggling to provide better services while available resources are diminishing. Sometime ago, health care costs in public facilities were borne entirely by the government. Out-of-pocket payment mechanism at the point and time of treatment was latter introduced to reduce the ever increasing burden on government in various countries. This was done as means of reducing financial burden on the government and also, to sustain healthcare delivery. This rather deepened the problem of financial barrier of access to quality health care. In response, most countries throughout the world are adopting health insurance scheme(s) as a means of financing health care and ensuring greater access to health care to all people.

African countries are also adopting health insurance schemes with the aim of improving access especially by the poor and vulnerable groups to health care. For instance, a scheme aimed at ensuring access to quality health care to all Kenyans has been introduced. By this every Kenyan pays affordable regular contributions to the National Health Insurance Scheme Fund (Ngulu, 2005). In Ghana today the principal health sector financing mechanism are government
budgetary allocations and user fees. General tax revenue and pool fund account for 80% of public health expenditure and 20% for user fees (Akor, 2002).

Financing health care has gone through a chequered history in Ghana. At independence health care in the public facilities was “free” for all Ghanaians. This implied that there was no out-of-pocket payment at the point of consumption of health care in public health facilities and health care financing in the public sector was therefore entirely through tax revenue (MOH, 2004). Following the decline in the economy in the nineteen sixties and seventies, the sustainability of free medical service in the public facilities became a problem. In 1969, therefore user fees were introduced at public health facilities in Ghana. Under the additional pressure of deteriorating health infrastructure, falling living standards of quality of care and budgetary constraints, costs recovery programme for health services was implemented in 1971, the aim was not to generate revenue but to discourage the abuse by users of the services.

Prior to revision of these fees, the country’s health services were characterized by structural decay of poor maintenance and frequent breakdown of facilities without replacements and shortage of essential drugs. This culminated in low staff morale and losing of public confidence in the health professionals (Donkor, 2001).

This situation continued until 1985 when a comprehensive unit costing of the ministry of health services was introduced resulting in massive increment in user fees (Arhin 1995). The user fees were supposed to exclude specified communicable diseases but this exemption was not implemented in practice (MOH, 2004). This created a financial barrier to health care and reduced utilization of health facilities.

In the year 1992, the government of Ghana introduced a payment mechanism known as “cash and Carry” system with the aim of ensuring regular availability of drugs and improved quality of
care. However, the implementation of “Cash and Carry” compounded the utilization problem by creating financial barrier to health care access especially, by the poor. Since the policy of “Cash and Carry” was oriented more towards full cost recovery of drugs and partial recovery for cost of services, it was described as over ambitious.

Due to the problems associated with the “Cash and Cash” system, and in response to Ghana’s need to maintain cost recovery while at the same time improve equity, affordability and accessibility to quality health care, the government has initiated action to replace the out-of-pocket payment for health care at the point of service with the insurance scheme. To these effects, the National Health Insurance Act (Act 650) was passed in October 2003 which mandates every resident in Ghana to belong to a health insurance scheme of their choice within a specified period of time. Currently, most of the schemes are fully operational.

2.7 Health Insurance in Ghana

The issue of healthcare financing in Ghana has travelled a long and winding road from colonial times through the First Republic under the great Osagyefo Dr. Kwame Nkrumah the founder of our nation through the ‘Cash and Carry’ era under the Provisional National Defence Council (PNDC) and the National Democratic Congress (NDC) Governments both under former President Jerry John Rawlings, to the present health insurance regime of healthcare financing promulgated under the New Patriotic Party (NPP), and is still seeking refinement under the guide of the current NDC Government to meet the aspirations of Ghanaians.
The challenge since 1981 has been how to find the best combination of Government-Peoples-Partnership that would meet each other part of the way and satisfy the needs and pockets of Ghanaians as well as the government’s finances in the healthcare sector.

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

Under Cash and Carry’, patients were required to pay for drugs and some medical consumables, as and when they visit hospital, while the state bore all other costs including consultation, salaries and emoluments for doctors, nurses and other healthcare workers in state hospitals.

For this system, people went to hospital only when they were very sick and had money to readily meet their side of the bargain, to pay for those stipulated expenditures. That meant most often people went to hospital when they were really very sick and often at the terminal end of their lives. It was pointed out that ‘cash and carry’ constrained citizens from accessing healthcare except when they were in very dire situations resulting in needless deaths.

The search for an alternative to ‘cash and carry’, as a means of healthcare financing in Ghana gain momentum in the period from 1996 under the National Democratic Congress (NDC) regime but could not materialize for implementation though the foundation was laid with some pilot projects in the Dangme West District in the Greater Accra Region and Nkoranza District of the Brong Ahafo Region as a means of laying a firm foundation for what eventually became the National Health Insurance Scheme (NHIS).
The New Patriotic Party (NPP) government under former President J. A. Kufuor, which took over from the NDC Administration in 2001 moved to finally implement the conceived new healthcare financing regime of a health insurance scheme with a statutory enactment, the National Health Insurance Act, Act 650 in 2003 and the establishment of a National Health Insurance Scheme (NHIS) in 2004 under a National Health Insurance Authority (NHIA) as a governing council. This has been the system of healthcare financing in Ghana for the past five years.

The National Health Insurance Act, established three types of health insurance schemes in the country consisting of the District Mutual Health Insurance Schemes (DMHIS), Private Mutual Health Insurance Schemes (PMHIS), and Private Commercial Health Insurance Schemes (PMHIS).

The National Health Insurance Authority (NHIA) as established by Act 650 is the regulator of all forms of health insurance business in Ghana, as well as the implementer of the National Health Insurance Scheme in the Country. The dual role of industry regulator and implementer of the national health insurance scheme places the National Health Insurance Authority in a position of conflict of interest, which is untenable. However, Act 650 has remained in force and unchanged in its original form until now.

Funding for healthcare financing under the National Health Insurance Scheme as established by Act 650, comes from a Fund created by the Act, with income from two main sources. These are the National Health Insurance Levy (NHIL), a 2.5 percentage top up of the Value Added Tax (VAT), and a 2.5 percentage transfer from the existing Social Security and National Insurance Trust. (NHIS,2010)
2.8.1 Sustainability defined

The concept of sustainability according to the Cambridge Advanced Learner’s Dictionary defines sustainability (from the word sustain) as “to cause or to allow something to continue for a long period of time”. Marchildren (2007) simply defines sustainability of health care system as a balance of resources necessary to fund a basket of public health care services available to all citizens on the same terms and conditions. As Pavignani and Colombo of the World Health Organization (WHO, 2006) observed: “Sustainability is continuously invoked as a key criterion to assess any aid-induced activity or initiative. Sometimes, the concept is given the weight of a decisive argument. Thus, to declare something ‘unsustainable’ may sound as equivalent of ‘worthless’ or even ‘harmful’, in this way overruling any other consideration.”

Sustainability is not invoked as a criterion to assess medical relief or an emergency situation, but it is invoked as a criterion to assess health development. In search of a new global health aid paradigm, rooted in a human rights approach Pavignani and Colombo, mentioned above, also observed: “Sustainability tends to be employed as an all-encompassing term, but it seems useful to distinguish between technical sustainability, which relates to the capacity to carry out certain functions, and financial sustainability, which results from resource availability, fiscal capacity and the relative priority of health care provision.” (Pavignani and Colombo 2006)

When we talk about sustainability, whether in ecology or economics, we’re referring to the potential longevity of a vital support system – a state that can be maintained at a certain level indefinitely. Typically, it is a system that is self-contained and maintains an interior logic and systemic integrity. It’s a system that makes sense that stands up, that holds together. Ooms (2006)
2.8.2 Empirical Literature

Many authors have come out with several prominent works on sustainability. The reviewed works talks about sustainability and portrays ideas that are of importance to the topic under consideration. Such renowned authors include Gorik Ooms(2008), Jorgen Darre(2007) among others.

Ooms(2008) who conducted a research on the right to health and the sustainability of healthcare for developing countries to explain why a new global aid paradigm is needed concludes with the extract below: ‘The Case for Increased Aid’, seems to feel uncomfortable at the prospect of national sustainability being achieved after 20 years or more:

On plausible assumptions, if Africa uses aid to increase public spending, the continent as a whole should be able to sustain the increased per capita spending levels from domestic revenues within 8-10 years if aid is doubled, and within 12-15 years if it is tripled. Unfortunately, this reassuring conclusion needs to be modified in the case of several of the major recipients of increased aid. A combination of low domestic revenue, high public spending following the aid increase, and relatively rapid population growth, implies that it will be many years before revenue growth in countries like Tanzania and Ethiopia catches up with and begins to overhaul the annual increases required simply to maintain the higher per capita spending levels. The increased level of per capita spending could only be sustained if the higher aid levels are maintained for 20 years or more in the case of Ethiopia and Tanzania, with the absolute aid need continuing to grow for several years even though the percentage of spending financed from domestic revenue is falling. This creates a major challenge for donors- the MDGs are a long-term goal for the international development community, and require predictable long-term flows if they are to be met and then sustained.(Ooms,2008)
The works of Kersti and Margus (2004) pioneered a study which aimed to assess the efficiency and sustainability of using health resources in Estonian primary health care during 1998-2002. Three economic criteria- allocative efficiency, technical efficiency and financial sustainability were analysed from the original set of indicators, in parallel with the analyses of the Estonian economic development in 1998-2002.

He gathered data from the Estonian Health Insurance Fund and other state departments. This data encompassed 22 empirical indicators that covered the most important areas of primary health care provision and utilization for the period 1998-2002 were calculated, the results indicated that since 1999, Estonian economic growth has been approximately 7% each year. In 2000-2002 the average growth of consumer prices was approximately 4%. The number of family doctors has increased because the relevant education has been provided on a regular basis. Family doctors are using both group and solo practice. The size of family doctors' patient lists has stabilized, but can still vary between different counties and between countryside and towns because of variations in the density of population in different areas. The new combined system of financing primary health care provides a financial sustainability in using resources in Estonian primary health care.

Moreover, he concluded that the indicators of allocative efficiency demonstrate improved accessibility in 1998-2002: there are more family doctors, smaller patient lists, and the share of group practices is increasing.

