KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY, KUMASI

THE IMPLEMENTATION AND CHALLENGES OF RISK POOLING SCHEMES IN HEALTH CARE FINANCING; A CASE STUDY OF PRU AND BAWKU-WEST MUTUAL HEALTH INSURANCE SCHEMES.

by

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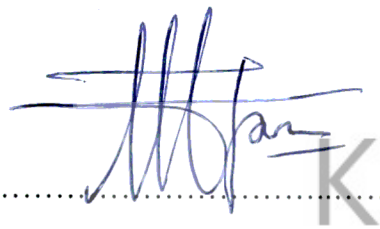
DECLARATION

I hereby declare that the work presented is the result of my own research and that no previous submission in this University or elsewhere has been made for a degree. However, works by other authors served as a source of information and guide, which have been acknowledged by the references for the literature cited.



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ABSTRACT

The rising cost of health care financing the world over in the 1980s led to a paradigm shift in health care financing, from point of service; user fees; out- of- pocket- payments other wise referred to as 'cash and carry', to prepaid systems and for that matter health insurance as an alternative health care financing system. Health insurance is said to be an efficient and effective system which ensures the provision of accessible, affordable, equitable and quality health care services to a majority of people, especially the poor and vulnerable, hence, its adoption by the Government of Ghana as part of its poverty reduction strategy in 2003. Even though a good health financing system, the implementation of health insurance has posed a lot of challenges with respect to its technical design, managerial capabilities, organizational and institutional arrangements. The study therefore seeks to find out whether the health insurance scheme and its implementation is capable of ensuring adequate risk pooling and sharing, efficient management for sustainability, and the achievement of the Millennium Development Goals 4 and 5 on health.

The study was done using both quantitative and qualitative techniques. The questionnaire was the principal instrument used to solicit information from 200 households, scheme managers, district directors of health and key informants such as Nurses and Assemblymen. The study reveals that the scheme experienced a smooth take off with a design that ensures formal and informal sector contributions, public-private participation with a comprehensive benefit package that covers 90 percent of basic diseases. It has also enrolled averagely about 47 percent of the target population and has increased access to health care services from out patients department to about 43 percent. Sustainability indicators of the scheme include: (i) the creation of a national health insurance fund for re-insurance; (ii) The existence of more than one source of funding for the mutual health insurance schemes; (iii) A high level of community participation and support for the insurance policy; (iv) An appreciation and support for the policy by almost all political divides of the country. Challenges faced include: lack of skilled personnel for both schemes and providers; a stagnant enrolment drive with a 10 percent drop out rate of membership; inadequate infrastructural facilities; and risk management. Measures such as: intensifying education and sensitization; establishing effective training programmes and a

human resource policy for scheme officers; increasing the number of provider staff and facilities; and supporting health promotion activities would help sustain and push the scheme towards universal coverage as anticipated by the policy thrust.

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TABLE OF CONTENTS

CONTENTS **PAGE**

LIST OF TABLES

LIST OF FIGURES

ACRONYMS

NHIF	-	National Health Insurance Fund
SSNIT	-	Social Security and National Insurance Trust
DANIDA	-	Danish International Development Agency
OPD	-	Out Patient Department
MHIS	-	Mutual Health Insurance Scheme
ILO	-	International Labour Organization
WHO	-	World Health Organization
GNP	-	Gross Domestic Product
GH¢	-	Ghana Cedis
ID	-	Identity Card
NGOs	-	Non Governmental Organization

CHAPTER ONE

1.0 INTRODUCTION / BACKGROUND

The long-term growth of the global economy suffered serious disruptions in the 1980s as a result of significant energy price hikes; against this background was a souring rise in expenditures of essential social services such as Health care. This state of affairs brought many countries to their feet in search of an alternative to health care financing, which was one area with heavy expenditure increases. This rapidly rising health care costs spurred the development of many cost containment measures that could assure quality health care. Adjusting to these changes brought about a paradigm shift in health care financing, to Health Insurance – a policy initiative adopted by most countries in the developed and presently developing countries (Dunlop and Martins 1995).

Health Insurance is a kind of prepaid scheme which requires subscribers to pool their financial resources called "premiums" together, to help meet the cost of health care services of its members. Health insurance traces its origin to "accident policies." There are basically five types of health insurance policies, namely; Basic Medical Expenses Insurance, Major Medical insurance, Disability insurance, Medi-care supplement Insurance, and long-term care insurance. Among these two main designs of Heath insurance are identified, they include; the social insurance design which provides universal health insurance, coverage, and usually a government-run plan with standardized benefit structure and contribution rates. The other one is the Pluralistic design which provides coverage through public hospitals with private insurance opt-outs.

The National Health Insurance Scheme in Ghana emerged as part of a development policy strategy under the Ghana poverty Reduction strategy (GPRS) to help reduce poverty among its people (Ministry of Health, August 2004). Thus paradigms shift in Health Care Financing. Which calls for a community based participatory scheme (Mutual health Insurance) that requires people in each district to pool their resources to cater for their Health Care Services Financing in times of need. This design unlike the universal coverage

of government run that of Ghana includes, private insurance opt-outs, and provides opportunities for both formal sector and informal sector contributions into a common pool (William C. Hsiao 2001).

The National Health Insurance Authority in Ghana is established by National Health Insurance Act 650, the main features of the policy include the following;

- It offers universal coverage where every body is eligible to subscribe to the scheme and takes care of both out-patient (OPD) and Inpatient (admissions) costs. More over, it covers the poor and vulnerable and the abject poor, children below eighteen years, the aged and others (the indigents).
- It is funded through public sector workers contributions of 2.5 percent of their social security contributions as premiums, while people in the informal sector contribute a minimum of seventy-two Ghana cedi (72 GC) per annum to District Mutual Health Insurance Schemes.
- Health insurance levy of 2.5 percent sales tax (exempts essential items – EDL, water, education, seeds, fishing equipment, etc. 2.5 percent SSNIT Government funds Investment income, grants, donations, etc. (MOH 2003)

Health insurance is viewed by its proponents as a policy that is capable of providing universal and equal access to reasonable Health Care Services, keeping health care expenditures at affordable and manageable levels (both micro and macro levels) and to make effective use of available resources with the ultimate aim of achieving poverty reduction. However, the achievements of these objectives and goal depend largely on the sustainability of the Health Insurance Scheme as an effective and efficient development tool.

The key factors identified by the proponents for the successful use of Health Insurance as a development tool include the following;

- The appropriate Institutional and Management Structure
- Appropriate premium to cover the cost of providing benefits
- Adequate population size to facilitate risk pooling
- Limited adverse selection and moral hazards

(WHO 1987)

1.2 PROBLEM STATEMENT

All developing countries face three major policy issues in health care financing; how to mobilize sufficient funds to finance health care, how to allocate these funds and organize health care delivery to produce more health benefits for the majority of people, and how to control the cost of health care services (William C Hsiao, 2001).

Health Insurance is said to be an efficient and effective method of heath care financing that provides easy access and equity to health care services to people especially the poor and the vulnerable. Since health is a critical and basic human need which affects other livelihood assets, it is important to find measures that will ensure the continuous survival of any mechanism that provides for access to affordable health care. The ability of health insurance as a policy intervention to provide for easy access, equitable, efficient and sustainable health care, will depend on the establishment of appropriate institutional and management structures, appropriate premium to cover the cost of benefits based on a risk sharing principle, and adequate coverage to facilitate risk pooling for an equitable and sustainable financing (Martins and Dunlop 2001). Successful implementation would also depend on the nature of the design, level of solidarity, management capacity, and establishing sustainable risk sharing mechanisms that can benefit the informal sector (WHO, 1997).

The National Health Insurance Scheme and for that matter the District Mutual Health Insurance Scheme (DMHIS) has very laudable objectives that are aimed at improving the livelihood of most Ghanaians, by making Health care services accessible to all at reasonably low cost. However, whether this insurance policy especially for those in the predominantly rural communities would stand the test of time as a development strategy to achieve the objective of poverty reduction depends on the implementation strategies and efficiency, given the socio-economic nature of the Ghanaian society.

Most of the Districts in Ghana are predominantly rural communities, such that people of the rural communities constitute about 70 percent of their total populations. These people engage in peasant farming, that is characteristically subsistence and therefore earn very low and inadequate family incomes for their livelihood. More so, the income earned from Agricultural products does not only fluctuate, but also continues to attract lower prices over the years. This will make regular payments of premium difficult.

Moreover, the informal sector which constitutes a greater part of the rural setting is larger than the formal sector and hence, poses a problem of assessing and collection of contributions as premiums, with its associated cost and irregular collection periods.

Furthermore, most people within the rural settings are illiterates and who are culturally traditional, such that, their receptiveness to new ideas or ways of doing things will depend largely on the level of enlightenment, sensitization and the employment of appropriate techniques of awareness creation. This requires special expertise, which is lacking.

Against this background of low income earnings of the targeted population is the ever increasing cost of health care services as a result of technological advancement and techniques, coupled with the emergence of such chronic and high cost treating diseases such as cancer, tuberculosis, diabetes sickle cell, HIV/AIDS and others. More so, there will be an eventual withdrawal of government support as the burden on the tax payer in the formal sector, which is the smaller but highest contributor increases with harsh economic conditions.

With low income earnings of about 70 percent of the targeted population as against price hikes, high illiteracy rate, that pose a problem of receptiveness to the scheme; a larger informal sector which makes premium collection difficult and at a higher cost, and a subsequent low participatory rate in terms of subscription and administration, an obvious question that comes to mind is; whether the mutual health insurance scheme will survive as a development instrument to achieve its objective of improving the livelihood of rural communities.

1.3 RESEARCH QUESTIONS

i. What is the operational status of the health insurance schemes?

ii. What measures have been put in place by the mutual health insurance schemes to serve the objectives of securing adequate access, equity, and sustainable financing to cater for the health shocks of the rural poor?

iii. Is the risk pooling and sharing mechanism for the informal sector and the benefit package sustainable?

iv. What are the main constraints and obstacles to improving arrangements to provide adequate, equitable and sustainable financing of the scheme?

1.4 GENERAL OBJECTIVE.

To assess the implementation effectiveness and challenges of the District Mutual Health Insurance Scheme (DMHIS), in predominantly rural communities of the country and to help suggest policy strategies for implementation

1.4.1 Specific Objectives

In furtherance to achieving the general objective, the following objectives shall be pursued;

- To identify the operational status and structures of the scheme.

- To find out whether the risk pooling and sharing mechanism ensure access to affordable, equitable and quality health services for the poor and vulnerable.

- To find out whether there are in place any strategies to ensure adequate revenue mobilization and efficient management for financial sustainability of the scheme.

- To identify the challenges associated with the implementation of the scheme.
- To come out with findings and policy recommendations.

1.5 JUSTIFICATION AND SIGNIFICANCE OF THE STUDY

The significance of this study lies in the fact that, Health insurance is a new system of Health Care Financing introduced into the Ghanaian society, hence the need to examine its operations with respect to certain structural rigidities inherent in the Ghanaian society, so as to come out with policy recommendations to promote the smooth implementation and sustainability of the scheme.

The study would also help provide useful information on the institutional, technical, managerial, and organizational capacities of the National Health Insurance Scheme to serve as a data source that would help technocrats and planners to design appropriate strategies that would strengthen the health delivery system in Ghana.

More over, it is also an academic exercise through the findings and recommendations that would bring to the fore not only new ideas, but also emphasize on what have already been observed by others that will not only add to the existing literate on health insurance, but would also serve to give an insight into other sectoral studies that could be undertaken on health insurance.

1.6 SCOPE OF THE STUDY

1.6.1 Geographical Scope

The study was conducted on the District mutual Health Insurance Scheme of the Pru and Bawku-West Districts, which are newly created districts in the Brong Ahafo and Upper East Regions respectively in 2004. These districts were chosen because they are representative of predominant rural communities

Pru district is one of the newly created districts in Brong –Ahafo Region established by Legislation Instrument 1778 in 2004. It shares boundaries with six other districts in the country namely, East Gonja in the north, Sene in the East, Nkuranza and Atebubu-Amanten in the south, and Kintampo-south and Kintampo North in the West. It was carved out of the then Atebubu District in 2004, with a land size of 2195km square. Pru has a population of 93859 according to the 2000 population census, and a projected population of 97238 in 2007 based on an annual growth rate of 1.25 percent. The projected population is made up of 49591males and 47647 female. About 55.8 percent of the population falls within the active labour force, which is quite higher than the regional and national active labour force of 52.4 percent and 55.2 percent respectively. This could be mobilized into farming and fishing to exploit the rich agricultural potentials of the district. Sixty-six (66 percent) of the people earn their livelihood from agriculture, Seventeen percent (17 percent) from the services sector, Thirteen percent (13 percent) from commerce and Four percent (4 percent) from industry. (Pru District, Medium Term Development Plan 2006-2009)

The Pru distinct has one district hospital which serves four (4) other sub-districts in addition to Yeji community, these include, prang, Abaasde, Parambo and Zambarema.
The Bawku-West district has Zebilla as its capital, it is predominantly a rural community with large household sizes, high illiteracy rate, and a total population of about 113,889 (2000 population census). A majority of who are subsistent farmers. Bawku- West has a district hospital at Zebilla, which serves sub-district communities such as; Sapeliga Tilli, Binaba, Kusanaba and Zongoyire.

1.6.2 Textual Scope

The study examined the general characteristics of the schemes, the drop out rate, the participation of the members in terms of design, implementation with respect to risk pooling, revenue collection mechanism, benefit packages, regulatory framework, purchasing strategies, as well as the issue of claims management and challenges. It also looked at the social status of the people in terms of employment levels and cultural diversity

1.7 LIMITATIONS

Time involved in moving from one study area to another to collect information is quite tedious and expensive, and hence did not allow for in-depth exploration of all the issues. More so, it also determined the number of questionnaires determined and administered on the field.

Furthermore, the inability of scheme managers to release some information due to the inadequacy of such records also served as a limitation. However this in no significant terms has affected the information gathered and the results obtained.

1.8 ORGANIZATION OF WORK

The report is organized into five chapters. Chapter one gives an overview of the study .the second chapter, deals with the review of literature. The methodology is contained in chapter three. The analysis and discussions are presented in the fourth chapter, whiles chapter five concludes the study with the findings and conclusion from the analysis, and also presents recommendations for policy action.

Found below is the map of Ghana indicating the study areas

Figure 1.0: Map showing the demarcation of study areas (Geographical scope)

Political Map of Ghana

CHAPTER TWO

2.0 LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

This chapter reviews relevant information on health insurance as a system of risk pooling in health care financing. It looks at the function and types of health care financing as well as the emergence of health insurance in developing countries. The concept of health insurance and risk pooling are also looked at briefly. The review also covers key factors and prerequisites required for the smooth implementation of health insurance schemes and challenges faced by these schemes in the process of implementation.

2.1 HEALTH CARE FINANCING

Health care financing involves three basic functions of collecting revenue, pooling resources, and purchasing goods and services (WHO 2000). Policies concerning these functions provide an opportunity to make reforms effective throughout the health sector. *Revenue collection* is the way by which health systems raise money from house holds, business, and other external sources in order to finance health care. Pooling deals with the accumulation and management of revenues so that members of the pool share collective health risk, and hence, protecting individual members of the pool from unpredictable health expenditures. *Purchasing* refers to the mechanisms used to secure services from public and private providers.