Out of the indicators of technical efficiency the increased number of visits demonstrates improved efficiency as the workload has increased and more patient problems are solved in primary care under the capitation payment. Though the indicators of financial sustainability show quite a stable funding of primary health care, in long term perspectives the whole health
care system in Estonia needs higher level of funding – within the European Union it is not possible to continue with public health care that is funded by about 5% of GDP. Indeed, similar sets of indicators may prove useful in other countries which are undergoing rapid changes in their health systems like Ghana, yet do not have the complex health information systems like those in the developing countries, and enable comparative analyses.

Jorgen Darre (2007) worked on how to ensure sustainability of health information systems (HIS) in India. He claims the study could not be feasible due to a number of reasons with mediocre political support and the delay in implementation process being the lead factors. These factors were seen to be mutually dependent on each other. This is evidenced on the fact that politicians gave poor support because the implementation process was slow, and the implementation process was slow because political support was poor, hence the question of sustainability. Subsequently, the HIS is not allowed to scale unless it is sustainable and it does not become sustainable because it is not on a certain scale. This clearly indicate that sustainability is always not dependent on one particular factor but is made feasible through the accomplishment of a set of issues or factors which must be achieved at any point in time.

2.9 Conclusion

Access to quality health care is high in the advanced countries but low in the developing countries mainly due to socio-economic factors. Health insurance schemes are being introduced in many countries including those in Africa. In the advanced countries however, coverage of health insurance is high compared to the developing ones.
Following from this picture, Ghana can only sustain the ongoing health insurance, by tapping the experiences from nations already using the schemes, and hastening poverty reduction strategies as poverty has direct impact on acceptability and coverage of (NHIS) and hence, increasing access to health care through cross-subsidization, exemptions, risk equalization, quality care, reinsurance etc. (MOH,2004).
CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter presents the methodology employed for the study. It presents a concise description of the case study that was used. It explains the research design, the population, sample as well as the sampling procedure adopted to achieve the objectives of the study. Also, it describes the research instrument used, validity and the reliability of the instrument, data collection procedures, and how the data collected was analysed.

The study was aimed at substantiating the sustainability of the Health Insurance in Ghana. The focus was Sekyere East District Mutual Health Insurance in the Ashanti Region of Ghana.

3.1 Design of the Study

The study was a descriptive survey designed to assess the sustainability of health insurance in Ghana using Sekyere East District as a case study. A survey research is well suited to descriptive studies, or where researchers want to look at relationships between variables occurring in particular real life contexts. A descriptive survey, according to Varkervisser, (2003), aims predominantly at describing, observing and documenting aspects of a situation as it naturally occurs rather than explaining them. It is therefore appropriate when a researcher attempts to describe some aspect of a population by selecting unaided samples of individuals who are asked to complete questionnaires, interviews or tests. They continued by saying that the advantage of descriptive survey is that it has the potential of providing a lot of information obtained from quite a large sample of individuals. Descriptive survey is concerned with the
conditions or relationship that exist, such as prevailing practices, conditions and attitudes, processes that are going on, opinions that are held; or trends that are developed (Varkervisser, 2003).

Descriptive survey design was an ideal one for this study because it only elicits the ideas, perceptions and level of acceptability as well as the level of satisfaction of clients, challenges and effects associated with the implementation and sustainability of the NHIS with specific reference to the Sekyere East District in Ghana.

3.2 Study Population

According to the 2007 annual report, population projections at the District stands at 179,919 (GHS, SED).

The target population is the people of the Sekyere East District, specifically, those in the formal and informal sector of eighteen (18) years and above who are residents in the District for the past five years. This was done to reduce the effect of population mobility and to capture as much as possible the true picture of the people in the District.

3.3 Sampling Techniques and sample size calculation

This involves the selection of a number of study units from a defined study population. Due to limited time, money and personnel to cover the entire population, a sample of the population was taken. For the purpose of this study respondents were classified into health providers consisting of formal and private sectors as well as NHIS manager and general public. In all, the sample size was 363. The sample for the study was divided into 3 sets: health providers, The scheme Manager and the general public of Sekyere East. The sample for the health providers and the
scheme manager were purposely chosen. This was done to get the right respondents. In all, 12 health providers and the scheme manager were interviewed. 350 as defined in the population were randomly sampled. In the community every forth (4\textsuperscript{th}) house or resident in every forth (4\textsuperscript{th}) house were interviewed until the sample were obtained.

3.4 Data Collection Techniques and Tools

The researcher used both purposive sampling and simple random sampling methods in drawing sample from the population. Purposive sampling because the researcher identified some key informant thought to be relevant to the research like the Head of the health facilities and manager of the National Health Insurance Scheme in the District. Simple random sampling method was employed in finding out people perception on acceptability of the scheme using the general public as sample.

The researcher used data from the primary and secondary sources. The primary sources involved the use of questionnaires and interviews employed to pose specific and pertinent issues regarding the study’s objectives.

Data from secondary sources include articles, journals, newspapers, publications, internet and reports from the District Assembly (DA), District Health Administration (DHA) and the Sekyere East District Mutual Health Insurance Scheme as well as Tano Health Insurance Scheme.

3.5 Profile of Study Area

3.5.1 Location, population and Economic Activities

The Sekyere East District is located at the central part of Ashanti Region. It lies approximately between longitude 0\textdegree 15-1\textdegree 22 West and latitude 6 \textdegree 45 – 7 \textdegree 32 North. Carved out of the former Sekyere Local Authority, Sekyere East District is one of the new districts created in 1988 and
shares common boundaries with Sekyere south to the West; Sekyere Afram Planes to the North; Ashanti Akim South to the South-East; and Ejisu-juaben to the South-West Districts in the Ashanti Region. Before 2008, Sekyere East District and the Sekyere Afram planes District was one big district and was known as Sekyere East district. In fact it was the biggest district in the Ashanti Region. Because of the land mass and to ensure effective and efficient control, the district was divided into two in the year 2008 by the government. The district has a population of 85,702 (2009 population projection) and has two sub-districts. These sub-districts are Effiduase/Asokore with a population of 52,740 (61.5%) and Mponua with a population of 32,962 (38.5%). There are 37 communities in the district with Effiduase as the district capital (District Health Directorate, 2009).

Prior to the separation of the Sekyere East District into two, the scheme operated as one scheme. It still continues to run as a single entity in the two district even though these districts are administratively run differently. For the purpose of the study, the profile that existed before the separation will be used for the project work. This has succinctly been described in the ensuing pages.

The Sekyere East District lies at the North-Eastern part of Ashanti Region and shares common boundaries with Sekyere West (to the West), Ashanti Akim (to the North-East), Ejisu Juaben (to the south-West) Districts in Ashanti Region, Sene in the Brong Ahafo and Kwahu North in the Eastern Region. Sekyere East District lies at the North-Eastern part of Ashanti region with approximate land size of 3965km2. It is the largest in the region consisting 16% of the total landmass of Ashanti Region. About two-thirds of the district falls within the Afram plains, which is hard to reach, due to poor terrain. The district has a total population of 179,919. (GHS,
Females constitute 49.3% of the total population whilst the male form 50.7% of the total. Agriculture is the main occupation of the people in the district. It has a population growth rate of 3.5% per annum (G.S.S, 2000). This is due to the increasing number of settle farmers into the Afram plains portion of the District from Northern Ghana. The population of the district can be demographically described as youthful with 46.04% under the age of 15. From the 2000 census, four settlements namely Effiduase, Kumawu, Asokore and Bodomase are regarded as urban centres. All other settlements are of rural type. Indeed, the district can still be regarded as rural. The dominant religion in the district is Christianity, which covers 69.88% of the population. In terms of ethnicity, the indigenous people (Ashanti’s) constitute 70.64% of the district population.

3.5.2 Background of the Sekyere East District Mutual Health Insurance Scheme

Plans to establish the Sekyere East District Mutual Health Insurance Scheme started in 2003 when the District Assembly began preliminary preparations towards its establishment. By the directive of the government, full scale implementation of the Scheme started in April 2004 when the government allocated thirty five thousand Ghana cedis (GH¢35,000) from the HIPC funds for the District to start the first phase of the implementation process. The scheme was registered at the Registrar Generals Department and incorporated as a company limited by guarantee on 3rd February, 2005 and was issued a certificate to commence business on 4th February, 2005. The scheme’s head office is situated in Effiduase, the Capital of the Sekyere East District. The scheme commenced claims administration on 1st August, 2005 and has since been operating as such. (SEDMHIS, 2004)
3.5.3. Organisational Structure of the scheme

3.5.3.1 General Assembly

The health insurance general assembly has been formed, comprising of all the chairpersons of the various health insurance committees in the district. The General assembly is considered the highest decision making body among all the bodies under the District Mutual Health Insurance Scheme. All other organs act on the authority of the General Assembly. They are the only members of the scheme that has been mandated to vote at the annual general meetings of the scheme. (SEDMHIS, 2004)

3.5.3.2 District Implementation Committee/Board of Directors-(DIC/BOD)

Before coming into being of the scheme, the DIC was functioning. It ensured the formulation and implementation of the policies of the scheme at the implementation stages. This function was taken over by the BOD after its inauguration in January, 2005. A member had the opportunity to serve for only two terms of two years each. The first Chairman of the Board was Nana Owusu Kwadwo II, the chief of the Oyoko traditional area. He was succeeded by Mr. Emmanuel Bob Adu – a retired Educationist. He continued as chairman of the BOD until the dissolution of all scheme’s Boards in the country by the National Health Insurance Authority (NHIA). The schemes have since 2009 been governed by a caretaker committee put in place by the NHIA. This committee is headed by the District Co-ordinating Director with the District Finance Officer and the scheme Manager as members respectively. (SEDMHIS, 2004)
3.5.3.3 Management Team

The management team comprises of the scheme Manager, the Accountant, the Management Information Systems Officer, the Public Relations Officer, the Claims Manager and a data entry clerk to make up full complement of the team. This team was selected after a thorough interview conducted by the district and representative from the Ministry of Health in Accra. Apart from these core staffs some Assistants are recruited as supporting staff to augment the effort of the core staff.

The Management team is solely charged with the day to day running of the scheme. The Scheme Manager is the head of the organization. The Accountant, the Management Information Systems Officer, the Public Relations Officer and the Claims Manager take orders from the Scheme Manager. On the other hand the Accountant, the Management Information Systems Officer, the Public Relations Officer and the Claims Manager are functional associates. They are at the same level (horizontal relationship) and do not take command from each other, but co-ordinate with each other. So the command line is vertical between the line managers and the Manager but it is horizontal between the line managers.

Below each line manager is sections (supporting staff) which take direct command from the manager. Example, the MIS Manager is the head of all I.T functions. The accountant is the head of finance and revenue. The Claims Manager is also the head of claims administration; and the Public Relations Officer (PRO) is the head of Marketing and Public Relations. There is a vertical command line between each of the section and the line manager. Details of this have been provided in the figure below (Figure3.1)
3.5.3.4 HEALTH INSURANCE COMMITTEES

The District is divided into towns and communities. SEDMHIS has divided the various towns and communities into health insurance communities. A health insurance community is coordinated by the health insurance committee. All the health insurance community committees in the district have been formed. 70 Health Insurance communities in the Southern portion and 27 in the Northern portion (Afram Plains) of the district. Every community has five (5) health insurance committee members, bringing the number to four hundred and eighty five (485). These
members are entrusted with the responsibility of administering health Insurance in those communities on behalf of the management team. (SEDMHIS, 2004)

**3.5.4 Health Providers**

There are quite a number of health service providers who are playing their various roles to make health service delivery accessible to residents in the district. There are thirteen (13) health facilities made up of three (3) Hospitals and ten (10) health centres. All of them provide static service clinical services with the district hospital serving as the referral centre in the district capital (Effiduase). However, some residents in the district patronize other health facilities in the neighbouring districts. Regular meetings are organized to train, educate and sensitize these providers on the implementation processes of the scheme.

The various health providers in district have been provided in the (table3.1) below:

<table>
<thead>
<tr>
<th>FACILITY</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEALTH CENTRES</td>
<td>10</td>
</tr>
<tr>
<td>HOSPITAL</td>
<td>1</td>
</tr>
<tr>
<td>REGIONAL HOSPITAL/TERTIARY HOSPITAL</td>
<td>1</td>
</tr>
<tr>
<td>MISSION HOSPITAL&amp;HEALTH CENTRES</td>
<td>4</td>
</tr>
<tr>
<td>PARA-STATALS (SSNIT, POLICE, UNIVERSITY etc.)</td>
<td>-</td>
</tr>
<tr>
<td>PHARMACY SHOPS</td>
<td>1</td>
</tr>
<tr>
<td>CHEMICAL SHOPS</td>
<td>39</td>
</tr>
<tr>
<td>LABORATORY SERVICES</td>
<td>4</td>
</tr>
</tbody>
</table>

(SEDMHIS, 2004)
3.5.5 Health

The district has health infrastructure including three hospitals and seven Government health centres. There is also a new Optical Technical training Institute (OTTI) which was handed over to Ministry of Health (MOH) /Ghana Health service (GHS) in 2004 by the authorities of Wesphalian Hospital at Oyoko in the District. The distribution of health facilities in the district is skewed towards the Southern portion. Apart from Anyinofi health centre, there are no other health facilities in the Afram plains. The health staff strength in the district indicate, population to Doctor ratio of 62012:1 and population Nurse ratio of 4429:1, Outpatient visit per capital:0.3, Hospital admission rate: 1.9 (GHS/SED, 2007)

3.6. Scope of Study

The study was carried out in the Sekyere east District. Also health insurance is a broad concept; this study therefore looked particularly at the sustainability of the NHIS with specific reference to the Sekyere East District Mutual Health Insurance Scheme (SEDMHIS).

3.7 Pre-Testing

The data collection tool (questionnaire) was pre-tested in a nearby district (Sekyere West District) to identify potential problems and gaps in the tools.

3.8 Plans for Data Handling

Data was collected daily by checking and cross-checking to find out whether data gathered was complete. Data was also sorted and kept safely. Also knowledge of trained research assistants were upgraded in the areas of basic research methods.
3.9 Data Analysis

The researcher used the statistical package for social science (SPSS) during the data entry, coding and analysis. Frequency distribution table, bar graphs and pie charts were used to show findings.
CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

Introduction

This chapter presents a deeper analysis of the data obtained from the study and arranged under specific objectives enlisted in chapter one. The specific answers to the objectives are provided in the form of graphs, tables, charts and prose.

Even though a sample size of Three hundred and fifty (350) persons was selected for questionnaire administration, three hundred (300) responses were returned. This represents a return rate of 86%. The reason for not achieving 100% was the reluctance of some persons to give out information for fear of authority and cultural believes. Below is the analysis of the results.

4.1 Demographic characteristics of respondents

4.1.1 Sex

From Table 4.1, the sex composition of the individual respondents (IR) was 144 males and 156 females representing 48% and 52% respectively, showing a slight female dominance over males. This further lends credence to the fact that the sample is very representative of the study area as the total sex composition in the district portray similar statistics.
### Table 4.1 Sex Distribution of respondents.

<table>
<thead>
<tr>
<th></th>
<th>MALE</th>
<th></th>
<th>FEMALE</th>
<th></th>
<th></th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent (%)</td>
<td>Frequency</td>
<td>Percent (%)</td>
<td>Frequency</td>
<td>Percent (%)</td>
</tr>
<tr>
<td></td>
<td>144</td>
<td>48</td>
<td>156</td>
<td>52</td>
<td>300</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Author’s Field Survey, December, 2010

#### 4.1.2 Age

For the sake of convenience, the age of the respondents has been categorized into six groups as shown in Table 4.2. The largest cohort, 31% of the individual respondents (IR) were those of age 20-29, followed by those in the 30-39 (24.1%) and 40-49 with 22.33%. Others included 50-69, ≥70 and <20 consisting of 13%, 5% and 4% respectively. The age distribution is again representative of the age composition in the district.

### Table 4.2 Age of Respondents

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>MALE</th>
<th></th>
<th>FEMALE</th>
<th></th>
<th></th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category</td>
<td>Frequency</td>
<td>Percent(%)</td>
<td>Frequency</td>
<td>Percent(%)</td>
<td>Frequency</td>
<td>Percent (%)</td>
</tr>
<tr>
<td>&lt;20</td>
<td>3</td>
<td>1.00</td>
<td>9</td>
<td>3</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>20-29</td>
<td>45</td>
<td>15.00</td>
<td>48</td>
<td>16</td>
<td>93</td>
<td>31.00</td>
</tr>
<tr>
<td>30-39</td>
<td>38</td>
<td>12.67</td>
<td>36</td>
<td>12</td>
<td>74</td>
<td>24.67</td>
</tr>
<tr>
<td>40-49</td>
<td>40</td>
<td>13.33</td>
<td>27</td>
<td>9</td>
<td>67</td>
<td>22.33</td>
</tr>
<tr>
<td>50-69</td>
<td>15</td>
<td>5.00</td>
<td>24</td>
<td>8</td>
<td>39</td>
<td>13</td>
</tr>
<tr>
<td>≥70</td>
<td>3</td>
<td>1.00</td>
<td>12</td>
<td>4</td>
<td>15</td>
<td>5.00</td>
</tr>
<tr>
<td>Total</td>
<td>144</td>
<td>48.00</td>
<td>156</td>
<td>52</td>
<td>300</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Author’s Field Survey, December, 2010
4.1.3 Marital status of individual respondents.

Out of the 300 respondents, 153 (51%) were married, 87 (29%) single and 60 (20%) were separated. This means that the individual respondents were dominated by married people. This will certainly influence their responses in the ensuing pages as the discussion continues.

Table 4.3 Marital status of respondents

<table>
<thead>
<tr>
<th>MARITAL STATUS</th>
<th>MALE</th>
<th>Percent(%)</th>
<th>FEMALE</th>
<th>Percent</th>
<th>TOTAL</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>45</td>
<td>15.00</td>
<td>42</td>
<td>14.00</td>
<td>87</td>
<td>29</td>
</tr>
<tr>
<td>Married</td>
<td>72</td>
<td>24.00</td>
<td>81</td>
<td>27.00</td>
<td>153</td>
<td>51.00</td>
</tr>
<tr>
<td>Separated/Widowed</td>
<td>27</td>
<td>9</td>
<td>33</td>
<td>11.00</td>
<td>60</td>
<td>20.00</td>
</tr>
<tr>
<td>Total</td>
<td>144</td>
<td>48</td>
<td>156</td>
<td>52</td>
<td>300</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Author’s Field Survey, December, 2010

4.1.4 Religion of individual respondents

With regards to religion, those who responded to the questionnaire were 168 (56%) Christians and 105 (35%) Muslims. The remaining 27 (9%) were believers in Traditional African religions. Some cultural believes in the area of the study discouraged participation in exercises like this one. This may have accounted for the result as depicted in table 4.4 below.
Table 4.4 Religion of Individual Respondents

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>MALE</th>
<th>Percent</th>
<th>FEMALE</th>
<th>Percent</th>
<th>TOTAL</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>72</td>
<td>24.00</td>
<td>96</td>
<td>32.00</td>
<td>168</td>
<td>56.00</td>
</tr>
<tr>
<td>Islamic</td>
<td>57</td>
<td>19.00</td>
<td>48</td>
<td>16.00</td>
<td>105</td>
<td>35</td>
</tr>
<tr>
<td>Traditional/Others</td>
<td>15</td>
<td>5.00</td>
<td>12</td>
<td>4</td>
<td>27</td>
<td>9.00</td>
</tr>
<tr>
<td>Total</td>
<td>144</td>
<td>48</td>
<td>156</td>
<td>52</td>
<td>300</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Author’s field survey, 2010

4.2.5 Academic Qualification

Educational levels were aggregated into seven basic categories. The first three cohorts included those with Basic education 86 (28.67%), no formal education 72 (24%) and secondary education 52 (17.33). The others included Diploma, Degree and other with 15.67%, 14.33% and 0% respectively. The largest group is therefore those with basic education. This further indicates that the level of illiteracy is still quite high in the district.
Table 4.5 Academic Qualification of Individual Respondents

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Males</th>
<th>Females</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent</td>
<td>Frequency</td>
</tr>
<tr>
<td>No Formal educ.</td>
<td>30</td>
<td>8.00</td>
<td>42</td>
</tr>
<tr>
<td>Sec. educ</td>
<td>28</td>
<td>9.00</td>
<td>24</td>
</tr>
<tr>
<td>Basic educ.</td>
<td>37</td>
<td>10.00</td>
<td>49</td>
</tr>
<tr>
<td>Diploma</td>
<td>29</td>
<td>11.00</td>
<td>18</td>
</tr>
<tr>
<td>Degree</td>
<td>20</td>
<td>10.00</td>
<td>23</td>
</tr>
<tr>
<td>Others</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>144</td>
<td>48.00</td>
<td>156</td>
</tr>
</tbody>
</table>