The efficiency and equity elements are critical aspect of any healthcare financing systems. Thus, equity with respect to financial resources, level of payment and pooling, services provision, provider payment and physical access to care. Efficiency concerns - revenue collection, allocation of resources, and technical services production.

Healthcare financing are put broadly into three basic models or methods, they include;

- *National Health Service*, which gives compulsory universal coverage and derives its resources from general government revenue. It has national ownership of health sector inputs.
- *Social insurance*; this also has compulsory universal coverage for only employment targeted coverage under social security in the public sector, and it is financed through employer and employees contributions into a non profit insurance fund. It has a joint ownership of the public and private sectors.
- *Private insurance* is one model with a profit motive and covers individuals of both the public and private sectors. It is not compulsory and privately owned (Preker and Haring, 2000).

Most developing countries are severely challenged in providing quality and accessible health care to their populations and also in providing financial protection to the majority poor. The challenge is two fold, the task of mobilizing sufficient funds for operating the healthcare system, and to apply those funds efficiently. Mobilizing funds to finance healthcare interventions is difficult both because heath care is costly and because raising revenues in developing countries is not easy (Gottret & Shieber, 2006).

The *National Health Service* is the health financing model that was adopted by most developing countries after independence. However worsening economic conditions in the 1980s and the introduction of Structural Adjustment Programmes (SAP) led to the implementation of cost recovery policies in most sectors of the economies of these countries, including the health sector. This brought about the introduction of user fees where out-of-pocket payments are made at the point of service delivery, popularly referred to as ''cash and carry'' in Ghana. This state of affairs resulted in the deterioration of the health status of most people in these countries, especially the rural poor and the vulnerable most of whom died out of curable diseases, because they could not afford to pay for their health care services at the point of delivery (WHO, report 1997).

In recent years, great progress has been made in the effort to securing better access and financial protection against cost of illness through collective financing of health care. Thus, the introduction of health insurance schemes in some developing countries. Experience has shown that, without clear spending policies and effective payment mechanisms, the poor and other disadvantaged people are often left out (Gottret & Shieber, 2006).

2.2 THEORY OF INSURANCE

Health insurance builds on the 'law of large numbers', which states that the average behaviour of a group of individuals is more predictable than that of a single individual (Black 1997). In other words, the tendency to behave more systematically and predictably increases with the size of the group. This is the rationale for pooling individual risks, the key function of an insurance fund.

The four values in health insurance – equity, solidarity, risk pooling, and community empowerment. Community empowerment will take place when the community pays the premium and requests for better quality services. Risk pooling is enhanced when there is risk sharing between not just the healthy and the sick, but also between the rich and the poor. Equity is strengthened when people pay according to their ability and get benefits according to their need. And this is possible only when people are bonded in solidarity. As it is difficult to promote solidarity solely through a health insurance mechanism, it is important that health insurance programmes be piggy backed on existing institutions that have inherent solidarity (Baeza 2001)

2.3 THE CONCEPT OF HEALTH INSURANCE

Prepayment and Risk pooling are important for providing financial protection for the poor. Pooling health risks enables the establishment of insurance and improves people's welfare by allowing individuals to pay a predetermined amount to protect themselves against large unpredictable medical expenses.

2.3.1 Health Insurance

It is primarily viewed as a means of offsetting catastrophic financial losses associated with severe illness or injury through risk pooling among many people (Joseph Kutzin, 1996). It is a kind of prepayment scheme, where subscribers are made to pool their financial resources together into a common fund, to cater for their unpredictable expenses of health care services.

Insurance schemes can be compulsory and cover a whole population or they can be limited to certain people say only those in the formal employment sector. They may also be voluntary, as in the case of private commercial, non profit coverage publicly managed in prepayment schemes.

They may also apply to some or all levels of health care, with or without restrictions. The objective of a health insurance system will depend on the perspective of the stakeholders, but would generally include the following:

- To mobilize additional resources and transfer some or all of the cost of health care to those who can afford to pay (risk pooling and subsidizing function);
- To change the source and pattern of provider payment and related incentives to keep down the cost within health schemes so as to slow down growth rates;
- To improve the technical efficiency by separating the financing and provision of services, thereby introducing competitive mechanism into the health sector; and
- To expand access to health services by transferring resources from those who can afford insurance to the poor (risk shaving function).

(Joseph Kutzin 1996).

2.3.2 Types of Health Insurance

There are four main health insurance mechanisms that are used to pool health risks, promote prepayment, raise revenues, and purchase services; they include:

- State – funded systems through ministries of health or national health services;
- Social Health Insurance;
- Voluntary or private Health insurance; and
- Community based health insurance. (Gottret & Shieber, 2006).

State-Funded system

State funded systems are characterized by three principal features, their funding comes from the general revenues of the state, they provide medical coverage to the whole population, and they usually deliver health care through a net-work of public providers or hospitals. An example is the scheme of Britain.

Social Health Insurance

Social health insurance has different definitions among different people. However, its characteristic features that distinguish it from other schemes include: the scheme is financed through a combination of pay roll and taxation, and provides universal coverage with standardized benefit package for all members. It also involves some degree of autonomy from government in its management – it requires solidarity among the populace for a successful running. While it is noted for making "funding available, as well as set the right financial incentives for providers, to ensure that all individuals have access to effective public health and personal health care" (WHO 2000.). It also has poor coverage for chronic diseases and preventive cares are complex and expensive to manage (McKee, Delnoij and Brand, 2004). It has a kind of unitary risk pooling, promoting risk sharing and subsidizing.

Private or voluntary insurance

It provides health insurance economically for profit by private organizations. It is also characterized by premiums not based on the levels of income. Hence, premiums are based on the risk profile of the subscriber. The principal objective of this type of insurance is to eliminate expenditure uncertainty associated with heath care. But not cross subsidization.

Community-Based Health Insurance

These types of health insurance schemes have no single applicable definition because of their diverse nature, since the perspective their stakeholders differ from community to community. However, three common features of existing schemes include the following:

i. Affiliation is based on community membership, and the community is strongly involved in managing the system.
ii. Beneficiaries are excluded from other kinds of health coverage, since they usually have specific coverage.
iii. Members share a set of social values (Jakab and Krishman 2004)

Community-based Health Insurance has limited protection for its members (ILO and STEP 2002) and also has questionable sustainability (Bennet, Kelly and Silvers 2004).

2.4 THE CONCEPT OF RISK POOLING IN HEALTH CARE FINANCING

World Health Organization(W H O) defines risk pooling as "*the practice of bringing several risk together for insurance purposes in order to balance the consequences of the realization of each individual risk*" (WHO 2000). Its main purpose is to share the financial risks associated with health interventions for which need is variable and uncertain, WHO illustrates two redistributive issues implicit in risk pooling as follows;

- Members might make equal contributions but the pool effectively enables a transfer to be made from the relatively healthy to the sick (the risk pooling function). This is expected from a community-financing program charging flat rate;

Members might also make equal financial contribution and make equal use of health care across their life times. The pool enables transfer to be made depending on the stage of individual life cycle (*this is the life cycle redistributive function of the risk pool*).

2.4.1 Modalities of Risk Pooling and how they affect Performance of a Health Care System

The nature of risk pooling arrangement is a policy choice that is heavily influenced by a nation's circumstance and its policy priorities. There are four main classes or approaches to risk pooling.

- no risk pool
- unitary risk pool
- fragmented risk pool and
- Integrated risk pool.

(Rice and Smith 2001)

No-risk pools

The individuals are responsible for their own health care costs when they arise; these patients take care of user charges, as they are incurred. With no price subsidies for the poorer people and denial of treatment to people who have no financial ability to pay. Hence, insurers will set premiums based on the risk profile of the subscriber. (*Private insurance*).

Unitary risk pool

Revenue is contributed into a central pool, which takes care of a defined package of health care services. It is mandatory to include the rich and the poor, to counter the inefficiencies and inequities associated with adverse selection in this case, unless systems of provider reimbursement are chosen properly, there may be an incentive for supply induced demand (McGuire 2000), which would further lead to variations in the package receipts-nullifying the equity principle. This type of risk pool has little incentive to moderate demand on health care services and therefore has the potential of moral hazard, in the form of excessive consumption of health care services (*promotes risk sharing*).

Fragmented Risk

Due to associated managerial control, information flow, and coordination associated with unitary risk pooling, it becomes necessary for fragmentation into particular pools according to:

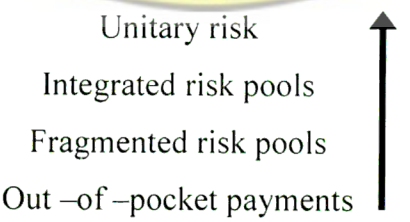
- Where the people live (geographical risk pool);
- Nature of employment (formal and informal);
- The personal characteristics; age or states; and
- Personal choice.

Fragmented risk pools with higher population of older and sicker members will incur higher expenditures. In the extreme, fragmented risk pools become house holds or individuals, where the system reverts to one of no risk pooling. Hence fragmented implies that, pools with smaller and poorer memberships must either charge higher premiums or offer more constraint packages of care.

Integrated risk pools

Under this arrangement, the individual risk pool remains, but transfers are arranged between pools so that, some or all the variations in fragmentation are eliminated. Funding of integrated risk pool should be based on capitation payments. The integrated pyramid illustrates the stages of risk pooling that ensures social inclusion and financial protection.

The integrated pyramid



As risk pooling becomes progressively integrated the uncertainty associated with health care expenditure can be reduced. Out- of- pocket payment exposes the individual to the greatest uncertainty. Private insurance does little to compensate for variation in health

status or income. Fragmented risk pool allows for local sharing of risk, but also exposes members to variations among risk pools. Integrated seeks to reduce variations, which are eliminated under truly united system.

2.4.2 Practical issues on risk pooling

According to (Smith & Wither 2005), numerous practical issues arise in seeking to make the principle of risk pooling operational. These issues include: The institutional frame work for risk pooling; membership criteria for risk pools; size of risk pools; prospective risk shearing; overlapping risk pools; retrospective risk sharing; variations in the benefit package; and purchasing arrangement and risk sharing.

The institutional frame work

The most important for risk pooling is the establishment of appropriate and reliable system of governance, to ensure the mobilization and stewardship of finances and also to ensure appropriate reimbursement to `providers. These are fundamental basic requirements. This implies the existence of a long-term trust in the health care institutions, adequate flow of information and reliable enforcement of contracts. Without these, risk pooling and collective purchasing of health care would not be feasible.

Membership criteria for risk pools

It can be voluntary or mandatory. If it were mandatory, citizens would have no choice. These are established membership status; under mandatory insurance is less straight forward, if membership is based on factors such as: income, wealth, health status or employment status. On the other hand, if insurance is voluntary, "safety Net" arrangements must be made for catastrophic health care costs, borne by the uninsured. This is usually defined by geographic residence or employment sector. In such systems individuals with adequate resources might go out to take private insurance.

Size of risk pools

There are usually trade offs between large risk pools that are ideal for risk sharing and small risk pools that are easier to manage and responsive to local preference; the size of

risk pool is therefore a crucial consideration in designing a risk pool, since it forms a basic principle underlying the theory and concept of health insurance.

Rudimentary universal indicators of the success of risk pooling integration arrangement include:

- *Insurance coverage:* The proportion of the population covered by health insurance arrangements;
- *Insurance premiums:* The extent to which credential individuals in different risk pools pay different premiums;
- *Variation in the package of care:* The extent of differences in the benefit package from one risk pool to the other;
- *Variation in quality:* The extent of quantitative differences in health care received by members of different risk pools (in waiting times);
- *Variation in user charges:* The extent of variation in out of pocket charges to individuals in different risk pools; and
- *The desirability of risk pool integration... the debate surrounds how it can be practically implemented in Low-and-middle income countries, particularly when a radiance on community financing and user charges leads to fragmented risk pools* (Smith & Witter, 2005).

Several characteristics particular to low- and- middle income countries must also be considered in the reform or design of a health insurance system. These characteristics will be outlined in the areas of financing, risk pooling, purchasing, and social solidarity (Anderson and Hussey 2008) in a World Bank paper.

Perspective of risk sharing

This is based on the issue of risk integration with its mechanism of risk adjustment process, which enables a standard premium contribution for a standard package of care with standard efficiency. The risk adjustment at the local level intended to redistribute central pools to deliver standard package of care to each geographical area.

Variation in Benefit package

A satisfactory package definition is found under unitary and integrated risk- pooling arrangements. This implies that, variation in benefit package compromises the equity objectives. Moreover, specification of benefit package is essential to ensuring the choosing of a health system within the means of the country.

2.5 KEY FACTORS AND PREREQUISITS FOR THE SUCCESSFUL IMPLIMENTATION OF A HEALTH INSURANC SCHEME

Allison Beatti & Co (2000) in a seminar paper series concluded from their studies that, for a successful implementation of a prepayment scheme (Health insurance Scheme) the following should be taken into consideration during implementation; that there should be: an appropriate institutional Context level and management structure, which should support a level of community participation in the design, implementation and evaluation, which will depend on: the level of the premium in relation to peoples incomes; the imposition of user fees at health centers and referral facilities; the time of payment; the mode of payment the unit of payment (household or individual); the general economic environment; the distance from people's home to Health facilities and associated transportation costs; the quality of services with respect to, supply of drugs, staffing level and qualification, and nature of infrastructure; and the population's awareness and acceptance of the schemes benefits.

They continued to point to the following features as essential for the successful implementation and sustainability of a health insurance scheme;

a. Integration of the scheme in the health care system, where participation in the scheme as a subscriber assures free services not only at the first point of contact in the health care delivery system, but at other levels based on referral.
b. Sound financial management based on a decentralized system; the existence of adequate managerial skills, the investment of unused revenue or premium income to preserve the funds value in the face of inflation, and a level of control to reduce fraud and other risks.

c. The social environment which describes the extent of social solidarity among households and communities where the norm or tradition of the community is that of one being the others keeper. This ensures, and promotes the principle of risk-sharing which is necessary for the success of any scheme.
d. The economic environment should be stimulating such that, there should be stability in the macro economic variables such as interest rates, inflation etc.

In a World Bank sponsored work entitled "Health financing Revisited"... the following were cited as conditions for implementing social health insurance in developing countries: level of income, size of the informal sector, distribution of the population; labour cost; administrative capacity, quality health care infrastructure, consensus, and political stability.

2.5.1 Level of income;

They noted that, a variety of nations started implementing social health insurance when their GNP was in a lower-middle-income range, and had strong economic growth during the transitional period leading to universal converge (Carring and James 2004); they suggested that, in countries where growth is slow or non existent it would be better not to implement social health insurance because, social health insurance would not be able to mobilize additional resources. Korea is said to be a good example of rapid implementation of health insurance due to a booming economy with an average annual growth of 13.3 percent which made universal coverage possible within Twenty-six (26) years. After its creation in 1965 (Barhighause and Suaevborn 2003) while Bolivia who had her social health insurance founded in the 1930s covered less than 10 percent of its population due to slow economic growth rate.

2.5.2 The Size of the informal sector

Where the informal sector is large, the payroll base for contribution is very narrow providing limited ability to raise significant resources for health care. In contrast, countries where the formal sector is dominant are able to register workers much more easily. It is noted that, the informal sector is still growing in developing countries (ILO 2005) and it is always difficult to assess and levy taxes on the income of self employed workers and even

more difficult to do so with respect to people with the Agricultural sector, since their incomes are irregular and falls from year to year (Normand and Weber 1994).

2.5.3 Distribution of the population

Case studies show that, countries with preponderant rural population have seen much slower implementation of social insurance. while it is noted that, experiences of successes are associated with growing urbanization and increased population density, since characteristics of urbanization such as larger formal sector and organized informal sector employment make it easy for the registration of social health insurance members and the collection of contribution (Ensor 1999; Carring and James 2004).

2.5.4 The Margin to increase labour costs

Another necessary condition for the successful implementation of social health insurance as noted. It is observed that, increased wages due to payroll contributions affect the competitiveness of a given economy. Labour cost in some cases may represent an excessive burden and negatively affect growth and employment. They may also affect the labour market through an increase in tax evasion, and reducing the size of the formal sector. More so, in many countries, salaries are already a major source of taxation (income tax, unemployment insurance contributions, etc) and this burden limits the potential to impose significant new payroll taxes (Normand and Weber 1994).

2.5.5 Administration Capacity

It is another factor required to successfully run a social health insurance scheme. Skilled administrative staff is needed to run health insurance funds and to regulate and supervise their activity. In any case, it is critical to determine whether the capacity to run these systems exist before establishing them or to build up the capacity along side implementation to ensure efficiency. For example, Kenya has the oldest insurance scheme in Africa established in 1966 and is supposed to pay for hospital stays, treatment and drugs for the whole population, but the reality is completely different, a mere seven percent (7 percent) of the population is insured. The main reason for the failure is the fact that, it is

generally believed that the scheme is one of the most corrupt institutions in the country and more than half of its budget is spent on administrative costs due to poor management and supervision on the implementation.

2.5.6 The availability of good-quality health care infrastructure

The availability of good-quality health care infrastructure is also cited as critical to the success of social health insurance systems. The best designed social health insurance system remains an empty shell, if a country does not have the infrastructure to provide the health services included in the benefit package. In countries where there are inadequate facilities available to the subscribers, those who can afford it, prefer to pay out- of- pocket or to buy private insurance to gain access to quality services, a phenomenon which can endanger the whole system. The existence of good-quality infrastructure will encourage the population to join the system and support it (Savedoff 2005).

Another factor noted is the political stability and political rights which are said to play a fundamental role in the successful implementation of social insurance. Higher levels of political rights are needed as are incentive for the improvement of the living conditions of the population through health care reforms. Thus, the people should be involved in the planning and implementation stages of the scheme to ensure some level of success.

2.5.8 The ability to contain cost

Another important factor for a successful and sustainable implementation of an insurance scheme, Health Insurance is often associated with high cost, it is therefore fundamental for the institutions running the system to contain costs, especially by controlling *adverse selection* ,where only sick people are registered ,and *moral hazards* which are induced behaviour on the part of patients and providers. The tools that can be used to achieve this goal include: performance related provider payments, expenditure cuts, risk adjusted capitation arrangements, and well- designed contractual agreements between providers and Health insurance funds, and good monitoring of the system among others.

According Dunlop & co (2000), in a World Bank sponsored paper concluded from various case studies that, the key features necessary in a Health insurance design to achieve the objectives of making a health delivery system functional and accountable to the community; human resource management, community involvement, decentralization, rigorous monitory and evaluation against standards. They noted that, the pre-requisites for health insurance include:

a. The existence of a body that will be able to organize the health insurance programme this can be a specific department or ministry. It should also have the basic capacity, managerial skills, administrative skills, technical skills (understand the complexities of health insurance), and social skills to understand what the communities need.
b. There must be a well structured net work of competent health care providers, either public or private to ensure that supply of health care services can be easily negotiated. In other words, scanty provider net woks will make it difficult to provide access.
c. The people must be able to pay the premium especially in a contributory program, where the people are expected to pool their financial resources, no matter how well the programme is designed, if the people cannot afford it, there will be no takers.
d. There must be availability of data with respect to the demographic profile of the communities, their morbidity rates, their facility utilization rates, and the cost per unit utilized among others. It should also be able to collect primary data.
e. The population strategy should also be adopted as in the developed countries, where they move from "formal" to "informal" sectors. Developing countries could consider other categorization to include:
    - formal sector employers with their families;
    - People in the informal sector: - organized farmers, unorganized, the indigents; and
    - Geographical strategy (village, district wide, zonal etc).

According to a World Health Organization review report (1997) which focused on improving access to health care through health insurance in 1997, experience with

innovative risk sharing schemes shows that, there are some lessons to be learnt by governments, on the implementation of health insurance schemes. These centre on ensuring better linkages with the rest of the health system and with the overall health objectives; improving accessibility, quality and efficiency of health care services.

The report noted that, government's role is to provide an enabling environment for a well-designed insurance scheme for people outside formal employment through legal regulations and providing for a useful partnership between stakeholders. A clear policy framework is also needed to publicize and guide the future development of insurance initiatives; the policy frame would establish the roles and responsibility of major stakeholders such as; the communities' insurance organizations, government and health care providers. It emphasized that, "*five key issues in the design of a successful insurance scheme*", include;

a. It requires a broad risk pool with both healthy and unhealthy members with low income and higher income groups.
b. The waiting or qualifying period should be more than a month is required to allow the scheme to adjust financially. This is particularly important for schemes offering insurance cover for more expensive hospital inpatient services.
c. It is important that schemes should reinforce and not undermine the referral systems. Since hospital based schemes would encourage subscribers to by pass clinics and health centers, unless a referral requirement is built into the design. It is noted that, schemes which do not practice the "gate keeping" and referral system become unsustainable, as people are not given any motivation to use the most cost effective services first.
d. The need to ensure that "preventive and promotive services are included in the service provider's activities to help improve sustainability by containing overall costs.
e. The scheme management needs to have an investment strategy for the money under their control in order to keep ahead of inflation.

f. The World Health Organization emphasizes that, "establishing sustainable risk-sharing mechanisms for the benefit of people out side formal sector employment is an enormous challenge. There are no "blue print" solutions suitable for all situations (World Health Organization annual report, 1997).

2.6 HEALTH SHOCKS, HOUSEHOLD WELFARE, AND RISK OF POVERTY

In a World Bank sponsored paper (Baez Christian and Frogmen Packard, 2005) *entitled beyond survival protecting homed hold from Health Stocks in Latin America* stated that, Health care costs are rising all over the world, and noted that, adverse health events such as sickness, accidents, or normal lifestyle events such as old age, sap the health of individuals, and can impoverish the household. It is also indicated that, besides treatment costs, households' bear the cost of productive time lost from work, as well as opportunity costs due to days spent taking care of ill family members. Thus, the combined costs and loss of income for a serious illness can compel individuals and households to reduce non medical consumptions drastically, which for the poor lead to the perpetuation of poverty.

They concluded under this heading by stating that, Governments and households have alternative options for protection against health shocks; By prevention, saving, and risk pooling and that, risk pooling is a common public policy intervention, which is most given the distribution and composition of households spending in health care in developing countries, an alignment of an array of instruments would allow risk pooling coverage to be extended to lower- income and poor households.

The internal functioning characteristic of a risk pooling arrangement determines the effectiveness of a scheme as a risk protection tool. This, suggests that, no matter what specific type of risk-pooling arrangement chosen, success in improving the health status and financial protection of the population depends highly on the way principal health financing functions are implemented. They identify the following as the principal health financing functions (Baez C and others. 2006) these include;

a. Achieving the highest possible contribution for insurable health events before services is needed.

b. Achieving the largest possible risk pool within a population which is sufficiently large for financial viability and economy of scale. To allow for the transfer of subsides from low risk to higher risk individuals (risk subsidy).

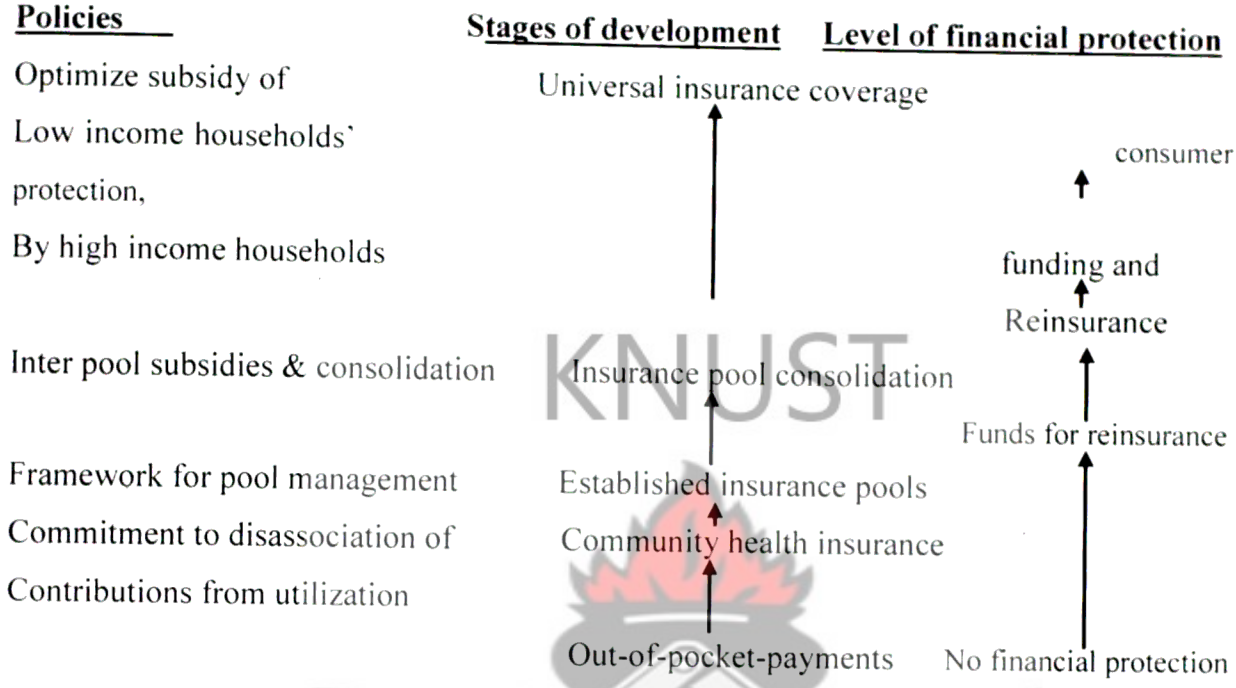
c. Achieving adequate equity to ensure reliable flow of subsidy from higher income groups to lower income groups (equity subsidization).

d. Developing purchasing capacity and a provider payment system that creates incentives for providers to deliver quality health services in a timely manner while keeping cost down (strategic purchasing). This also depends on the competence of management.

e. Characteristics and composition of the benefit package, the extent of strategic purchasing, by the risk pooling organization, the size of the pools, the availability of the size of equity subsidies and the regulatory framework play an important role in the success of any risk-pooling scheme.

   - Under the social insurance system, where every member of society as at least in theory, has access to the same package of services independent of their contribution, fiscal sustainability is the challenge, which explains why many countries have no option, but to have mixed systems.
   - Efficiency and targeting are the challenges when the poor and old aged is included in a risk pooling scheme.

2.7 STAGES OF FINANCIAL PROTECTION / SUPPORTING POLICIES IN THE IMPLEMENTATION OF A HEALTH INSURANCE SCHEME



Source; Adopted from; Preker & Carrin, (2001).

This shows that, health insurance schemes must move from community based to universal coverage in order to provide adequate financial protection for its subscribers.

2.8 CHALLENGES OF HEALTH INSURANCE SCHEMES

Like high income countries, developing countries are experiencing aging demographics and an increasing burden of non-communicable diseases (WHO 2003) more so, the demand for expensive technologies and pharmaceuticals is projected to rise with income levels. In the wake of all these pressures, developing countries are expected to spend more on health than their current commitment.

Another challenge in health care financing is the **inequitable and ineffective systems**, low-income groups in developing countries pay more towards health care as a percentage of household resources than those of a higher income groups. They are therefore more at risk of falling into poverty as a result of prolonged health events, because they have fewer

household resources and less safety net protection through private health insurance. (Baeza and Packard, 2006).

Hence the *lack of universal coverage and financial protection are symptoms* of ineffective financing instruments and the misalignment of policy incentives in these countries. To move beyond the status of community based prepayment for universal coverage, developing countries need to better mobilize resources and use them efficiently.

An insufficient equity subsidy is another challenge. This is attributable to inefficient management of collected funds in the context of poverty, institutional and organizational instability, all of which inhibit adequate generation and pooling of funds for an equity subsiding. In addition to this are the problems of inequitable allocation of fiscal and physical resources which are a result of public policies. (Kutzin, J, 2001)

2.8.1 Challenges of Health Insurance Market

According Eyitayo Lambo, in a World Health Organization paper on sustainable health care financing noted that, challenges to over come in the implementation of prepayment schemes in Africa includes the following:

- Inadequate membership for risk pooling;
- In ability of a majority to subscribe because of poverty;
- Ineffective management of the scheme;
- adverse selection;
- Moral Hazard; and
- Insurance fraud.

1 Inadequate membership for risk pooling

An adequate fund size is required to enable risk pooling from a low risk population to a high risk population. This is only made possible where there is an adequate membership to enable enough pooling of funds that can sustain the schemes operations and providing the schemes prescribed benefits (Tabor, 2005).

Inability of many people to subscribe to the scheme because of poverty

A majority of people within the continent (Africa) are poor especially those in the rural areas who engage in subsistence farming, which provides not only inadequate income to survive a livelihood, but which is also irregular as prices of their farm products face the threat of marketing obstacles.

Given such a situation, no matter how well the premium level is determined, a majority of people would not be able to afford money to pay. Policy designers should be able to provide an effective exemption mechanism to ensure that the abjectly poor are not denied health hare services (Normand and Weber 1994).

Management of the Scheme

The management of prepayment schemes requires a maximum level of management capacity and skills, which are in short supply in developing countries. According (Lambo) this is the reason why schemes organized on a district-level basis would do better than the ones under village levels. Scheme managers are charged with financial controls, keeping records of all members, receiving contributions and spending.

The ability for management to perform these tasks adequately and provide a transparent and accountable management to the people is identified to be a land mark of good management (Crease and Bennett, 1997). It is noted that, financial mismanagement is one of the obstacles to schemes sustainability (ILO, 2002).

Adverse selection

A scheme experiences adverse selection when people with a high risk of sustaining a severe illness or injury and the chronically ill, dominate the scheme.When this happens, they tend to demand more services including more costly clinical services, which leads to the rapid depletion of the schemes revenue base. The occurrence of adverse selection is a function of the nature of the subscription unit (individual or household) and the proportion of illegible people who join the scheme. The subscription unit can be controlled, but the issue of the proportion of eligible subscribers cannot be controlled. The scheme requires a

minimum subscription rate before it comes into operation. Investigations have however shown that, individual subscription basis has maximum adverse selection than household subscription (WHO 2000).