Source: Author’s field survey, December, 2010

4.1.6 Occupation of individual respondents

With occupation, five different occupations were identified. Greater percentage of the individual respondents (34%) was farmers followed by the self-employed (29%). The third cohort (15.67%) was salaried workers. This was followed by the unemployed and student with 11.33% and 10% respectively. The major three occupations are then farmers, self-employed and salaried workers in order forming 78.67% of all occupations.
Table 4.6 Occupation of Individual Respondents

<table>
<thead>
<tr>
<th>OCCUPATION</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent</td>
<td>Frequency</td>
</tr>
<tr>
<td>Category</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Farmer</td>
<td>36</td>
<td>12.00</td>
<td>39</td>
</tr>
<tr>
<td>salaried worker</td>
<td>48</td>
<td>16.00</td>
<td>24</td>
</tr>
<tr>
<td>Student</td>
<td>18</td>
<td>6.00</td>
<td>12</td>
</tr>
<tr>
<td>self-employed</td>
<td>27</td>
<td>9.00</td>
<td>66</td>
</tr>
<tr>
<td>Unemployed</td>
<td>15</td>
<td>5.00</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>144</td>
<td>48.00</td>
<td>156</td>
</tr>
</tbody>
</table>

Source: Author’s field survey, December, 2010

4.2. PEOPLE’S PERCEPTION AND ACCEPTABILITY

4.2.1 Sources of information about NHIS

Out of the 300 individual respondents, all (100%) answered yes, indicating that they have heard about the (NHIS). The sources from where the respondents heard about the NHIS include the radio, television, newspapers, church/mosque, friends and relatives, mobile van announcements and house to house visits. Greater number of people heard on the radio/FM, followed by Church/Mosque. The third source is the television followed by community visits, Friends, mobile vans and newspapers were the 5th, 6th and 7th sources respectively. These indicate that the radio, church/mosque and the television are powerful sources of information to the general public. The scheme in its educational programmes should let this revelation guide them as to the
choice of channels for communication. The blending of some of these channels of communication can equally play complimenting roles in achieving the desired results for the scheme.

Figure 4.1 Sources of information about the NHIS

Source: Author’s field survey, December, 2010

4.2.2 Meaning and functionality of the NHIS

Two hundred and fifty (250) respondents representing (83.33%) were able to clearly explain the meaning of health insurance in a simple language. 50 of the remaining respondents (16.67%) could not tell us the meaning of NHIS when they were questioned. They simply said “no idea”. Regarding the functioning of the scheme in the district all the 300 respondents (100%) affirmed that the scheme was active and functioning well.
This portrays that the presence of the scheme is well felt in the district but just that the Managers of the scheme will do well to intensify education since a significant number of respondents could not give meaning to health insurance as indicated earlier.

4.2.3 Perception on Acceptance

Out of the 300 hundred respondents all (100%) of them stated that the NHIS is the most acceptable mode of healthcare financing in Ghana. Most of them supported their response with the following reasons:

“The health insurance affords the poor in society access to quality health care”

“It saves us a lot of money on health care for other use other than healthcare”

“The popular acceptance of it by the public is enough to tell you that it is the best thing to have happened in Ghana”

This is an indication that the scheme is a poverty reduction strategy or a pro-poor concept that has shown a real impact in the lives of the common person in society. All efforts must be taken to protect it and nurture it for success for the benefit of all Ghanaians.

4.2.4. Positive influence of NHIS

150 respondents representing 50% stated that the most positive influence of the NHIS is that it guarantees and affords the poor in society access to quality health care, followed by 110 respondents (36.67%) who said it saves money for other spending other than health care. The rest of 40 respondents (13.33%) said “public acceptance” has a very strong positive influence on the NHIS. This again goes a long way to assure the nation of the availability of the most needed human resource that are prerequisite for the development of the country to an appreciable level.
4.2.5 Negative influence of the NHIS

90 out of the 300 representing (30%) pointed out the abuse of hospital attendance at the health care facilities and followed by 70 respondents (23.33%) who claimed it to be political interference by successive governments. The third factor was undue delay at the health facilities which was claimed by 50 respondents (16.67%). The forth and fifth factors were claimed on misappropriation of funds by the staff of the scheme and non-transferability of membership from one district to the other in Ghana with 47 (15.67%) respondents and 43 (14.33%) respondents respectively. The analyses show that majority (30%) of people in the district see abuse of hospital attendance as one sure way of working against the wellbeing of the scheme. Another issue negating the success of the scheme was pushed on political interference. The foregoing revelations at least informs one that there is the need for the employment of co-ordinated effort on the part of all stakeholders to fight these issues militating against the success of the scheme.

4.2.6 Sustainability

Out of the 300 respondents, 180 representing 60% think it is sustainable, 80 (26.67%) thought it was not sustainable while 40 (13.33%) did not comment. 50% of those who think it is sustainable indicated reasons such as the increase in coverage of membership, 30% think the revenue base of the scheme is strong and reliable while 20% think effective management with a well motivated staff.
Reasons for unsustainability were offered as political interference, abuse by members and dishonest staff of the scheme with responses of 47.50%, 35% and 12.50% respectively. The scheme Manager thinks the current trends do not guarantee sustainability as being portrayed by the general public. He claims these dichotomies exist because the political connotations associated with the scheme continue to paint a good picture about the situation which informed the general public in completing the questionnaire. He said the fact still remains that most of the schemes cannot meet their bills with the funds that they generate to cover such bills. They always have to file for distress funds to be able to settle their bills. This is a clear symptom of unsustainability.

On problem of the scheme, 90 (30%) respondents indicated political interference as the main issue. Secondly, 77 (25.67%) pushed it on abuse of scheme services and the third, forth and fifth were blamed on untimely settlement of bills from providers, dishonest staff and affordability.
(poverty) with respondents of 66 (22%), 35 (11.67%) and 32 (10.67%) respectively. This is represented in the figure below:

*Figure 4.3. Problems facing the scheme.*

![Problems of scheme](chart)

Source: Author’s field survey, December, 2010

One way of sustaining the scheme is to increase coverage in terms of membership and locations. The most predominant reason that respondents gave for not joining or renewing their membership with the scheme was “did not have money (poverty)”. This appears that poverty is still hampering people from joining the scheme hence the need to employ appropriate strategies to deal with this problem.

Thus the scheme should again look at its registration process and see how it could be done to bring the poor on board. They suggested that enhanced education and scheme marketing, reduction in premium and encouraging installment payment will encourage them to join the scheme.
Further more the insured also suggested intensification of education on the benefits of the scheme, inclusion of most of the exempted diseases to the minimum benefit package and prompt and timely payment as a way of generating income as some important ways of making the scheme sustainable.

4.3. MEMBERSHIP REGISTRATION AND RENEWAL

4.3.0 Introduction

For the sake of clarity and understanding, a table showing details of registration and pictorial situation of coverage in the district has been presented. This objective has been analysed into registration, renewals and intention on renewals.

*Figure 4.4: Pictorial view of coverage of membership of scheme.*

<table>
<thead>
<tr>
<th>Year</th>
<th>Membership</th>
<th>Dist. Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>8,000</td>
<td>157,000</td>
</tr>
<tr>
<td>2006</td>
<td>23,500</td>
<td>157,000</td>
</tr>
<tr>
<td>2007</td>
<td>76,000</td>
<td>157,000</td>
</tr>
<tr>
<td>2008</td>
<td>93,008</td>
<td>157,000</td>
</tr>
<tr>
<td>2009</td>
<td>117,385</td>
<td>157,000</td>
</tr>
</tbody>
</table>

Source: Author’s field survey, December, 2010

4.3.1 Registration.

297 respondents (99%) out of the 300 persons questioned said they have registered with only 3 (1%) dissenting.
This portrays that about 99% of the respondent had joined and embraced it as more humane means of health care financing for their health needs. The 3 respondents who had not registered at the time of administering the questionnaire offered the following reasons:

It is too political and being forced on Ghanaians
Don’t have money (poverty)

4.3.2 Renewals

When the respondents were questioned on whether they have renewed their membership 270 (90%) out of the 300 said yes with 30 (10%) saying no.

Those who said no offered the following reasons:

- No money (poverty) 27 (90%)
- Coverage of minimum benefit inadequate 3(10%)

Records at the scheme level reveal high level of registration and renewal of membership as detailed in table 4.7 below and figure 4.3 above.

It can be seen that membership and coverage of the scheme kept increasing year on after year from a moderate number of 8000 members in year one (in 2005) to the 117,385 members at the end of the fifth year in (2009). This represents over 1367% increase over the first year. This further demonstrates the popular acceptance of the scheme by members of the district as there have been positive trends in registration and renewal of membership. Though the coverage looks impressive as portrayed in the graph above, the scheme will still need to step up their campaign strategies on membership coverage since about 25% of residents still stay out of health insurance in the district. This will go a long way to enable it hit the hundred percent coverage envisaged by the nation.
Sustainability of the scheme is guaranteed through the increase in membership and mass coverage of the population. The records at the district indicate high patronage of the scheme by the residents in the district. This certainly is on course with the national medium term policy objective of ensuring that at least 50% to 60% percent of residents of Ghana will belong to a health insurance scheme. This is expected to be achieved ahead of time since the coverage in the district is already higher than the national target.

4.3.3 Intention to stop renewal of membership

When the respondents were questioned as to whether they have intention to stop renewing their membership in the near future, 267 (89%) of the respondents said no but 33(11%) of the respondents confirmed their decision to stop renewal their membership of the scheme with varied reasons. Most of them have these to say:

No special care and attention at health care providers.

No increase in the minimum benefits package to cover more diseases.

Lackadaisical attitude of health workers especially those in the government institutions.

It is heart warming to note that majority of members (89%) indicate they have no intention of stopping to register or renew their membership in the near future. It is advised that the concerns of the members (11%) who for various reasons would like to suspend their membership be addressed in a dispassionate manner to meet their expectation. Indeed, these concerns are very real and have the potential of ruining the gains made so far if no proper attention is paid to these issues. Again in line with the broad objectives of the scheme, the health of the residents in the district are protected from problems associated with finding money before receiving health care as it used to be in the “cash and carry” days.
Finally, it is a fact that the 100% coverage of the population is still not attained. Scheme managers and all key stakeholders will therefore work together to make this ultimate goal of the scheme a reality.