Moral Hazard

The risk behaviours of moral hazard occur when members of an insurance scheme use services more frequently than they would have, if they were not members. The occurrence of moral hazards are influenced by the time of premium payment, the level of premium relative to the cost of services at various levels of the health system, the enforcement of referral risks, and the incentive provided for non use of benefits provided to the subscriber - provider payment mechanisms such as fee-for-service reimbursement, and the lack of incentive to providers could give rise to a supply side moral hazard where providers could give unnecessary and expensive treatment to subscribers. The combined effect of both the demand side and supply side moral Hazards leads to a rapid increase in the cost of services, and that could jeopardize the viability and sustainability of the scheme.

Fraud and abuse

This describes the situation where the insurance system is subjected to a free rider behaviour which allows individuals to enjoy the benefits of the scheme without bearing the cost, and also misrepresentation of facts about health care services for a benefit. Methods used on the supply side include; over billing, billing for unnecessary health care services or for services not provided; falsifying medical records; and paying kick backs. Physician ownership of clinics and diagnostic facilities also proved a major complication in the fight against health care fraud. On the demand side, fraud results from impersonation and misrepresentation where a subscriber could report sick to collect drugs for non members of the scheme. All these turn to increase the cost of the scheme and siphon a larger proportion of the schemes funds, there by jeopardizing the sustainability of the scheme (WHO 2000)

2.9 RISK MANAGEMENT

The sustainability of any risk pooling scheme would depend to a large extent on the ability of the scheme to manage its risk to the barest minimum. Risk is defined by the World Health Organization as the probability of an adverse outcome, or a factor that raises this probability (W H O 2002). It is any element, activity, or occurrences that threaten the sustainability of an organization. Principal risks among mutual health organizations include; adverse selection, moral hazards, underestimation / overestimation, and fraud and abuse. Minimizing adverse selection, moral hazard, fraud and cost escalation are very important for the success of any health insurance programme. Some of the measures to achieve this are given below.

Table 2.1 Strategies for Risk Management

Risk	Measures to manage risk
Adverse selection	· Have a large unit of enrolment, e.g. a family, a village, a self-help group · Have a definite collection period · Have a definite waiting period · Have a compulsory enrolment as opposed to a voluntary enrolment · Exclude pre-existing diseases
Supply side moral hazard	· Have a flat/case-based payment mechanism as opposed to a fee for service mechanism · Preferably pay the providers a fixed salary – this will minimize incentives for interventions · Insist on standard treatment guidelines · Insist on medical / chart audits
Demand side moral hazard	· Have a referral system or a pre-authorization system · Introduce co-payments
Fraud	· Introduce photo identity cards for the insured · Use social audits to identify fraudulent admissions · Take strict action against fraudulent events · Keep proper registers and records
Cost escalation	· Try different provider payment mechanisms · Insist on standard treatment guidelines · Insist on generic medicines

Source: Arrow, K.J. 1996

These measures as stand alone methods as well as in combination are powerful tools to enhance the chances of success.

2.10 REVIEW SUMMARY AND CONCEPTUAL FRAMEWORK

2.10.1 Review Summary

From the above review of studies on health care financing it is made evident that, policy interventions in health care financing started with the National Health Service, user fees with public-private collaboration and now the emergence of prepayment / health insurance schemes. The reviews have also revealed that health insurance policy implementation is a recent development in developing countries, hence the need to monitor how they are being implemented and the challenges they encounter in order to ensure their sustainability.

Further more, it is also well articulated by most of the authors from their studies that, the main rationale for the adoption of health insurance is for the fact that;

- Health insurance provides an opportunity for risk pooling as well as risk subsidization, and risk protection for the larger proportion of a community, especially the poor;
- It also helps to mobilize extra funds for the provision of quality and efficient services;
- It ensures managerial efficiency by separating the function of financing from that of the function of provision in health care services; and
- It provides for equity, accessibility, and affordability in the provision of health care services.

Reviewing the concept of risk pooling in health care financing brought to the fore that risk pooling is for the purpose of financial risk sharing and protection to forestall uncertain, but larger health shocks. Literature also noted that, the implementation of any risk pooling arrangement should be primarily influenced by a nation's choice given the circumstances and policy priorities. Three risk pooling approaches identified include; fragmented risk pools, integrated risk pools, and unitary risk pools .The following are also enumerated as

features that should be put in place in the implementation of a risk pooling mechanism, institutional framework as well as technical, managerial, organizational, and a regulatory framework.

The following are considered as conditions, prerequisites key factors that support the successful implementation of any health insurance scheme as stated by the various authors work were reviewed:

- The existence of consensus and solidarity in favour of social health insurance, thus, the acceptance of health insurance as well as a higher level of participation of the people;
- The economic environment that has stable macro economic variables, a higher level of income that is propelled by a strong economic growth rate;
- The size of the informal sector as compared to the formal one and how well it is organized .and the level of literacy of the informal sector;
- The administrative capacity available; thus, the managerial capacity and skills needed to keep the scheme functioning efficiently and effectively;
- The existence of a good quality health care infrastructure and quality services that is well integrated to ensure a cost effective and efficient provision of health care services that would win the confidence of the people;
- A clear and precise regulatory framework with prudent supporting policies and implementation strategies; and
- A well-established and integrated, preventive health care services, in order to promote sustainability.

The commonly identified challenges of health insurance schemes that threaten their sustainability, include the following; fraud and abuse, adverse selection, moral hazards, mismanagement ,inflation, and inadequate membership.

2.10.2 Conceptual framework

From the review, it can be deduced that every Health Insurance Scheme as it were, Mutual Health Insurance schemes in Ghana should consist of four basic operational

characteristics; Technical, institutional, managerial, and organizational. It should also have clear and precise policies with a comprehensive regulatory framework that should support the operational characteristics, through well defined implementation strategies. This general operational frame determines the strength and weaknesses, as well as the challenges of the insurance system, which would also determines the level of growth, defined by the stages of development and the level of risk pooling and financial protection as principal policy objectives. This conclusion constitutes the conceptual frame work of the study

CHAPTER THREE

3.0 METHODOLOGY

3.1 THE STUDY DESIGN

This study applied both qualitative and quantitative research techniques. Hence, the study employed principles of qualitative data collection and analysis that explored social relations and sort to describe the reality as experienced by the respondents. (Sarandakos, 1996) and helped to establish relationships between variables. It also used quantitative measurements as well as employing statistical analysis to make vivid presentation of information.

3.2 SAMPLING TECHNIQUE

Sampling is a procedure of selecting the research units from the target population. Multi-stage sampling was used. The study areas were first divided into identified communities, where the sample of communities was selected purposefully from these clusters. Thus, communities with health facilities were considered, from which sampled households were drawn from each identified community through a sample frame-(pqz^2/E^2)(S. Sarantakos1996) from which a Hundred (100) households was proportionately drawn from each of the Two study areas (Pru and Bawku- West) thus, a total of two Hundred (200) households were selected as respondents. This was done to ensure that a sizable and manageable, but representative sample was obtained. More so, purposeful sampling was also used to enable sourcing information from key informants like the scheme management and health care providers.

Table 3.1Sample frame **PRU DISTRICT**

Community (cluster)	Total Number of households
Yeji	3343
Sawaba	453
Abease	141
Prang	1092
TOTAL	**5029**

Size=pqZ2/E2 where;

P=population estimate

q=proportion from hundred

Z=value corresponding to confidence level

E=maximum deviation from True proportions

P=1.98, q=98,Z=1.96andE=2.7

Source: (population census, 2000)

Table 3.2.Sample Frame- BAWKU- WEST

Community (cluster)	Total Number of households
Zebilla	1354
Kusanaba	131
Gbantongo	42
Binaba	323
Sapelliga	131
Tilli-Natinga	163
Zongoyire	74
TOTAL	**2218**

P=4.5, q=95.5, Z=1.96, and E=4.25

The differences in *p* and *q* values for the two districts are as a result of differences in the total household sizes considered.

Source: (Population census, 2000)

3.3 METHOD OF DATA COLLECTION

Both primary and secondary sources of data were explored for information. The survey method of data collection was used, with the questionnaire as the principal instrument designed to collect relevant information from 200 respondents with respect to the characteristic features of the schemes and their implementation strategies and obstacles.

The primary data was collected through interviews from both closed-ended and open-ended questions, and discussions with four key informants from each district, such as the scheme managers, as well as management of provider facilities from a special questionnaire that was designed for them. Household heads were the sample unit that was also interviewed to ascertain information on basic features of the schemes, the strategies adopted in the implementation of the schemes and their general perception about the schemes. Literate household heads were allowed to respond to the questionnaires personally, while non literates were guided. However, managers of the schemes and management of service providers were interviewed personally to ascertain some detailed information and their perception about the scheme.

The houses were chosen randomly using the enumeration maps provided by the Statistical Service Department for the 2000 population census. The assemblymen for the various communities helped to locate the houses sampled. Secondary data was also gathered from documentary sources such as annual and quarterly reports of the schemes, government publications, seminar papers and magazines. Key Variables Examined in the study are illustrated in table 3.3

Table 3.3 Variables and Indictors

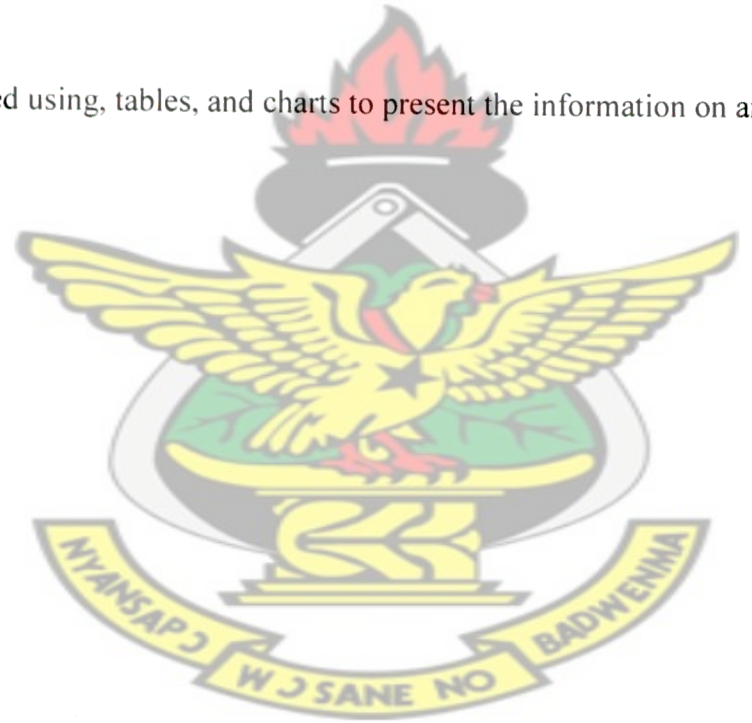
Variables	Indicators	Techniques
Technical design	• Revenue collection mechanism. • Arrangement for pooling revenue and risk sharing. • Purchasing and resource allocation.	Interviews And records of the schemes
Management	• Staffing situation. • Access to information. • Level of community participation.	Interviews and records of the schemes
Organization	• organizational reforms • incentive regime	Records & interviews
Institutional	• Governance of the scheme • Insurance market operations. • Stewardship.	Records & interviews

Source; Preker and others 2002

Data was collected on design characteristics such as:

- The technical design, where the revenue collection mechanisms, risk pooling and sharing arrangements, as well as purchasing and resource allocation. To help find out how revenue is mobilized for risk pooling and risk sharing.
- Under management characteristics –quality of staff, culture of community involvement, and access to information were examined. To identify sustainability indicators for improvement.
- With organizational characteristics-organizational forms, incentive regimes, and linkages between schemes, public and private providers.
- On institutional characteristics, -stewardship, and governance of the scheme were looked at.

The data was analyzed using, tables, and charts to present the information on analysis.



CHAPTER FOUR

4.0 ANALYSIS AND DISCUSSIONS

The vision of the national health insurance policy as it were, in the National Health Insurance Act, (Act 650) as part of the Poverty Reduction Strategy is to ensure equitable universal access for all residents of Ghana to a package of essential health services of an acceptable quality without out-of-pocket payment being required at the point of use. It is committed to universal coverage with gradual extension to cover sixty percent (60percent) of the population within ten years of its implementation as a pro-poor policy.

This chapter analyzes information collected from a sampled population in two districts; Pru and Bawku-West, in Brong Ahafo and Upper-East Regions respectively. The analysis focuses on the personal characteristics of the respondents, as well as the Technical, Managerial, Organizational, and Institutional features, as well as perceptions of people about the operations of the schemes.

4.1 CHARACTERISTICS OF RESPONDENTS

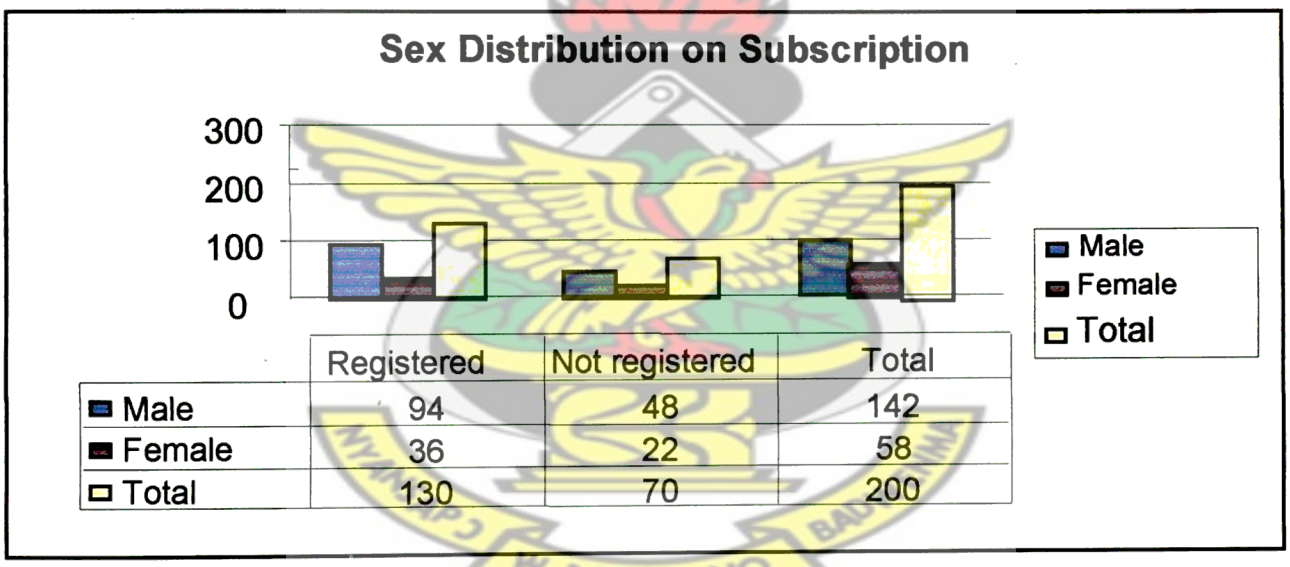
Disaggregating the information of household heads interviewed according to age groupings beginning with the minimum age of twenty (20) and the maximum of above seventy (70), the information in the table 4.1.1 shows that, the age group between 20 and 39 constitutes the majority of household heads, more so, they are also the modal class in the informal sector that have subscribed to the scheme. This group constitutes the active working force whose potentials could be harnessed to ensure the sustainability of the various schemes as income earners.