Table 4.7: Clients registration over the various years

<table>
<thead>
<tr>
<th>YEARS</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members</td>
<td>8000</td>
<td>23500</td>
<td>76000</td>
<td>93008</td>
<td>117385</td>
</tr>
<tr>
<td>Change in % (2005 base year)</td>
<td>0.00</td>
<td>193.75</td>
<td>850</td>
<td>1062.6</td>
<td>1367.31</td>
</tr>
<tr>
<td>Year on year change in %</td>
<td>193.73</td>
<td>223.40</td>
<td>22.38</td>
<td>26.21</td>
<td></td>
</tr>
</tbody>
</table>

Source: Author’s field survey, December, 2010

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4.4 PATTERN OF PREMIUM REVENUE AND EXPENDITURE ON CLAIMS

4.4.0 Introduction

This objective as stated above has been presented and analysed in the following categories for clarity and easy understanding. That is, revenue and expenditure on claims, claims administration, vetting of claim, benefit package, utilization of scheme and provider payment system. Tables and graphs have also been used to aid a vivid description of the situation.

4.4.1 Revenue and expenditure on claims

The pattern of revenue and claims expenditure as can be seen from table 4.8 and figure 4.5 below, started on a positive trend.
The operation of the scheme regarding claims payment was less than the revenue generated over the same period for the first one, two, and three years with percentage of 73.68%, 1.87% and 19.71% respectively.

This took a downward trend in the 4\textsuperscript{th} and 5\textsuperscript{th} years as the figures registered a negative trend over the period with the gap widening. Thus claims expenditure exceeded revenue by 71.02% an increased to 120.70% over the 2008 and 2009 year period respectively. The scheme on each occasion paid more than they were able to generate as revenue. This was made possible by filing for distress funds from the NHIA as a form of reinsurance by the authority. A probe into the result revealed that utilization of the scheme increased tremendously around these periods as shown in figure 4.4. This was coupled with the introduction of new tariff system that saw bills from the health providers increasing astronomically. Abuse of use of services of the scheme by members (some obviously to test the authenticity of the scheme) equally contributed to this negative trend.

According to the scheme manager some bills from the health providers were three times more than their previous submissions but scheme had to pay since the new tariff regime mandated such payment.

He felt that the new tariff was not in favour of scheme but this position is totally at variance with the authority which feels that the new tariff is a much improved one over the previous billing system.

According to the records at the scheme the new tariff does not cater for the inefficiencies of the providers as the old one did. It is hoped that stakeholders will take a critical look at this policy since cost containment is seen as one sure way of sustaining the scheme. The scheme has to file for distress funds from the Authority to be able to settle claims any time such negative trends in
claims administration came up. He further intimates that this is not a very good development since it is one clear sign of unsustainability of the scheme.

Table 4.8 Claims Revenue and Expenditure

<table>
<thead>
<tr>
<th>YEAR</th>
<th>CLAIMS REVENUE</th>
<th>CLAIMS EXPENDITURE</th>
<th>VARIANCE IN VALUE</th>
<th>VARIANCE IN %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>56615.70</td>
<td>14,895.78</td>
<td>41,719.92</td>
<td>73.68</td>
</tr>
<tr>
<td>2006</td>
<td>299419.56</td>
<td>293817.50</td>
<td>5602.06</td>
<td>1.87</td>
</tr>
<tr>
<td>2007</td>
<td>1094327</td>
<td>878,632</td>
<td>215695</td>
<td>19.71</td>
</tr>
<tr>
<td>2008</td>
<td>1271543.30</td>
<td>2174618.33</td>
<td>-903075.03</td>
<td>-71.02</td>
</tr>
<tr>
<td>2009</td>
<td>1164786</td>
<td>2570668.09</td>
<td>-1405882.09</td>
<td>-120.70</td>
</tr>
</tbody>
</table>

Source: Author’s survey, 2010.

Figure 4.5: pictorial view on premiums and claims expenditure.

![Figure 4.5: pictorial view on premiums and claims expenditure.](image)

Source: Author’s survey, 2010
4.4.2 Claim administration

The scheme has signed contract with 15 service providers who are all accredited by the national health insurance authority (NHIA).

The break down is as shown in table 4.4.

Table 4.9: Details of health providers

<table>
<thead>
<tr>
<th>TYPE</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tertiary-KATH</td>
<td>1</td>
</tr>
<tr>
<td>Hospital</td>
<td>5</td>
</tr>
<tr>
<td>Health centres</td>
<td>5</td>
</tr>
<tr>
<td>Clinic</td>
<td>3</td>
</tr>
<tr>
<td>Maternity home</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
</tr>
</tbody>
</table>

Source: (SEDMHIS, EFFIDUASE)

4.4.3 Vetting Of Claims

There is a vetting procedure put in place to ensure that all bills submitted by health providers to scheme are duly vetted before payment is effected.

According to the scheme, both manual and electronic vetting take place but the electronic version is extremely slow and can not pick most claims of the health care facilities thereby making the preference of manual vetting over the electronic. There is also a vetting committee in place but not very active due to inability of committee members to meet together as a committee. They manage to meet at least once a quarter to clear all outstanding issues on claims. The composition of the committee is made up as follows.
Claims manager

Scheme manager

Accountant

District Pharmacist

District medical superintendent

4.4.4 Benefit Package

The benefit package has also not changed over the period except when there is a general review by the authority. This has been done on two occasions to bring on board more drugs that were initially not on board.

4.4.5 Utilization of Scheme

Figure 4.6 Gender distribution of respondents

Source: Author’s field survey, December, 2010
The table 4.10 below details the usage of scheme by the members over the five year period.

There has been a speedy increase on utilization of the scheme with a start of 3283 clients for the first year rising to 160,448 clients in the 5th year (2009).

The year on year change in percentage terms shot up at the initial years of 2006 at 1004.51 %. This dropped to 110.41% in 2007 and continued in that trend for the remaining years of 2008 and 2009 with 67.64% and 25.44% respectively. The trend seems to have saturated as the rate of increase is not increasing at such an increasing rate like it was in the beginning. The study revealed a consistent dominance of females over males for all the period under consideration. The trend does not only agree with the demographic variables for the study but also for the district. This indicates that females for a very long time are going to be major patronizers of the services of the scheme. The manager cited the high incidence of usage of the scheme to abuse on the part of some members of the scheme. He further advised that co-payment at point of service use should be introduced to curb that situation. Continuous public education by all stakeholders was also suggested. Electronic vetting is being encouraged to ensure that the whole process is monitored by the integrated I.C.T platform at the authority. The incident of fraud which is becoming rampant in the health facilities will be checked by the use of the ICT Platform.
Table 4.10: utilization of scheme.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
<th>CHANGE IN NUMBER</th>
<th>% CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>985</td>
<td>2298</td>
<td>3283</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2006</td>
<td>14142</td>
<td>22119</td>
<td>36261</td>
<td>32978</td>
<td>1004.51</td>
</tr>
<tr>
<td>2007</td>
<td>36623</td>
<td>39674</td>
<td>76269</td>
<td>40036</td>
<td>110.41</td>
</tr>
<tr>
<td>2008</td>
<td>57558</td>
<td>70348</td>
<td>127906</td>
<td>51609</td>
<td>67.64</td>
</tr>
<tr>
<td>2009</td>
<td>60670</td>
<td>99478</td>
<td>160448</td>
<td>32542</td>
<td>25.44</td>
</tr>
</tbody>
</table>

Source: (SEDMHIS, EFFIDUASE)

4.4.6 Provider Payment Systems

The scheme employs monthly vetting and payment as a mechanism for settlement of claims. On the bases of assessment of the payment mechanism the scheme sees it to be satisfactory. Health providers, on the other hand, assess the payment mechanism to be unsatisfactory. 10 (83.33%) of the 12 providers assess it as poor while the remaining 2 (16.67%) said it is very poor. There appears to be some contradictions between the two stakeholders of the scheme.
4.5.0 HUMAN RESOURCES AND LOGISTICAL NEEDS.

4.5.1 Background Characteristics of Health Providers

There are 15 providers in all at the district but 3 of them fall outside the district. For the purpose of the study only the 12 providers within the district are used.

The profile of the district’s health providers is made up of both public and private. 5 (41.67%) represents the public providers while 7 (58.33%) represents the private sector providers. The private providers therefore dominate in the provision of healthcare in the district as provided in the table below.

*Table 4.11 Analysis of health providers*

<table>
<thead>
<tr>
<th>FACILITY</th>
<th>PUBLIC</th>
<th>PRIVATE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Health centre</td>
<td>4</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Clinic</td>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Mat. Home</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Percentage</td>
<td>41.67</td>
<td>58.33</td>
<td>100</td>
</tr>
</tbody>
</table>

*Source: Author’s field survey, December, 2010*

4.5.2 Availability of human resource at health institutions

The study shows a general shortage of staff at the health facilities as can be seen from the table 4.12 below.
Out of the 233 (100%) staff expected to be available for effective delivery of healthcare in the district, 58 (24.89%) are not available creating a gap for health care delivery in the district. As indicated the professional group is the hardest hit. For the 7 (100%) doctors that are needed, only 3 (42.86%) are available. 3 (100%) pharmacists are required but only one (33.33%) is available. For the 15 medical Assistants needed only 3 are present and the 45 general nurses needed only 30 are present. Similar trends are portrayed as can be seen from the table provided. The district has a doctor-population ratio of 1:62012 and a nurse population ratio of 1:4896. According to the health provider’s response, 17% indicated that they have adequate staff whilst 83% claimed staff was inadequate. The Scheme Manager also asserted that they had adequate staff, even though some few staff will be needed to compliment the current team. The Doctor-population ratio in the study area is too high, which confirms the assertion by the MOH’s. Human Resource Policies and Strategies for the health sector (2002-2006) which explains the human resource inadequacy of critical health workers such as doctors, nurses etc.

The results of the study showed that the staff inadequacy was 24.89%. Even though 75.11% of the respondents perceived the staff strength as adequate they were perhaps comparing the current situation with the previous situation. It could therefore be inferred that they meant a massive improvement in the situation rather than the adequacy they claimed. This is confirmed by the fact that 42% of the health workers are outsourced to assist with the health delivery system in the district, which was attributable to problems such as accommodation, transportation, motivation, inadequate facilities as revealed by the study.
Table 4.12: Showing availability of human resources at health facilities

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>EXPECTED NO.</th>
<th>CURRENT NO.</th>
<th>GAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Officers</td>
<td>7</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Medical Assistants</td>
<td>15</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Midwives</td>
<td>16</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>General Nurses</td>
<td>45</td>
<td>30</td>
<td>15</td>
</tr>
<tr>
<td>Lab. Staff</td>
<td>12</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Dispensary Control</td>
<td>14</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>Disease Control</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Account</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Nutrition</td>
<td>10</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Drivers</td>
<td>14</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>Health Aids</td>
<td>36</td>
<td>36</td>
<td>0</td>
</tr>
<tr>
<td>Preventive Nurses</td>
<td>32</td>
<td>26</td>
<td>6</td>
</tr>
<tr>
<td>Others</td>
<td>22</td>
<td>19</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>233</strong></td>
<td><strong>175</strong></td>
<td><strong>58</strong></td>
</tr>
</tbody>
</table>

*Source: Author’s survey, December, 2010*
4.5.3 Adequacy of staff

Figure 4.7: Adequacy of staff

In table 4.13, below, 41.67% of health providers said that other health staff are outsourced to assist with the health delivery system. The professional groups largely outsourced were anesthetist nurses representing 38.1%. The other groups outsourced are nurses 33.33%, doctors 9.52% and pharmacist 19.05%. However all the respondents indicated that there exist human resource problems in the district? The scheme manager engaged in the study indicated that there are human resource problems. The problems mentioned were lack of transportation, inadequate staff and poor accommodation and motivation.

Source: Author’s field survey, 2010
### 4.5.4 Outsourcing of staff

Table 4.13: Outstanding and type of staff outsourced for the district health services

<table>
<thead>
<tr>
<th>Categories outsourced</th>
<th>Frequency (No. of Respondents)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outsource staff</td>
<td>5</td>
<td>42</td>
</tr>
<tr>
<td>Don't outsourced staff</td>
<td>7</td>
<td>58</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Categories outsourced</th>
<th>Frequency (No. of Respondents)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthetists</td>
<td>8</td>
<td>38</td>
</tr>
<tr>
<td>Nurses</td>
<td>7</td>
<td>33</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Doctors</td>
<td>4</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Author’s field survey, 2010
4.5.5 Availability of logistics at various facilities

The logistical concerns at the district appear quite good. The result of the study is such that 10% of the respondent feel the situation is very adequate, 64% indicated adequate while inadequate and very inadequate were 24% and 2% respectively. There was mixed feelings as the adequacy of equipment in the district healthcare needs were adequate whereas it was inadequate by the World Health Organisation (WHO) standards, Department of Essential Health Technologies assertion that “the quality of essential surgical care is frequently constrained by inadequate basic equipment to perform simple but vital invention such as resuscitation, the provision of oxygen, assessment of anaemia, chest drains etc. This has also been confirmed by the WHO (Mbwele.2003) that health personnel at district or rural health centres are often unable to carry
out essential surgical procedures or emergency care, either because of untrained staff, or due to inadequate facilities, equipment and supplies and/or a combination of both. Essential equipment is invariably missing, too sophisticated for local or not functioning due to disrepair or lack of spare parts.

Also, it more or less agrees with the findings by international Rescue Committee (IRC) in Democratic republic of Congo (2005), that Congo has a population one quarter that of united states, clinics and hospitals in most rural areas are in a serious state of despair and neglect. Operating theatres have leaking roofs, the wards are dirty and basic medicines are often lacking.

It is therefore not surprising that many people die out of treatable and preventable diseases such as anaemia CVA in the study district (GHS, SED Annual Report 2007). Furthermore, a research conducted by GHS 2006 proved that most of the equipment that will facilitate diagnoses and treatment were not available (Cofie et al, 2004). One is tempted to believe that providers responses were very much informed by the fact that their facilities were able to render some basic healthcare services without special recourse to WHO standards on logistics and equipment for healthcare.

The health provider assessment of the adequacy of equipment in healthcare delivery has been diagrammatically presented below in figure 4.9.
Figure 4.9: Adequacy of logistics

Source: Author’s fields survey, 2010.
CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.0 Introduction

This chapter summarizes the major findings based on the specific objectives of the study, conclusions and also makes recommendations based on the findings.

5.1 SUMMARY OF THE FINDINGS

5.1.1 People’s Perception and acceptability

All the respondents stated that the NHIS is the most acceptable mode of healthcare financing in Ghana. Hence, majority of the respondents indicated that the scheme have had positive influence on their lives. For instance, 150 respondents representing (50%) stated that the scheme guarantees and affords the poor in society access to quality health care, while 110 respondents (36.67%) posit that it saves money for other spending other than health care.

However, abuse of hospital attendance at the health care facilities, and political interference by successive governments was cited by majority as negative influence of the scheme. With minority citing undue delay at the health facilities and misappropriation of funds by the staff of the scheme as well as non-transferability of membership from one District to the other in Ghana as negative influence factors.

Contrary to majority of respondents view that the scheme is sustainable, the Scheme Manager interviewed was of the opinion that the current trends do not guarantee sustainability as being portrayed by the general public because most of the scheme cannot meet their bills with the
funds that they generate to cover such bills and always have to file for distress funds to be able to settle their bills.

5.1.2 Membership registration and renewal

It can be seen that membership and coverage of the scheme kept increasing year on after year from a moderate number of 8000 members in year one (in 2005) to the 117,385 members at the end of the fifth year in (2009).

When the respondents were questioned as to whether they have intention to stop renewing their membership in the near future, 267 (89%) of the respondents said no but 33 (11%) of the respondents confirmed their decision to stop renewal their membership of the scheme with varied reasons. Among them include, no special care and attention at health care providers, no increase in the minimum benefits package to cover more diseases, lackadaisical attitude of health workers especially those in the government institutions, who said no offered the following reasons:

5.1.3 Pattern of premium revenue and expenditure on claims

The operation of the scheme regarding claims payment was less than the revenue generated over the same period for the first one, two, and three years with percentage of 73.68%, 1.87% and 19.71% respectively.

This took a downward trend in the 4th and 5th years as the figures registered a negative trend over the period with the gap widening. Thus claims expenditure exceeded revenue by 71.02% an increased to 120.70% over the period. The scheme on each occasion paid more than they were
able to generate as revenue. This was made possible (payment) by filing for distress funds from the NHIA as a form of reinsurance by the authority.

The scheme has signed contract with 15 service providers who are all accredited by the national health insurance authority (NHIA).

According to the scheme, both manual and electronic vetting takes place. There is also a vetting committee who approves and clears outstanding claims but are not very active due to inability of committee members to meet together as a committee.

5.1.4 Human resources and Logistical needs

According to the health provider’s response, 17% indicated that they have adequate staff whilst 83% claimed staff was inadequate. The Scheme Manager also asserted that they had adequate staff, even though some few staff will be needed to compliment the current team. The Doctor-population ratio in the study area is too high, which confirms the assertion by the MOH’s. Human Resource Policies and Strategies for the health sector (2002-2006) which explains the human resource inadequacy of critical health workers such as doctors, nurses etc.

The results of the study showed that the staff inadequacy was 24.89%. Even though 75.11% of the respondents perceived the staff strength as adequate they were perhaps comparing the current situation with the previous situation. It could therefore be inferred that they meant a massive improvement in the situation rather than the adequacy they claimed. This is confirmed by the fact that 42% of the health workers are outsourced to assist with the health delivery system in the district, which was attributable to problems such as accommodation, transportation, motivation, inadequate facilities as revealed by the study.
Moreover, untrained staff, inadequate facilities, equipment and supplies and/or a combination of both were cited as logistical problems.

5.2.0 CONCLUSIONS

On the strength of the findings made by the study (see chapter four: presentation and discussion of results) the following conclusions are made.

5.2.1 Background Data

The study revealed a slight female dominance over males, 144 (48%) males and 156 (56%) females.

The dominant age group of the respondents was 20-29, 93 (31%) out of the age group.

Gender of the respondents indicated that, 153 (51%) were married.

The self-employed cohort constitutes the largest component of occupations in the district.

Most people in the Sekyere East are Christians, 168 (56%).

More so, on a six point scale over a quarter (28.67%) of the respondents had basic education. It can therefore be concluded that most of the people had low educational background.

5.2.2 Adequacy of human resources and logistical needs

The doctor population ratio is 1:62012 which are too high compared to the desired estimated ratio of 1:5000 by 2006 of MOH Human resource policies and strategies for health sector (2002-2006).
It was discovered that the human resource base of heath workers were not adequate, because of that, the district outsourced staff, $5(41.67\%)$ to be able to meet their heath care needs. It can therefore be concluded that human resource is inadequate.

In the case of the 21 categories of staff outsourced to assist in health delivery, $38.10\%$ (majority) are anesthetist nurses. It can be said that anesthetists’ nurses form the majority of health professional group outsourced in the Sekyere East District.

On the whole, all the respondents (100\%) indicated that there was existence of human resources problems like transportation, accommodation, lack of motivation and this assertion conformed to that of the scheme manager. This indicates that human resource base was very inadequate.

Logistics and equipment were generally perceived to be adequate even though some sort of shortage existed.

### 5.2.3 People’s perception and acceptability of scheme.

All respondents have heard about the NHIS mainly through radio/Fm, churches/mosques, visitation by the scheme and friends/relatives.

On the whole, none of the respondents was unaware of the NHIS. It can therefore be concluded that level of awareness of the NHIS is very high,

Regarding the meaning and functionality of the NHIS, well over $83\%$ of the respondents were able to give correct meaning to the NHIS with only a handful unable to do so. On this note one can conveniently conclude that knowledge of the scheme was adequate.

On perception of acceptance of the scheme, all the respondents together with health providers and the scheme manager stated that the NHIS is accepted as the best mode of healthcare financing in Ghana. This indicates that acceptability was very high.
Guaranteeing of access to quality healthcare by the NHIS was seen as one of the positive influences of the NHIS. Abuse of hospital attendance on the part of clients of the scheme was seen as a negative influence of the NHIS.

On sustainability, a significant number of the respondents, 180 (60%) believe that the scheme was viable and sustainable provided that coverage of membership will increase and right policies be adopted in the management of the scheme. On the average the sustainability of the scheme is said to be skeptical as all the respondents could not state with certainty that the scheme was sustainable. This is premised on the fact that the scheme Manager who spoke from the records available at the scheme contends that the scheme portrays some symptoms of unsustainability. One can therefore conclude that the sustainability of the scheme is still in doubt.