Table 4.1.Age, Sex, Membership, and Employment Sector Distribution of Respondents

Age	Male	Female	Registered	Not registered	Formal	Informal
20-29	37	13	31	19	20	30
30-39	37	19	33	23	20	36
40-49	24	14	27	11	14	24
50-59	22	7	14	15	9	20
60-69	12	3	13	2	3	12
70and above	10	2	12	0	0	12
Total	**142**	**58**	**130**	**70**	**66**	**134**

Source; Author's field survey, May 2008

Figure 4.1: Sex Distributions of Subscribers from Sample



Source; Author's field survey, May 2008

Figure 4.1 above shows the registration status of respondents according to sex, the information indicates that, out of those who subscribed to the scheme, the female population represented the least constituting (27.7 percent) with the male population being 72.3 percent. This however reflects the ratio of female household heads and not their participation by subscription.

Table4.2 Personal Characteristics of Respondents

DMHIS	MALE	FEMALE	REG.	NOT REG	FORMAL	INFORMAL	CHRIST.	ISLAM	TRAD.
PRU	66	34	67	33	36	64	48	38	14
BAWKU-WEST	76	24	63	37	24	76	58	20	22
TOTAL	142	58	130	70	60	140	106	58	36
PERCENTAGE	71	29	65	35	31.5	68.5	53	29	18

Source; Author's field survey, May 2008

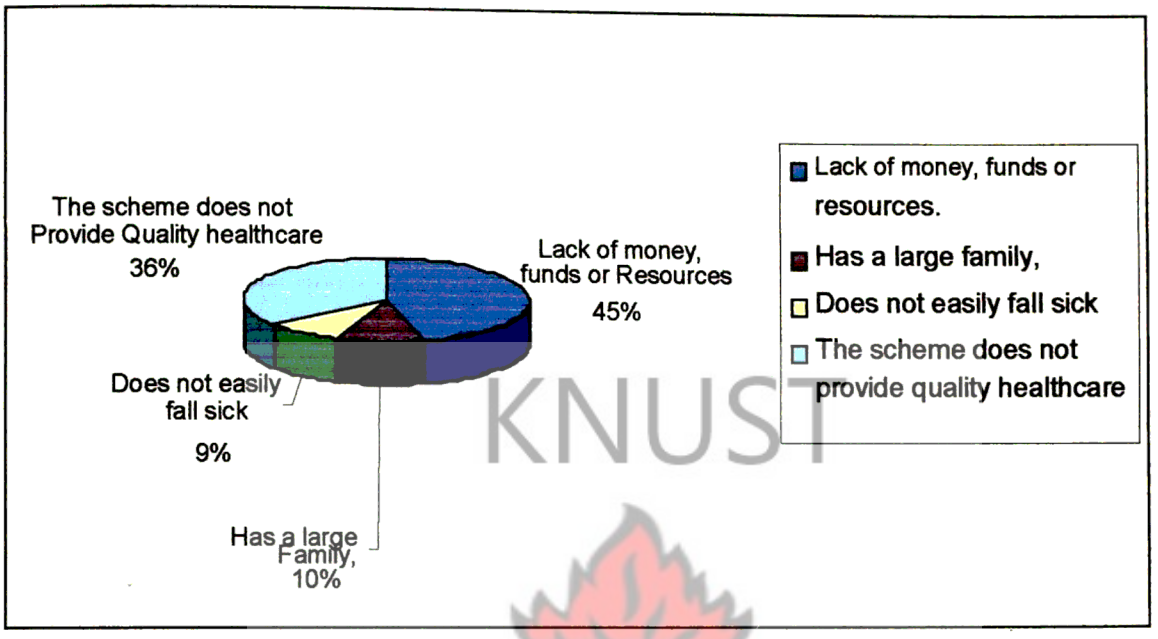
The statistical information in table 4.2 represent responses for a total of two hundred (200) respondents in Pru and Bawku-West Districts of Brong Ahafo and Upper –East Regions respectively, to a questionnaire on the Mutual Health Insurance Scheme that is being implemented. The disaggregated information as shown indicates the distribution of respondents across various sectors of the study population. Out of the total sampled population, 71 percent are male and 29 percent female, 65 percent have registered with the scheme and 35 percent had not. Formal sector workers constitute 31.5 percent and 68.5 percent being informal sector workers. Religious affiliation had the following distribution; Christianity-53 percent, Islam- 29 percent, and Traditional worshippers-18 percent the information gathered therefore reflects the views and opinion of all sectors of the society. The following reasons were given by respondents for their inability to register or enrol onto the scheme, the lack of money or funds, large family commitments which allow household heads to register only a few members of the family, who easily fall sick. Others did not register because they felt they do not easily get sick, while some refused to register for the reason that, the scheme provides poor quality health care services. These responses are analyzed on table 4.3

Table 4.3 Reasons why People did not register

Reasons	Frequency	Percentage
Lack of money, funds or resources.	32	45.7
Has a large family,	7	10
Does not easily fall sick	6	8.6
The scheme does not provide quality healthcare	25	35.7
Total	70	100

Source; Author's field survey, May 2008

Figure 4.2: Reasons why people did not register (Frequency)



These responses as indicated on table 4.2 imply that, about 64.3 percent of household heads who did not register, rather registered either only sick members of their families or those who easily get sick. This suggests the existence of the behaviour of adverse selection. This is major challenge facing Insurance Schemes, as cited by most authors in the literature.

4.2 GENERAL INFORMATION / OPERATIONAL STATUS OF THE SCHEME

The Mutual Health Insurance Schemes operate under regulatory Act, Act 650 Act 2003 as Limited Liability Companies. Each scheme operates within a district as its strategic geographical coverage area. Even though the schemes were statutorily established in 2003, the Pru and Bawku-West Mutual Health Insurance Schemes started full operations . The basic operational features of the schemes are indicated on table 4.2.

Table 4.4 Basic Features of Pru and Bawku- West MHIS

	TYPE OF SCHEME	SCOPE	YEAR	UNIT REG.	MEMBERSHIP	PREMIUM	BENEFIT PACKAGE
Pru	Mutual health insurance	District wide	2005	Individuals & Households	46596 (47.4%) of the population.	Flat rate GH¢ 10 2.5% SSNIT	Out patients& in patients
	Mixed system	Formal & informal Sectors					Services covers 90% of diseases
Bawku-West	Mutual health insurance	√	√	√	52706 (46.3%) of population	GH 8.5	√

Source; Author's field survey, May 2008

Both the Pru and Bawku-West schemes are operating as Mutual Health Insurance schemes. They operate within a framework of a mixed system that fuses formal sector workers with the informal sector of the society. Full registration and operation started in 2005; the household is the unit of registration, where the registration of any one parent of the household gives all children under eighteen (18) years old in the household automatic coverage under the scheme. The household head only needs to pay a registration fee of one Ghana cedi and fifty pesewas (GH¢1.50) as in Pru and one Ghana cedi (GH¢1.00) as in Bawku West for each child. Registration is voluntary and not compulsory, this call for private opt out, so that those who do not want to subscribe to the Mutual Health Insurance Scheme can register with the private ones and more so, it is to engender a level of competition. However, there is no private health insurance scheme formally in operation in any of the districts studied.

Table 4.5 Total Registration Categories of Pru and Bawku-West MHISs

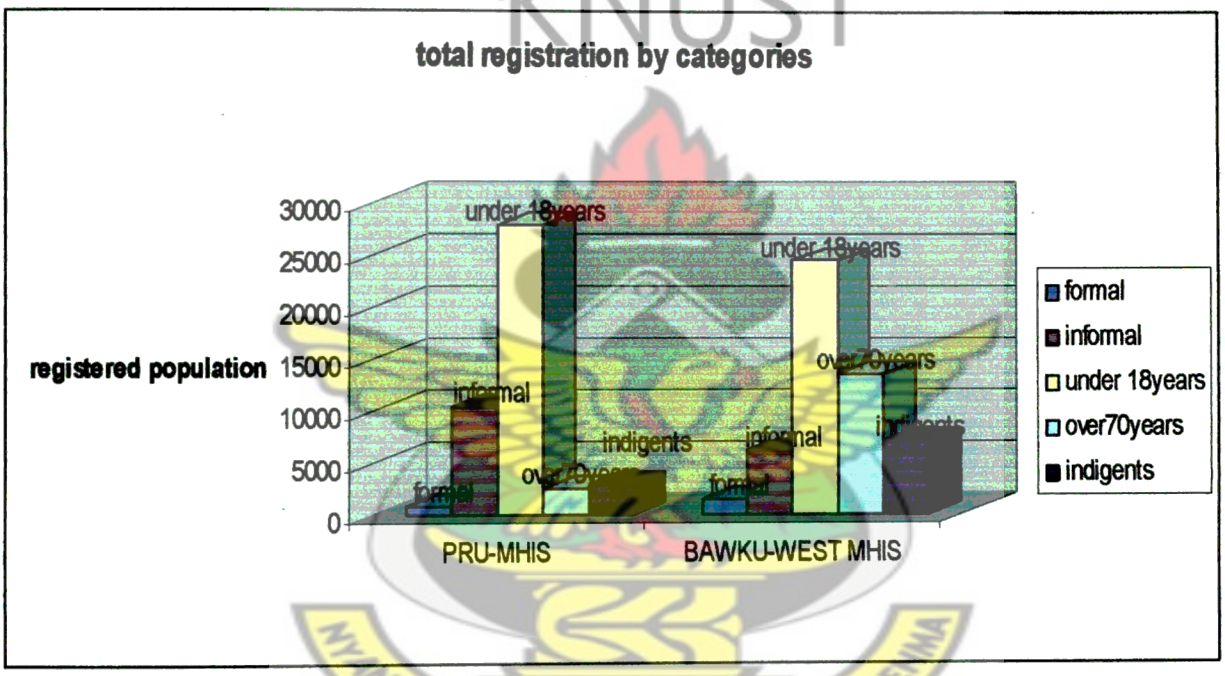
	Formal	Informal	Under 18years	Over 70years	Indigents	Male	Female	Total registration
PRU-MHIS	867	10,384	27,967	2,472	2,923	21,464	23,138	44,602
BAWKU-WEST MHIS	1,525	6,157	2,4468	13,559	6,997	23,065	29,641	52,706

Source: Schemes Quarterly Reports of Pru & Bawku-West MHIS, April 2008

Table 4.5 shows the membership of the schemes according to categories; those in the category of 'under eighteen (18) years' constitute the modal group registered by both

schemes. It is also indicated clearly that, people registered under exemptions categories (under 18 years, the core poor, and aged) constitute a greater proportion of the membership of the two schemes (Pru and Bawku-West) thus, 74.8 percent and 85.4 percent respectively. This situation implies that, the scheme has a pro-poor orientation. However, it also means low revenue mobilization levels from premium due to small numbers of contributors, and the burden on the National Health Insurance Fund. Figure 4.3 below gives a pictorial illustration of the membership by the various categories as tabulated in table 4.5.

Figure 4.3: Operational Statuses of Schemes



Source: Author's own construct, April 2008

The survey also reveals that, there is a ten percent (10 percent) drop out rate from the Pru mutual health insurance scheme. This is as a result of the failure of some registered members to renew their insurance. Out of 9,474 people who registered in 2005; 8,527 renewed in 2006 and out of a total membership of 22,563 in 2006; 20,306 people renewed. This shows that, yearly renewals consistently fall below registrations, which has serious implications for risk pooling and resource mobilization ability of the schemes.

4.2.1 Premium

The premium is a flat rate that ensures cross subsidization in terms of risk and income. It is based on annual payment in cash, to ensure a larger coverage to the schemes in terms of numbers, since higher subscription levels would bring about higher revenue mobilization to ensure the sustainability of the schemes. However, an analysis of the membership categories as illustrated on table 4.5, reveals that, the largest population of the membership of both the Pru and Bawku-West schemes constitute the non-premium paying categories (under 18 years, over 70 years, and the indigents) , which are also the high risk groups. This poses a challenge to the sustainability of the schemes.

Premiums are adjusted by the schemes with the advice of the National Health Insurance Authority. One hundred and thirty respondents (130) out of the sample population of two hundred (200) who registered all indicated payment by instalment as one method of premium payment.

4.2.2 Benefit package

Information collected from respondents and management of both the schemes and providers indicated that, the benefit package of the two schemes covers both out patients and inpatients treatments which constitute about 90 percent of diseases. However, 15 percent of respondents are not aware that the scheme offers inpatients treatments as part of the benefit package. This implies that, the level of education on the scheme is still low.

Out patients services includes, general and specialist consultations, requested investigations (laboratory investigations, x-rays and ultrasound scanning) and other services such as prescription of drugs on the schemes drugs list, surgical operations including hernia repairs, incision and drainage.

Inpatients (admissions) services include general and specialist care, requested investigations, (laboratory investigations, x-rays and ultrasound scanning), medication including prescription of drugs on the national heath insurance authority drug list, blood and blood products, cervical and breast cancer treatment, surgical operations,

physiotherapy, accommodation and feeding in ward. Oral health services are also provided, this includes, incision and drainage, tooth extraction, and dental restoration.

The excluded list of diseases for which treatment would not be given and hence, are excluded from the benefit package constitute the following; optical aids, hearing aids, orthopaedic surgery, dentures, supply of Aids drugs, treatment of renal failure, heart and brain surgery, others (National Health Insurance Authority, 2008)

4.2.3 The providers

The schemes have signed contractual agreements with some health service providers within and outside their catchments areas, both private and public providers, to provide accessible, affordable and quality health care services to their members. The Pru Mutual Health Insurance Scheme contracted five (5) public and two private providers, including the district hospital in Yeji. Out of the facilities within the District, one is a hospital, with three health centres' and two clinics. Each of the facilities is under staffed, and hence, this affects the quality of services provided. Presently, the doctor patient ratio stands at about 1:320., 7 87.3 people. Table 4.6 shows a summary of provider situation in Pru.

Table.4.6 Provider Staff situation Pru District

	Doctors	Medical assistance	Midwives	Nurses
Hospitals 1	3	1	3	7
Health centers 3	-	1	2	1
Clinics 3	-	-	3	2

Source; Author's field survey, May2008

In Bawku-West, there is only one Hospital located in the district capital Zebilla, with three other Health centres and two Clinics that are responsible for providing health care services to the registered and insured members of the scheme. The facilities are also inadequately staffed with a doctor-patient ratio of 1:12654.3 people.

Table 4.7Provider Staff Situation in Bawku-West District

	Doctors	Medical assistance	Midwives	Nurses
Hospitals 1	3	1	3	2
Health centres 3	-	2	2	5
Clinics 2	-	-	2	4

Source; Author's field survey, May 2008

Given the doctor patient ratio of 1:13683 and the nurse patient ratio of 1:1415, the following is the staff requirement of Pru and Bawku West districts.

Table 4.8 Staffing Requirement of Providers

	Doctor Requirement	Nurse Requirement	Backlog
Pru	7	68	48
Bawku West	8	79	58

This state of inadequate infrastructural facilities, coupled with inadequate staff, has brought a lot of pressure on the facilities creating congestions and on the staff resulting in longer time spent by patients at most of the facilities ,as a result of an increase in out patients attendance by card holders. The graph below shows rate of increase in out patient attendance in Pru district hospital as a result of the introduction of health insurance in 2005.