5.2.4 Membership registration and renewal

The study reveals that registration of members for the scheme has been very high as 99% indicated that they have registered. On renewals, about 90% of the people indicated that they have renewed the membership status with over 80% of them indicating they had no intention at all to stop renewing their membership in the near future. On the average, there is about 75% coverage of membership in the district. It can therefore be concluded that coverage of membership is very impressive and very high in the district.

5.2.5 Trends in premium and claims expenditure.

The pattern of revenue and claims has been touted with mixed feelings. This is because the trend started on a positive note at the starting years of 2005, 2006 and 2007 but took a downward trend in the 4th and 5th years. It is therefore increasingly becoming clear that the survival of the scheme
is in doubt since the scheme on two occasions had to file for distress from the authority to enable it survive.

The scheme on the whole dealt with 15 providers who rendered health care delivery for residents in the district. Again, the bills submitted by the providers were vetted by the vetting committee before payment is effected. The scheme operated within the minimum benefit package made available by the authority. This indicates that any service outside the minimum benefit package will not be accepted as genuine claims for payment. This means that providers adherence to this package guaranteed his being paid without much difficulty.

On utilization of services of the scheme, this has been very frequent with some staggering figures. In all 404,195 attendances at the hospital has been recorded with 42% male and 58% females. This shows a slight dominance of females over males. It can therefore be concluded that attendance and for that matter utilization of the scheme services has been very high.

Introduction of co-payment mechanism at the point of service use and continuous public education have been suggested as some of the ways of curtailing the abuse of attendance. From the foregoing analyses, one can boldly conclude that the sustainability of the scheme is not certain.

5.3.0 Recommendations

5.3.1 Introduction

In the light of the above findings, the following policy recommendations are being made for all stakeholders towards the sustainability of the NHIS in Ghana.
5.3.2 Ghana Health Service (GHS)/ NGO’S/NHIA

The study suggests that as a long term measure, the GHS, Sekyere East District Health Directorate and health related NGO’S like World vision, USAID, etc, should help in the provision of accommodation, transportation and other essential benefits which will be used as a means to attract adequate workers to solve the problem of inadequate human resources.

As a short term measure, it is suggested to the GHS ,NHIA, Sekyere East District Health Directorate and health related NGO’S like World vision, USAID, ADRA etc, to procure adequate logistics especially those on emergency services like oxygen, cylinders, fetal stethoscope, read lamps, curette, OPD benches and other very useful equipment that will facilitate diagnoses and treatment for the laboratory, ANC delivery, PNC records unit and also an X-ray for diagnoses for the health providers and scheme to solve its pressing logistics problems.

It is again recommended, as a short term measure to the Human Resource Unit of the GHS and the NHIA to give frequent in service training to its workers to enable them meet the challenges of changing times.

5.3.3 Sekyere East District Assembly (SEDA), SEDMHIS/Ghana Education Service (GES)

As a long term measure, SEDA in collaboration with GES and SEDMHIS should educate students and communities on health insurance in order to understand it and the need to use the health facilities whenever sick and also become economically empowered. This will in the long run break the barrier of ignorance and financial inaccessibility to health care and hence improve access to quality health care.
5.3.4 Sekyere East District Assembly (SEDA), SEDMHIS/Ghana Health Service (GHS)

The researcher would suggest that SEDMHIS Managers, the district Assembly in collaboration with the NHIA moves from awareness creation to continuous sensitization using community participation strategies to get greater number of the residents enrolled into the scheme to guarantee their access to quality health care at all times. This will go a long way to bridge the gap between acceptability and coverage in membership of the scheme in the district.

5.3.5 SEDA and the NGO’S

More so, as a medium term measure, the researcher suggest that the SEDA in collaboration with community leaders and NGO’S such as World Vision Ghana, National Board For Small Scale Industries (NBSSI), ADRA, etc give vocational training to the unemployed so that those who have accepted the NHIS but cannot join on the grounds of poverty or financial difficulties will be enrolled into the scheme.

5.3.6 SEDMHIS and the NHIA

Furthermore as a short term measure, SEDMHIS managers should embark on continuous education to get those not yet registered on board the NHIS to ensure that the 100% coverage envisaged by the nation is attained.

To achieve the above stated objective, it is suggested that the management team should allow people especially the poor to pay the premium by installment in order to encourage more people, especially the poor to get access to quality health care.

It is also suggested that the premium for the non-sick members should be reduced to keep them on board all the time.
Also, the exempt category for 70 years and above should be reduced to 60 years and above so that those in that group who are not in active and gainful employment can be covered and thus have access to quality healthcare.

Again, to ensure sustainability and to check on the abuse of utilization of the services of the scheme, co-payment and continuous education are being suggested to check this canker threatening the survival of the scheme.

Regular training of health insurance staff on all aspect of the scheme should be encouraged.

Regular routine audit of schemes to detect fraud early and to improve upon the weaknesses of internal controls at the scheme level should be encouraged.

Finally, the staff should be well motivated to give up their best towards the sustainability of the NHIS.

5.3.7 Health Training Institution / MOH

It is again suggested that the MOH in collaboration with institution such as the nursing training college, medical school and other health training institutions train, motivate and retain adequate health personnel and special attention given them. Again they should be given training in related field such as personnel management, human relations and provider customer relations so that they complete the various programmes with these skills at their disposal. This will make the health facilities customer friendly and attract patients rather than drive away patients.
5.3.8 All stakeholders of the NHIS

The study suggests that the DHMT could explore the possibility of receiving resources from the district assembly, MPS. Common fund, GETFUND, Trust Fund, industrial and economic concerns within and outside the district. More so the study suggest the SEDMHIS managers, district assembly, committees, DHA, the health providers, the MOH and all stakeholders as a short term measure, speed up all effort aimed at making the scheme sustainable.

5.3.9 Agencies and Departments

It is further recommended to the National Commission on Civic Education (NCCE), the Media, the Centre for Democratic Development (CDD), National Council on Women and Development (NCWD), CHRAJ, to educate the entire health workers and general public to stop the politicization of the schemes and the need to see it as a national policy and as such non-political.

5.3.10 Conclusion

From the foregoing discussion, it was reviewed that the human resources base of health workers as well as the scheme are not adequate and low as well. Logistical need was better in terms of adequacy and there existed human resources problems like accommodation, transport and motivation factors. Knowledge and acceptability of the NHIS are seen to be very high in the district. Coverage in membership is very high and encouraging due to constituency in increment in membership registration. Trends in claims revenue and expenditure are at variance as a result of high patronage and abuse of the scheme services. This revelation renders the scheme more unsustainable. To ensure sustainability, continues education on the parts of all stakeholders is the
way forwards. These should be adhered to by all stakeholders for policy update and subsequently, improve the health delivery system in the Sekyere East District.
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APPENDIX I

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY (KNUST)

SCHOOL OF GRADUATE STUDIES

FACULTY OF DISTANCE LEARNING

STUDY TITLE: SUSTAINABILITY OF THE NATIONAL HEALTH INSURANCE SCHEME (NHIS) - A CASE STUDY OF THE SEKYERE EAST DISTRICT MUTUAL HEALTH INSURANCE SCHEME (SEDMHIS), GHANA

QUESTIONNAIRE FOR HEALTH PROVIDERS

Dear Sir/Madam

My name is ………., I am with a research team from the faculty of Distance Learning of the Kwame Nkrumah University Of Science and Technology (KNUST), Kumasi.

As part of our academic programme and practical school requirements, we are conducting this study to collect information on the National Health Insurance scheme [NHIS] at Sekyere East District. The study aims at improving the sustainability of the NHIS to assure access to quality health care to all residents in Ghana.

You will be contributing to the research if you answer the following questions as frankly as you can. We wish to assure your outfit that whatever you tell us will be used purposely for the research.

Your refusal to partake in this study will not in any way affect your operations as a health institution.

Your facility will be contributing to the development of Ghana by responding to our questions.

Thank you.
PART 1: BACKGROUND DATA

Tick the appropriate box and supply information in the spaces provided.

1. Name of facility ..............................................................

2. Town/Location.........................................................

3. Type/ Status

PART 2 (A) ADEQUACY OF HUMAN RESOURCES BASE

4. Complete the Table Below:

<table>
<thead>
<tr>
<th>Health Worker</th>
<th>Expected No</th>
<th>Current No</th>
<th>Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Offices</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacists</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Assistants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mid Wives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Nurses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dispensary Control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disease Control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drivers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Aides</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: [Specify]</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. What is the current staff situation?
   (a) Very adequate [ ]
   (b) Adequate [ ]
   (c) Inadequate [ ]
   (d) Very Inadequate [ ]

6[i] In your view, are these health workers on the average adequate for your facility? YES [ ] ON [ ]

6[ii] Explain the reason for your answer in 11(i) ..........................................................

7. Do you outsource staff
   Yes [ ] No [ ]

8. If yes what category of staff do you outsource?
   .........................................................................................................................
   .........................................................................................................................
   ..........................................................

9. Are there any human resource problems at this facility?
   Yes [ ] No [ ]

10. If yes identify three (3) major human resource problems related to the Health Insurance
     Scheme in this facility?
     1. ............................................................
     2. ............................................................
     3. ............................................................

11. In your opinion, what steps can be adopted to curtail the human resource problems in this facility?
PART 2. B: LOGISTICAL NEEDS OF FACILITIES

12. Please complete the table below

<table>
<thead>
<tr>
<th>DEPARTMENT</th>
<th>Very Adequate</th>
<th>Adequate</th>
<th>Inadequate</th>
<th>Very Inadequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Records</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consulting Room</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OPD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ante-natal care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivery Ward</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-natal care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Office</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maint./Transport</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In your general view, what is the logistical needs situation of this facility?

Do you perceive any logistical constraints? Yes [  ] No [  ]
If yes, what practical steps can be taken to minimize this problem?

Scheme payment system:

16. How often are your bills settled by the scheme?

(a) Daily  (b) weekly (c) Monthly  (d) others (specify) .................................................................

17. How do you assess the payment arrangement reached with the scheme?

(a) Excellent (b) very good (c) good   (d) satisfactory (e) poor   (f) other specify.

18. If your answer to [QUESTION 17] is either poor or other, what are the problems?................................................................................................................