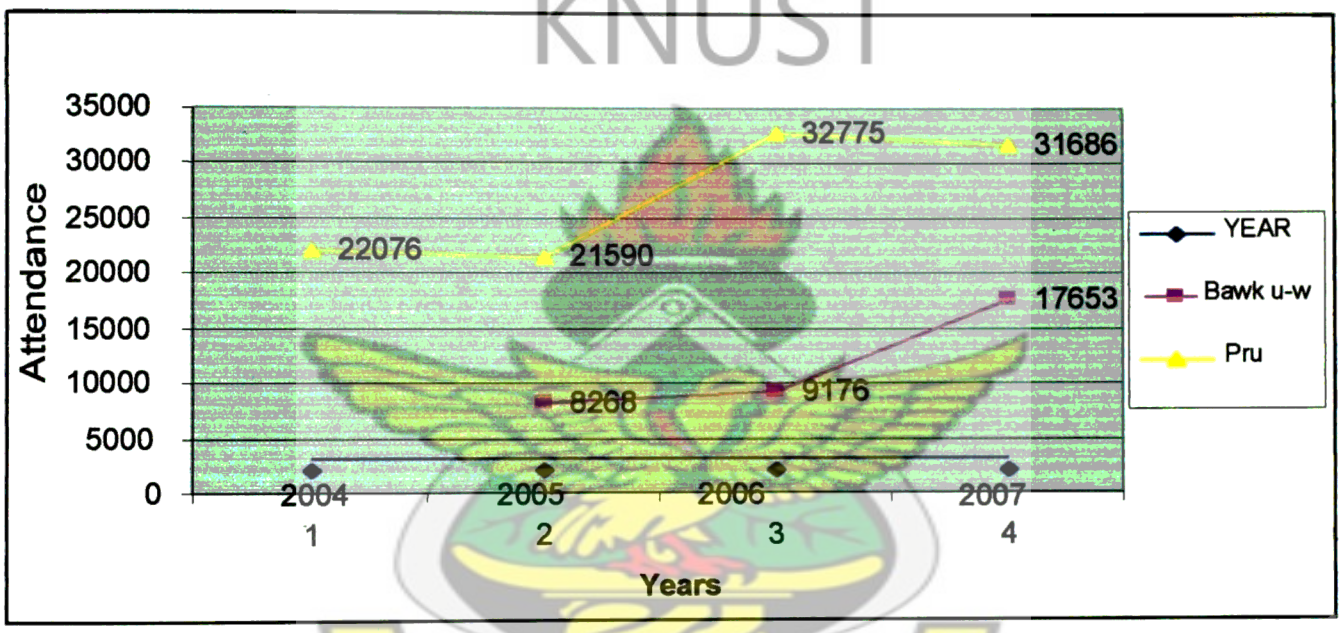
Table 4.9 OPD Attendance Trend in Bawku-west District I and St. Mathias Hospital of Pru 2004-2007

Year	2004	2005	2006	2007
Attendance Bawku-west	-	8268	9176	17653
Attendance Pru	22,076	21,590	32,775	31,686

Source; Author's field survey, May 2008

The trend in Outpatient's Department (OPD) attendance from 2004 shows a slight decline in 2005 for Pru, but a sharp increase to 10.9 percent and 34.12 percent in 2006 for Bawku-west and Pru respectively, with an astronomical increase to 92.4 percent for Bawku-west, but a slight declined again in 2007. This gives an average increase in OPD attendance to approximately 41 percent. This indicates a significant rise in hospital attendance after the introduction of health insurance in 2005.thus, implying an increase in access to health care. This is presented graphically below on figure 4.3

Figure 4.4: OPD Attendance Trend Bawku-west & Pru District Hospitals



Source; Author's own construct from field survey, May 2008

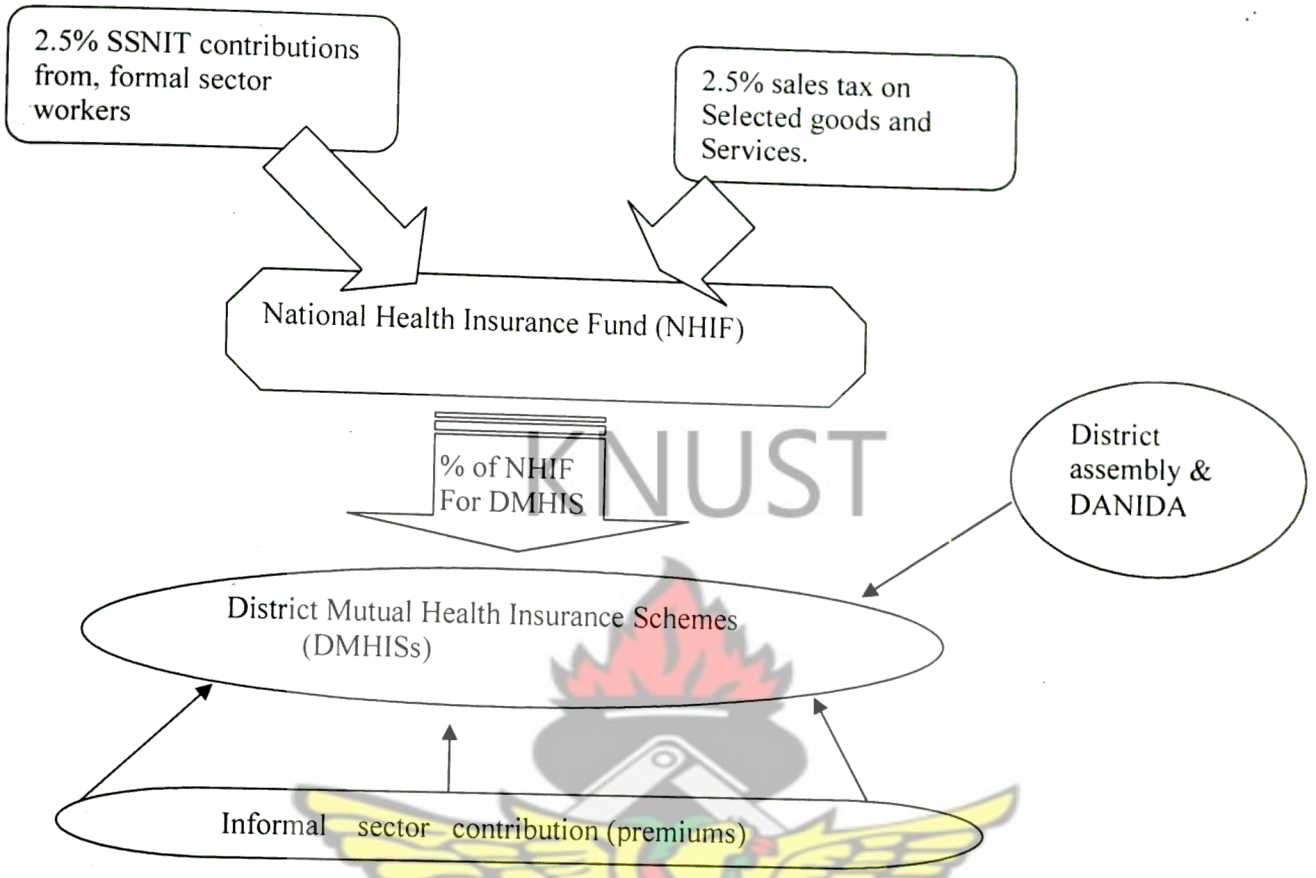
The study also revealed that, staff of providers feels they should be motivated to compensate for the pressure and increase in work load introduced by the health insurance scheme. This kind of feeling is a recipe for the introduction of fraudulent deals against the scheme for self motivation if steps are not taken quickly enough to curb them.

4.3 TECHNICAL CHARACTERISTICS

4.3.1 Revenue collection mechanisms

The survey conducted revealed that, the methods for revenue collection by the schemes include the following;

Figure 4.5: Revenue Mobilizations Flows of Mutual Health Insurance Schemes



Source; Author's own construct, May 2008

The revenue mobilization flow of the schemes illustrates that, whiles the schemes mobilize funds directly from subscribers as premium with the help of their field agents, a percentage of the revenue is given by the National Health Insurance Authority from the National Health Insurance Fund (NHIF), which is mobilized from 2.5 percent SSNIT contributions of formal sector workers and 2.5 percent of sales tax on selected goods and services. They also get short-term donor support from the District Assembly and DANIDA.

4.3.2 Arrangements for Risk pooling and risk sharing

The schemes operate a multiple risk pooling and risk sharing arrangement. The risk pooling arrangement includes,

- A probation period of three (3) months as in the case of the Pru mutual health insurance scheme, and six (6) as in the case of Bawku-West health insurance

scheme. This applies to only new registrants, and used by schemes to prevent the incidence of adverse selection and also to ensure enough accumulation of funds for payments of claims.

- There also exists an element of risk sharing where the rich are taxed 2.5 percent on value added tax into the National Health Insurance Fund to subsidize for the vulnerable groups such as the under 18 years, the aged, and indigents (core poor). There also exists risk sharing, as all subscribers pay a flat rate irrespective of their level of risks in terms of sickness, this describes a situation where the high risk are being catered for by the low risk members.
- Membership in terms of premium payers is very small at the district levels, especially those within predominantly rural communities. This is evident in Bawku-West and Pru. Hence revenue mobilization from premium is not sufficient. This serves as a serious obstacle to the consolidation of District Mutual Health Insurance Pools for financial sustainability.

4.3.3 Purchasing and resource allocation

The schemes focused basically on the purchase of curative health care for its members. The survey reveals that, the health insurance schemes allocate resources as claims for the payments of only curative health care services that fall within the defined benefit package of the National Health Insurance Authority, for their members. For instance, the Pru mutual health insurance scheme spent GH c 171,434, 436.8 in 2006, and GH¢ 436,665.86 in 2007, as claims for curative medicine provided for its clients by the various facilities. The management of the health insurance schemes and the District Health Management Team indicated that, the schemes do not support preventive health care services.

Information gathered from the scheme managers and the providers point to the fact that, the schemes signed contractual agreements with both public and private providers, where the mutual health insurance schemes negotiated for prices of drugs and other services, as well as payment mechanisms, which are subject to annual review. The accepted payment mechanism as of now is a monthly reimbursement of providers on claims vetted by a vetting committee of the scheme. Scheme managers however indicated that, the National Health Insurance Authority made some of the negotiations on its behave and thus, makes it

difficult for them to negotiate effectively for special incentives for their clients, from providers.

4.3.4 Claims management

Claims management involves procedures that seek to ensure that, claims or bills of insured members at the various accredited facilities (clinics and hospitals) are accurate and not over stated. The claims management procedure identified in the two schemes (Pru and Bawku-West Mutual Health Insurance Schemes) are similar and take the following steps,

Table 4.10 Claims Management Procedure

Procedure	Data identification requirements
1. Subscriber report at provider's facility	- provider name - Contact details, facility type, level of care, bank details.
2. Ascertaining subscribers eligibility status	- Members present ID card at facility for services. - Provider verifies member's insurance status.
3. Diagnosis and treatment (services)	- diagnosis information - Service information, cost of service and level of care offered. - Drug information and cost of drugs.
4. Provider submits claims to scheme for payment	- Claims forms provided by District Insurance Scheme should be filled in accordance with agreement between the National Health Insurance authority and the Ghana Health Service. - Drugs and services should be priced based on agreed fee schedules with the National Health Insurance Authority.
5 Claims are sorted and vetted (adjudicated)	- claims are sorted - claims are vetted by a committee - claims are accepted for payment or queried

Source: Author's own construct, May 2008

Even though the procedure above looks quite comprehensive, management complain of lack of skilled personnel to under take an adequate vetting of the claims, since most of the

services provided by the providers demand technical knowledge. It is also revealed that providers transfer cost of drugs they have not given to clients, to schemes for payments, thereby increasing claims for schemes to pay. This situation arises due to lack of adequate supervision of providers and data collection from members for analysis, in order to make informed decisions; this makes the system susceptible to provider fraud.

On the other hand, providers in Pru and Bawku-West complained about the delays in the reimbursement of claims, which often impedes the efforts of the providers from purchasing inputs including drugs.

4.4 MANAGEMENT CHARACTERISTICS

The analysis of Management characteristics is focused on staffing situation, the culture or management style adopted, and the flow and access to information.

4.4.1 Staffing situation of schemes

The staffing situation of the two schemes studied shows that, the schemes need more skilled personnel to contain the quantum of work at their disposal. The table below describes the situation.

Table 4.11 Staffing Situation of Schemes

	Permanent staff	Professionals	On the job training	Voluntary workers
Pru MHIS	6 (core staff)	3	3	66 (field agents)
Bawku-West MHIS	6 (core staff)	3	3	70(field agents)

Source; Author's field survey, May 2008

From table 4.11, the six (6) core staff represents the manager, the public relations officer, the claims manager, the accountant, and two data entry officers. The officers who are professionals include the accountant and the data entry officers. The other three (3) officers including the managers of the two schemes are being trained on the job through workshops

and seminars organized periodically by the National Health Insurance Authority. It was revealed from the survey that, there is no defined condition of service or service scheme for the workers with the National Health Insurance Scheme. This serves as a disincentive to most of the workers, for the fear of the uncertainty about their future career with the scheme.

In the case of the field agents who are the voluntary workers, they constitute teachers, Assemblymen, and school drop-outs in the various communities. They are trained to engage in social mobilization and registration of people within their communities. Apart from the six (6) core staffs who receive monthly allowances, the field agents only take a commission of what ever revenue they are able to mobilize from their communities as premium.

This situation lends it self to poor data collection and embezzlement of scheme funds on the part of the community agents as revealed by the managers , since the agents who are engaged in data and premiums collection are not motivated enough by the meagre commissions they collect from the small number of subscribers. More so, they also have to walk long distances around to collect the premiums.

Records keeping of the schemes are reported by management to have been very poor with the inception of the schemes, since almost all information was manually produced and stored. This was evident when the Bawku-West Health Insurance Schemes found it difficult to retrieve information on renewals. However, schemes studied have the necessary equipment such as cumputers to generate, analyze, store and retrieve information to ensure the smooth running of the schemes. Despite this inadequate staffing and capacity profile of the schemes, management of Pru and Bawku- West Mutual Health Insurance Schemes are keeping their respective schemes operating by increasing enrolments, paying claims and educating the people on the health insurance scheme.

4.4.2 Culture of management

Community participation in the management of the schemes was measured in terms of the level of subscription, representation, and consultations on major decisions that could affect the registration status of subscribers. Table 4.12 below shows the level of community participation in the management and decision making process of the schemes,

Table 4.12 Level of Community Participation

Forms of participation	Frequency		Percentage	
	Pru	Bawku-west	Pru	Bawku west
Participation by representation	66/67	60/63	98.5	95.2
Participation by consultation	10/67	14/63	14.9	22.22
Participation by subscription	44602	52706	46.4	46.3

Source: Author's field survey, May 2008

From table 4.12, it is evident that, the level of community participation in the management of the Health Insurance Schemes is moderate averaging 54 percent. While representation constituted 97.4 percent averagely, implying that one agent represented 753 registered people, consultation averaged 18.6 percent and participation by subscription averaged 46.3 percent. The Agents constitute community health insurance committees that form a General Assembly as the highest decision making body of the Mutual Health Insurance Scheme, and also responsible for the election of Board Members of the schemes. It was however revealed by responses from management that, the directives from the National Health Insurance Authority turn to marginalize the functions of the Management Boards of the schemes, thereby, rendering community participation in the management of the schemes ineffective.

4.4.3 Access to information

The existence of a good information system ensures effective feed back on all policies and strategies being implemented for efficient management. In other words, the information flow of management should be a two way mechanism, that accesses information easily to

the people and back to management. In the case of Pru and Bawku-West Mutual Health Insurance Schemes, they do not have any established mechanism to ensure information accessibility to their clients. A sampled population 86.5 percent indicated that, no meetings are organized to keep them abreast with the operation of the schemes, and also to get their views about what happens to them, when they visited the clinics and hospitals. The two schemes rely on their field agents to organize meetings and to educate the people in their communities about the operations of their respective schemes, after initial education and promotion drives to increase enrolment.

The interview conducted showed that out of 200 respondents 173 people acknowledged that, neither the scheme management nor their agents organized any meeting with them to educate them on issues concerning health insurance. They however noted that, they visited them to only collect their premiums. Table 4.13 shows the common sources from which people get information about the health insurance scheme.

Table 4.13 Sources of Information about the Health Insurance Scheme

Source	Frequency	Percentage
Radio broadcast	80	40
Local announcements	12	6
Mosques and churches	20	10
From people	40	20
Television	58	29
Total	200	100

Source: Author's field survey, May 2008

4.5 ORGANIZATIONAL CHARACTERISTICS/ STRUCTURE

Analysis of organizational characteristics measures the level of coverage with respect to the involvement of structures necessary for the smooth implementation of the health insurance policy. Basically, organizational forms, Incentive regimes and linkages are put in place to promote sustainable implementation of the various Mutual Health Insurance Schemes.

4.5.1 Organizational forms

The organizational forms identified in the study of the Pru and Bawku-West mutual health insurance schemes include;

Public-private partnership is one of the organizational features of the two schemes studied. The Pru and Bawku-West Mutual Health Insurance Schemes like others in other districts of the country are established by Government policy that spells out a comprehensive regulatory frame work within which all health insurance schemes should conduct their activities. However, the schemes are held in trust by the National Health Insurance Authority but managed by the people of each District. Even though the policy endorses private opt- outs, no private scheme is yet established in Pru and Bawku-West Districts. Hence, the Mutual Health Insurance Schemes in the two districts enjoy monopoly in the Health Insurance market. The schemes are using the existing public health delivery system (Hospitals, Health centers, and Clinics) including some private health centers and clinics to which, they have signed contracts with, to provide selected health care services to their subscribers for reimbursements.

Both schemes had organization by employment, where they are able to combined formal and informal sectors under one scheme with different contribution mechanisms. The formal sector workers have their premiums deducted at source, while the informal sector workers pay their contributions directly to their resident schemes. More so, the rural and urban communities are all accepted under the same scheme. The schemes also had inpatient and out patients' organization in their benefit package, which cover all categories of subscribers. This organization gives members of the various schemes access to be treated on 80percentof diseases covered by the scheme.

4.5.2 Incentive regimes

The incentive regimes identified among the schemes include categories of people exempted from paying premium and are subsidized for by government through tax. These categories of people include, children under eighteen (18) years of age, the aged over seventy (70) years, and the core poor (indigents).

Continuous payment of premium by instalments and registration in three phases across the year is another incentive instituted by the Mutual Health Insurance Schemes as an arrangement for their members to serve as an inducement for sustaining membership through renewals and as an incentive to prospective subscribers.

4.5.3 Linkages

The schemes studied indicate both vertical and horizontal linkages. Vertically, the schemes are linked to the Regional and National Health Insurance Authorities; as bodies they depend on for regulation of their operations and for reinsurance. Horizontally, they are linked to other mutual health insurance schemes, with which they have a mutual relationship that enables them to take care of each others clients for reimbursement.

Similarly, they also have a horizontal linkage with service providers, with whom they have a contractual relationship. However, the survey revealed that, there are usually delays in the release of reinsurance funds from the National Health Insurance Authority, and also reimbursements of claims from providers. This implies that, the linkages are not working effectively and efficiently, due to administrative lapses and has developed into the lack of confidence among the institutions involved.

4.6 INSTITUTIONAL CHARACTERISTICS

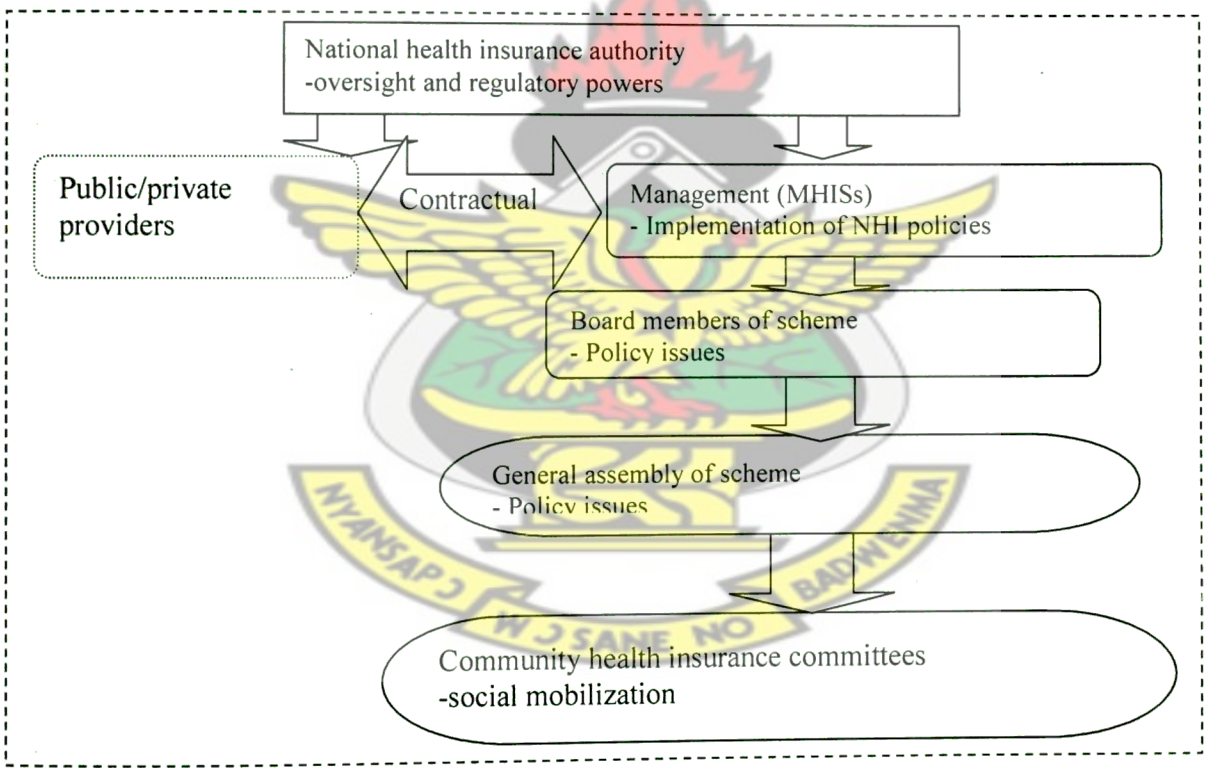
Institutional features here refer to the stewardship function, governance and ownership arrangements, and the insurance market.

Stewardship is in the hands of the government and exercised through the National Health Insurance Authority, which the statutory regulatory body to supervise, monitor and evaluate all activities involved in the implementations of the Mutual Health Insurance

Schemes, as well as all health care facilities under its accreditation. The District Health Insurance Boards and Management are also given powers to take decisions on policy, to ensure the smooth running of the schemes at the district level. Managers of the two schemes studied have explained that, they are not given the allowance to be flexible in their operations to regulate some activities of providers. This could lead to a weak oversight function and the creation of a poor regulatory environment, for the promotion of fraud and abuse on the part of providers and hence threaten the sustainability of the schemes.

Ownership and governance arrangements of the Pru and Bawku-West Health Insurance Schemes take the same structure as follows;

Figure 4.7: Institutional Relationship between Stakeholders and Control



Source; Authors own construct from survey. May 2008

Information gathered from the field in the Pru and Bawku-west Districts indicates that, the communities have less control and only feel to have a marginalized stake in the mutual health insurance schemes as subscribers, since they were never consulted on any decisions taken or given a forum to take their complains. When asked as to, who owns the scheme, (106) out of (130) registered members interviewed thus, 81.5 percent indicated the government as the owner. This is substantiated by management's indication that, the national health insurance authority that represents government regulates almost all activities of the schemes. The District management of the scheme in collaboration with the Board, General Assembly and the Committees for now is concentrating on the implementation of policies and directives from the National authority.

4.7 GENERAL PERCEPTION ABOUT THE SCHEME

The most populous perception expressed by people about the scheme is that, it is a very good system that is put in place to help the poor in society against health shocks, at a time when they will have no money. Issues on which peoples perception were measured in included the following; waiting period for identity cards; level of premium; period accepted for payment of premiums; time spent at hospitals; the quality of treatment given at the various facilities and the attitude of providers. Found in a table summary and analysis of the information collected on perception about the scheme.

Table 4.14 Perception of People about the Schemes

Issues	Pru Mutual Health Insurance			Bawku- west Mutual Health Insurance		
	Short/low	Moderate	High/long	Short/low	Moderate	High/long
Waiting period for ID cards	0	25	75	0	36	64
Level of premium	6	52	42	0	66	34
Period for paying premium	22	62	16	9	73	17
Time spent at hospital	1	42	57	6	60	34
Quality of treatment	53	0	47	40	21	37
	Normal	Cordial	Hostile	Normal	Cordial	Hostile
Attitude of nurses/doctors	17	61	22	21	62	17

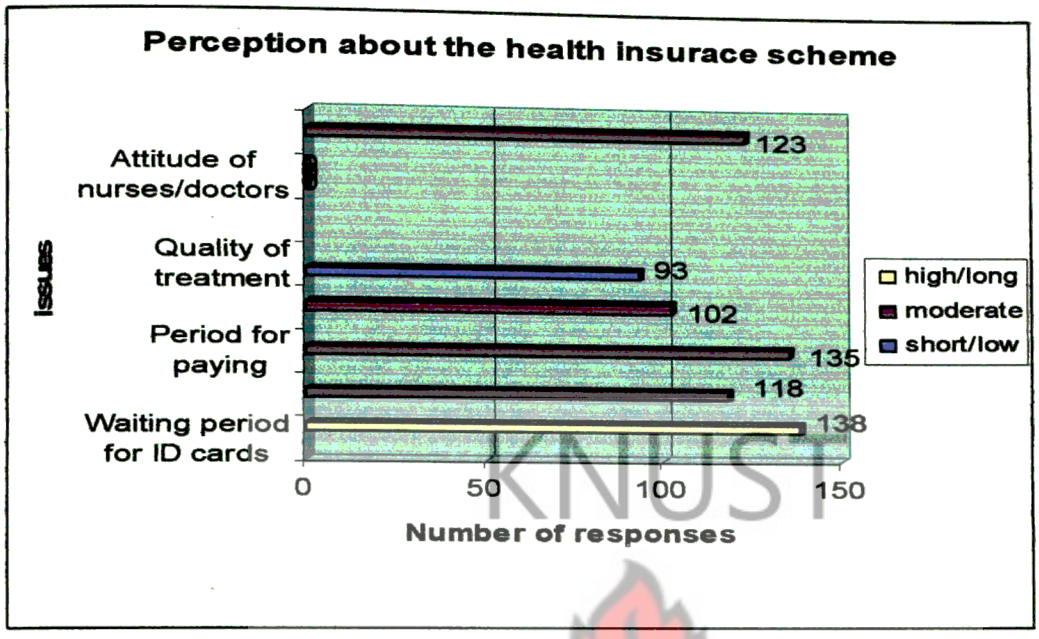
Table 4.15 Perception Ratings

	Cumulative frequencies and percentages			
Issues	**Short/low**	**Moderate**	**High/long**	**Percentage**
Waiting period for ID cards	0	61	138	69
Level of premium	6	118	76	59
Period for paying premium	31	135	33	67
Time spent at hospital	7	102	91	51
Quality of treatment	93	21	84	46
Attitude of nurses/doctors	Normal	Cordial	Hostile	
	38	123	39	62

Source; Authors field survey, May 2008

From the analysis on table 4.15 waiting periods for identity cards has been perceived to take a longer time as indicated by 139 people constituting 69 percent out of the 200 respondents interviewed. how ever, the Pru Mutual Health Insurance Scheme have reduced its waiting period from the initial six (6) months to three (3) months as an inducement to promote increase in enrolment. The level of premiums, which is presently GH¢8.5, is considered as moderate by 59 percent of the respondents, while 38 percent, who represent the poor in the two districts, see it as being higher. This implies that, there is a likely increase in the drop out rate of subscribers from the various schemes, since the present worldwide price hikes would affect prices of drugs and health care services, which could have rippling effects on premiums to rise above its present levels.

Figure 4.8: Perceptions of People about the Health Insurance Scheme



Source; Authors own construct from field survey, May 2008.

The period allowed for the payment of premium is considered moderate, suitable and flexible as shown by a 67 percent response. This is as a result of the fact that, the schemes allow people to pay premium by instalments. Thus under this arrangement, an all year round premium payment mechanism is adopted by the schemes. This mechanism if not managed properly could lead to a situation, where some people would never get covered by the insurance, since they would not be able to finish paying before the benefit year ends as required by the insurance law.

Time spent at the hospital is considered to be moderate by 51 percent of total respondents; most of these respondents stay within the rural areas and have health centers and clinics as their first points of contact, where the population in attendance at the various facilities is not much. On the other hand, 45.5 percent say it takes a long time as an insurance card holder to get treatment at the hospital. These category of respondents stay in the district capitals, where the district hospitals are sited, with a higher population, and more so, there is an increase in the out patients attendance as a result of the introduction of the health insurance (see figure 4.7), which has increased the work load of the workers at the out patients department involving the filling of more forms than before.

On the quality of services provided at the various facilities, 46 percent out of the 200 respondents had this to say, "Mostly, we are told the drugs are finished, and we are referred to the private drug stores to purchase the drugs". This category of people feel cheated and hence, disappointed about the operation of the scheme. The perception of these categories of people about the scheme is that, it connives with providers to give low quality services to its clientele. This perception could serve to reduce enrolment into the schemes. With respect to the attitude of providers to card holders, 61.5 percent indicated that, it is normal, 19 percent and 19.5 percent responded that there are hostile and cordial respectively. The scheme is however seen as a very good and helpful policy that should be supported for the fact that it is pro-poor.

Management of both health insurance schemes and providers of health facilities as well as other stakeholders asserted that, the national Health Insurance Scheme is sustainable for the following reasons; it is accepted by most people including politicians from all political divides and ethnic groups; the creation of a national health insurance fund that has a constant source of income from tax revenue; the existence of a well establish public health care provider net work; and the establishment of regulatory framework. They also mentioned the lack of adequate and skilled personnel, low enrolment drive coupled with a high drop out rate, the incidence of moral hazard, adverse selection, and management and provider fraud as factors that militate against the survival of the scheme.