19. Do you consider Health Insurance as a better health financing option for Ghanaians?

Yes [ ]  No [ ]

20. Give reason for your answer or in (19) above .................................................................

................................................................................................................................................................

21. Is the NHIS sustainable in your view? ............................................................................

22. What are your reasons for saying so? ........................................................................

................................................................................................................................................................

................................................................................................................................................................

23. What in your view can be done to ensure sustainability of the scheme?

................................................................................................................................................................

QUESTIONNAIRE FOR SCHEME MANAGER

PART 1: BACKGROUND DATA

Tick the appropriate box and supply information in the spaces provided.

Name of scheme..............................................................................................................................
PART (2) (A) ADEQUACY OF HUMAN RESOURCE AND LOGISTICAL NEEDS.

In your view, do scheme workers or staff have adequate training to uphold the NHIS?

Yes [ ] No [ ]

Why do you say so?

.................................................................

In your opinion are there any human resource problems faced by the scheme in the District?

Yes [ ] No [ ]

If yes, identity any (3) human resource problems associated with the running of the scheme in the District. ............................................................

What measures can be taken to curb the problems?

.................................................................

In your own opinion, how would you describe the status of the scheme in terms of availability of logistics and equipment?

Very adequate [ ] available [ ] not available [ ] very inadequate [ ]

Why do you say so? .................................................................
Complete the table below as it pertains to the scheme: staff strength of scheme

<table>
<thead>
<tr>
<th>Department</th>
<th>Staff Expected</th>
<th>Current Position</th>
<th>Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MIS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General /Admin</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. Complete the table below as it pertains to the scheme: Logistical needs

<table>
<thead>
<tr>
<th>Depts.</th>
<th>Expected</th>
<th>Current Position</th>
<th>Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computers &amp; Accessories</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport[Vehicle]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motor bike</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13. In your general view, what is the logistical needs situation of this facility?

…………………………………………………………………………………………………………………………

14. Do you perceive any logistical constraints?  Yes  [  ]  No  [  ]

20. If yes, what practical steps can be taken to minimize this problem?

…………………………………………………………………………………………………………………………
21. Do you consider Health Insurance as a better health financing option for Ghanaians?

Yes [   ] No [   ]

22. Given reason for your answer or in (21) above                                      …………………………………………………
    ……………………………………………………………
    ……………………………………………………………

23. Is the NHIS sustainable in your view?                                          …………………………………………………

24. What are your reasons for saying so?                                          …………………………………………………
    ……………………………………………………………
    ……………………………………………………………

25. What in your view can be done to ensure sustainability of the scheme?
    ………………………………………………………………………………………


Table [iv]  REVENUES

<table>
<thead>
<tr>
<th>Year</th>
<th>Informal Sector Payment</th>
<th>Exempt Category</th>
<th>Registration fees</th>
<th>Total premium</th>
<th>Reinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
EXPENDITURE PATTERN

Table [v] EXPENDITURE

<table>
<thead>
<tr>
<th>YEAR</th>
<th>ADMINISTRATIVE/OPERATIONAL</th>
<th>CLAIMS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2007</td>
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<td></td>
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<tr>
<td>2008</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[ii] Does the scheme have any reserved money set aside? Yes [ ] No [ ]

[III] If yes in [ii] above, how much money has been set aside?

For what purpose has the money been reserved?

[a]...........................................................................................................

[b]...........................................................................................................

[IV] If no in [ii] above, what would you do if the scheme should run into financial distress?

a]...........................................................................................................

[b]...........................................................................................................

[c].............................................................................................................
PART 4. (27) Annual Enrolment (Membership registration and renewal)

Table [vi]

<table>
<thead>
<tr>
<th>Year</th>
<th>Category</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>Informal Sector Contributors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Exempt from Payment</td>
<td></td>
<td></td>
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<td>Indigents Group</td>
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</table>
PART 5: (28) CLAIMS ADMINISTRATION

Please list your service providers and the sort of service agreement reached with them below: (select one of the following to describe your service agreement with the providers: (a) signed contract/Agreement (b) Gentlemen/unsigned contract, (c) memorandum of understanding, others specify.

For the General relationships with all your health providers select one of the following: Excellent, very good, satisfactory, poor, or very bad.

Table [vii]

<table>
<thead>
<tr>
<th>Health Provider</th>
<th>Type of Service Agreement</th>
<th>General Relationship</th>
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<tbody>
<tr>
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<td>13.</td>
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</table>
29. Are all providers of the scheme accredited by the National Health Insurance Authority (NHIA)? Yes [ ] No [ ]

30. Is there any vetting and procedure for the payment of claims? Yes [ ] No [ ]

31. If yes, what is the process like? ……………………………………………………………………………………………………………………
…………………………………………………………………………………………………………………………
…………………………………………………………………………………………………………………………
…………………………………………………………………………………………………………………………
…………………………………………………………………………………………………………………………

32. What kind of vetting is done? Manual [ ] electronic [ ] both [ ]

Which of the two is functional? And which is the preferred?
…………………………………………………………………………………………………………………………
…………………………………………………………………………………………………………………………
…………………………………………………………………………………………………………………………

33. Does the scheme have a vetting committee in place? Yes [ ] No [ ]

34. If yes, is it active and functional? ……………………………………………………………………………………………………………………

115
35. What is the composition of the committee?

1. .................................................................

2. .................................................................

3. .................................................................

4. .................................................................

5. .................................................................

Benefit package and utilization of the scheme

35. Has your benefit package changed over the period of 2005 to 2009? Yes [ ] No [   ]

36. If yes to 35 above, what did you add or remove from the benefit package?

Additions:  a  .........................

b.................................

c.................................

Removals

a  .........................................................

b.........................................................

c.........................................................
37. Please provide information on utilization of the scheme over the period of 2005 up to 2009.

<table>
<thead>
<tr>
<th>Year</th>
<th>How many people have used the scheme?</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>2005</td>
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<td>2008</td>
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<td>2009</td>
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</table>

38. Do you experience frequent use of the scheme as a form of abuse by some members? Yes ………… No ……………………….

If yes in [question 38], what do you think should be done to stop this frequent use and abuse?

……………………………………………………………………………………………………………………………………………………………………

Provider payment system:

39. What mode of payment do you apply to settle the bills of your providers?

(a) Daily vetting and payment     (b) weekly vetting and payment
(c) Monthly vetting and payment   (d) others (specify) ……………………..

40. How do you assess the payment arrangement reached with the providers?

(a) Excellent (b) very (c) good   (d) satisfactory (e) poor   (f) other specify.

41. If your answer to [QUESTION 40] is either poor or other, what are the problems?........................................................................................................................................................................

Sustainability
42. For the past five years, how do you rate the financial stability of your scheme?

[a] very stable  [b]stable  [c]instable  [d] very instable

43.[i] If your answer to [QUESTION 42] is either instable or very instable, please what are the problems?

.................................................................................................................................

43[ii] what are the two [2] most effective mobilization strategies that the scheme uses to mobilize resource and membership?

Resources:

a........................................................................................................................................

b........................................................................................................................................

Members:

a........................................................................................................................................

b........................................................................................................................................

[iii] What is the scheme most effective education campaign?

.........................................................................................................................................

[iv] What do you consider as the 2 key strength of your scheme?

[a]........................................................................................................................................

[b]........................................................................................................................................

[v] What do you consider as the 2 key weakness of your scheme?

[a]........................................................................................................................................

[b]........................................................................................................................................
RECOMMENDATIONS

44.[i] Please provide 2 main recommendations in the following areas, which will help improve your scheme mobilization of new members and retention of old members?

[a]…………………………………………………………………………………………………………………………

[b]…………………………………………………………………………………………………………………………

[ii] Financial management of the scheme:

1…………………………………………………………………………………………………………………………

2…………………………………………………………………………………………………………………………

[iii] Scheme viability and sustainability:

1…………………………………………………………………………………………………………………………

2…………………………………………………………………………………………………………………………

PART 1: BACKGROUND DATA

Tick the appropriate box and supply information in the spaces provided.

1. Sex:    male [        ]    Female [          ]

2. Age:   …………………………….

3. Marital Status:

   Single  [     ]

   Married/living together  [    ]

   Separated/Divorced/Widowed  [    ]

4. Academic Qualification

   No formal Education  [    ]
Secondary Education [   ]
Basic Education [   ]
Diploma [   ]
First Degree [   ]
Offer [specify] ........................................................................................................................

5. Religion
Christian [   ]
Islamic [   ]
Traditional/Other [   ]

PART TWO: PEOPLE’S PERCEPTION, ACCEPTABILITY AND MEMBERSHIP REGISTRATION

Have you heard about the NHIS?
YES [   ] NO [   ]

8. If yes, from where/whom did you hear about the NHIS?......................................................

If yes, what is the meaning of Health insurance?...........................................................................

What is the current status of health insurance in the District?
a. Functional [   ] b. Not functional [   ]

9. Have you registered for the NHIS? Yes [   ] No [   ]

10. If no why?................................................................................................................................
11. Have you renewed your membership with the scheme? Yes [ ] No [ ]

12. If no, why? .................................................................................................................................

13. Do you intend to stop renewing your membership after some years to come? Yes [ ] No [ ]

14 i. What do you perceive as the positive influence of the NHIS?
   a. .................................................................................................................................
   b. .................................................................................................................................

14 ii. What do you perceive as the negative influence of the NHIS?
   a. .................................................................................................................................
   b. .................................................................................................................................

15. Do you accept the NHIS as a good healthcare financing option? Yes [ ] No [ ]

   Compared to the other options of health care financing, what can you say about the
   NHIS? ........................................................................................................................................

Sustainability

17. In your opinion. Do you think the scheme is sustainable in the future? Yes [ ] No [ ]

18 i. If yes, what makes the scheme sustainable?
   a. .................................................................................................................................
   b. .................................................................................................................................

18 ii. If no, what makes the scheme unsustainable?
   a. .................................................................................................................................
   b. .................................................................................................................................

19. List what you consider as the two main problems facing the scheme.
RECOMMENDATIONS

2o.] Please provide 2 main recommendations in the following areas, which will help improve your scheme mobilization of new members and retention of old members?

[a]...........................................................................................................................................

[b]...........................................................................................................................................

[ii] Financial management of the scheme:

1...........................................................................................................................................

2...........................................................................................................................................

[iii] Scheme viability and sustainability:

1...........................................................................................................................................

2...........................................................................................................................................