CHAPTER FIVE

5.0 FINDINGS, RECOMMENDATIONS AND CONCLUSIONS

This chapter presents issues that are bought to the fore from the analysis that answers the research questions asked in this work, and the objectives that this work sought to achieve; the operational strengths and weaknesses; risk pooling and sharing mechanisms for access to affordable, equitable and quality health care services; the revenue mobilization strategies and efficient management practices for sustainability; and challenges associated with implementation and ability to achieve the Millennium Development Goals on health. The chapter also contains suggested policy recommendations to strengthen the operational weaknesses and also help find solutions to challenges identified in the analysis.

5.1 OPERATIONAL STATUS OF SCHEMES

The National Health Insurance Scheme is operating or implemented as an alternative health care financing mechanism to replace User fees otherwise known as "Cash and Cary" system in Ghana. This requires much devotion of government tax revenue in order to maintain the exemptions for the core poor (indigents), those under eighteen (18) years of age, and the aged over seventy (70) years. The scheme presently provides financial protection for a population of about 47 percent out of which the exempted constitute about 80 percent as indicated by information colleted from the survey.

The scheme is nationally administered through decentralized units District wide, with each district forming a Mutual Health Insurance Scheme, which is managed by the people within the District. The decentralization system of the National Health Insurance Authority is similar to that of the District Assembly concept at the grass root level. This is made up of the Community Health Insurance Committees at the various communities, who are engaged in community mobilization and registration of members and revenue collection. The Chairpersons of Community Committees constitute the District Health Insurance General Assembly, which serves as the highest decision making body of the Mutual Health

Insurance Scheme on policy issues. The Board members are elected from the General Assembly to ensure internal control of the scheme on policy decision and regulation. The Management of the Scheme is in the fore front of the implementation drive putting into operation all policies and decision of the scheme. This is the structure that is recommended by literature for Developing countries with lessons learnt from developed countries, to ensure sustainability and sound in decision making.

The combination of formal and informal sector workers less than one Health Insurance Scheme as a design element enables the scheme to cover a majority of the population, and gives the scheme a national outlook with the potential of a universal coverage. More so, it enables the scheme to mobilize enough resources for risk pooling, thus improving the size of the risk pool in line with the principle and theory of Health insurance which is based on higher numbers.

The Benefit package is comprehensive and serves as a safety net. It covers every insured individual irrespective of category, thus, whether under formal or informal, or exempted. More so, it is observed that, the interventions defined in the package are congenial with the Health care delivered; it is also found that, the benefit package services as an incentive to majority beneficiaries constituting 98 percent of sample population. The recent inclusion of maternal care in the list of the benefit package increases the scheme's ability to help achieve the Millennium Development Goals (MDGs) 3 and 4, thus, on Maternal and Child deaths.

With respect to the organization and functional arrangements of the scheme, the level of cross subsidization in terms of equity and risk pooling is moderately achieved due to the moderate coverage of about 47 percent of the target population. More so, there is a cordial relationship between the scheme and the providers with an appropriate timing for the delivery of Health Care services to insured members. This gives the various schemes the opportunity for strategic purchasing of Heath care services for their clients.

Community participation and involvement in the Management and implementation of the scheme is encouraging, since the General Assembly of the District Health insurance as well as the Community Committee Members (Agents) all represent the interest of the registered membership of the scheme. More so, the Board members who also constitute a higher decision making body on policy issues of the scheme, are also people from the community. This helps to exert compliance to implementation rules. It is however noted that, participation by subscription is stagnating due to the inability of people to renew their membership.

5.2 RISK POOLING AND SHARING MECHNISMS AND ACCESS TO AFFORDABLE, EQUITABLE AND QUALITY HEALTH CARE

The schemes operate a multiple risk pooling and risk sharing arrangement. The risk pooling arrangement includes,

1. A probation period of three (3) months as in the case of the Pru mutual health insurance scheme, and six (6) as in the case of Bawku-West health insurance scheme. This applies to only new registrants, and used by schemes to prevent the incidence of adverse selection and also to ensure enough accumulation of funds for payments of claims.
2. There also exists an element of risk sharing where the rich are taxed 2.5 percent on value added tax into the National Health Insurance Fund to subsidize for the vulnerable groups such as the under 18 years, the aged, and indigents (core poor). There also exists risk sharing, as all subscribers pay a flat rate irrespective of their level of risks in terms of sickness, this describes a situation where the high risk are being catered for by the low risk members.
3. Membership in terms of premium payers is very small at the district levels, especially those within predominantly rural communities. This is evident in Bawku-West and Pru. Hence revenue mobilization from premium is not sufficient. This serves as a serious obstacle to the consolidation of District Mutual Health Insurance Pools for financial sustainability.

Accessibility and affordability to health care services from the analysis indicated that, the scheme has been able to provide about 47 percent of the total population access to affordable health care, with the core poor (indigents), children under eighteen years, and the Aged above seventy (70) years being the majority constituting 87 percent of the total membership of the schemes. From the analysis it is also found that, about 43 percent of the population still fined it difficult to afford money to pay for premium either for registration or renewals. More so 10 percent of the registered members fall out of the membership annually due to lack of money to pay for premium.

With respect to equity and quality of health care, it is found out that, the scheme provides equity in terms of access to the interventions covered by the benefit package, since all insured members of the two schemes studied; both in the formal and informal sectors or exempted categories all have access to utilize both the inpatient and outpatient treatment. However, people in the rural setting suffer the lack of access to quality health care unlike their colleagues in the District capitals, where all the qualified staff and facilities are available. It is also found out that, due to consumer ignorance, some services providers provide low quality treatment to card holders with the pretence that, there are no drugs available. This is reported by 40 percent of respondent, who have been asked by service providers to buy drugs from private drug stores for the mere excuse that there were no drugs available. This serves as a disincentive to a majority poor who see the scheme as a perimeter to their health care problems.

5.3 REVENUE MOBILIZATION, MANAGEMENT AND SUSTAINABILITY

There is a shift away from "Cash and Carry" thus, point of service payments to increasing prepayment and risk pooling. Contribution of premiums is flexible and accommodates the income generating patterns of all category of households especially those in the informal and agricultural sector.

More so, from the analysis the scheme is found to be pro-poor oriented and covers the core poor, children under 18 years and the aged through exemptions of premiums and subsidies

for flat rate contributors. It is found that, health insurance committees are established with agents in each community who mobilize revenue (collect premiums) through registration and renewals of people for a commission. These agents sometimes fail to render account or even undertake effective revenue mobilization for the fact that, they are not engaged on full time, and are not motivated by the little commission to be committed.

The registration and renewals are also done in three phases throughout the year to ensure that anybody who wants to register or renew has the opportunity to do so, it also ensures frequent flow of revenue into the schemes funds and also to reduce the incidence of adverse selection. Even though the schemes as well structured decentralized systems, the active participation of the people is minimal, since they are not consulted on issues that concern or affect them directly such as changes in premiums, and also on their views and grievances on issues pertaining to how they are treated at the various facilities they visit.

Furthermore, the analysis also revealed that, the National Health Insurance Authority has put a lot of restrictions on the activities of management, which does not allow the structures at the local management level to be flexible enough to meet some challenges on the ground. Since management at the local level is not consulted for peculiar situation by National Authority before embarking on some policy measures that are related to implementation.

The analysis also highlights the lack of an appropriate monitoring and supervisory team at the District level to ensure quality control of provider services, especially at the village level, where providers take advantage of consumer (patients-clientele) ignorance on their rights to engage in fraudulent acts such as referring innocent patients to private drug stores to buy drugs with the excuse that, these drugs are not available while they sell to patients who pay at the point of service delivery. This issue came up in both the Bawku-West and Pru Districts. Hence, the referral mechanism under the gate keeper system is not made to operate.

The information management systems of the schemes are not pro-active. The analysis indicates that, there is a complete lack of effective information flow between stake holders of the schemes at the district levels as schedule officers are engaged in storing information

on identity characteristics of members to the neglect of generating information from the field through data collection to ensure effective policy formulation and implementation. There are a lot of disgruntled subscribers who are not given the opportunity to be heard and educated on critical issues.

The survey has further revealed that, the schemes operate both horizontal and vertical integration. Vertically it operates a top-down administration structure of the old decentralization system. The Mutual Health Insurance Schemes operate with instructions, policy directions and regulations from the National Health Insurance Authority for implementation drive. This stifles initiative and flexibility to cope with peculiar situations on the ground. On the other hand, the schemes are horizontally integrated with other District Mutual Health insurance schemes with whom they have mutual agreements to take care of each others clients for reimbursement. The schemes are also horizontally integrated with the service providers with whom they have signed contractual agreements to provide curative health care services to their members for monthly reimbursements. This serves to ensure smooth operations of the schemes and builds confidence of subscribers as well as service providers on the scheme.

The analysis however brought to light that, both levels of integrations are not operating effectively since the horizontal integration turns to bring about the centralization of all decision making to the National Health Insurance Authority, to the neglect and marginalization of the intended decentralization function, thus, stifling local initiative and participation, which is necessary for the sustainability of the scheme. The problem with the horizontal integration deals with administrative bureaucracies that bring about the lack of trust between the Mutual Health Insurance Schemes and the providers for delays in the payment of claims to their clients by other schemes outside their districts.

The survey also further revealed that, there is an increase in Hospital attendance to an average of 41.48 percent in out patient department of most health centers. The trend of out patient attendance in the Pru and Bawku-West Districts indicates that, there has been an average increase in OPD attendance to 33 percent and 51.7 percent respectively. This

situation has resulted in not only high claims payments, but also the delays in most hospitals and also putting pressure on human resource and infrastructure. Staff of the service providers especially in the public sector is of the opinion that, the scheme should compensate or motivate them for the increased pressure introduced by scheme.

Moreover, there is also revelation of a woeful inadequacy of provider staffing situation of a doctor patient ratio of about 1: 49,000 patients as in the case of Pru Distract and 1: 32000 as in the case of Bawku-West District. More so, most of the health centres and clinics do not have the requisite staffs such as Laboratory technicians, Dispensary technicians and other skilled supporting Nurses. This state of affairs sets in the provision of low quality services to patients including those of card holders, which is serving as a disincentive to the clientele and prospective members of the scheme.

The staffing situation and capacity of the Mutual Health Insurance Schemes is not encouraging with respect to qualifications and training. From the analysis of the two schemes it is found out that, apart from the accountant and the data entry officers who are professionally trained for their positions, the other four (4) core officers; the Claims Manager, Public Relation Officers, Information Management Officer and the Managers are being trained on the job to handle their schedules. It is sad to note that the crucial schedule of Information Management systems is being handled by non-graduates who have no idea about research and data collection techniques, skills that are necessary for information generation.

It is also realized that, National Health Insurance Authority from its inception has no comprehensive and well documented human resource policy for its staff. In other words, it has no defined conditions / scheme of service. Hence, the officers of the scheme are still being paid allowances. This state of affairs serves as a disincentive to the staff, since they do not know their fate with respect to promotions and how to pursue further studies. This also boarders on their general welfare as staff to the scheme.

In the case of Efficiency and sustainability of the scheme, it is realized that, there is better use of resources, since the schemes cater for both outpatients and inpatient costs, thus decreasing the opportunity costs and missed opportunities. It is also however found from the analysis that efficiency is highly affected by inadequate staffing and provider fraud, over estimation of cost as well as poor consumer protection mechanisms, for redress and provider monitoring. More so, the lack of skilled personnel to handle monitoring of over utilization, adverse selection, moral hazard and effective vetting of claims provide a situation where cost outstrips output. This state of affairs serves to threaten the sustainability of the schemes. Furthermore, the size of the exempted categories that falls on government tax revenue (the Health Insurance Fund) is about 80 percent of the insured population as against 20 percent of premium payers. Hence claims payments are always more than revenue collected from premium. Hence, claims of about 90 percent of the insured who attend hospital are subsidized from the Health Insurance Fund. This is not a good sign for sustainability.

Further more, it is also found out that about 40 percent of the population who are poor, but not considered as the core poor always find it difficult to make regular payments of their premiums, even though they are considered for payment by instalment, giving a drop out rate of about 10 percent as in the case of the Pru and Bawku-West Districts. Against this back drop is the persistent annual increases in the premium from 7.2 Ghana Cedis to 10.00 and 20.00 Ghana Cedis in predominately rural communities and urban canters respectively and the present energy and world price hikes, which would push up prices of medical inputs and cost of health care services and their consequences on premiums and apparent increase in the drop out rate.

The following are also found from the analysis, which indicate the sustainability of the scheme.

- Capital funds are found to be available from the National Health Insurance Fund to cover investment and working capital requirements and also in the short term to cover operating expenses.
- There exist more than one source of funding – extra taxation, SSNIT contributions and NGO's and the informal sector contributions, with support from the various District Assemblies.
- A higher level of community participation in the management of the scheme and wide acknowledgement of the scheme as a good policy by the general public and hence has their support
- An appreciation and support for the policy by almost all political parties as a good one.

5.4 CHALLENGES OF THE SCHEME

5.4.1 Inadequate revenue mobilization

Inadequate funds to pay for high cost of services provided to clients by health service providers, resulting from low revenue mobilization from premiums. Unstable and low levels of income (revenue) generation by the schemes, the high rate of poverty, affects the ability of the people to pay their premium and registration fees. This keeps the drop out rate increasing.

5.4.2 The problem of risk management

. More so, there is also the issue of adverse selection, where people enrol only sick members of their families to the scheme. There is also the critical issue of provider fraud manifested in multiple prescriptions, and shifting of bills of drugs that are not issued to members to the scheme, resulting in over billing and higher claims.

It was also found out that, the enrolment drive is still very slow and it is difficult to convince some people even the educated ones to join the scheme due to lack of adequate

funds and lack of confidence in the case of the later. Hence the majority of members constitute categories that do not make contributions in terms of premiums.

5.4.3 The lack of skilled and requisite personnel

This is for the fact that, the scheme is a new concept and hence only a few people have any skills about its operations and the complications involved, especially on risk and claims management resulting in higher claims, and delay in reimbursement of claims.

5.4.4 Political interference

Political interference in the implementation and operations of the schemes, serves as another challenge. While the party in government wants to have their members to control the management of the scheme those in opposition see all moves by the scheme in its operations as political, hence, give some destructive criticisms that turn to sabotage registration drive.

5.4.5 The inadequate and qualified staff in the various Hospitals and Health centers

To contain the ever increasing workload, resulting from the rising attendance to the various facilities by insurance cardholders.

5.4.6 The inadequate infrastructural facilities

Various Health facilities to contain the increased attendance, most health facilities have no enough space within the hospital to accommodate the increased numbers that attend health facilities for treatment as a result of the introduction of the Health Insurance Scheme.

5.5 CONCLUSION

According to – Arhin-Tenkorang (2002), financial risk protection is measured from the following indicators; affordability, appropriate payment schedule, and a comprehensive benefit package. Taking these inductors into consideration, the Mutual Health Insurance Schemes have provided modest financial risk protection for their people such that premiums are assessed to be affordable to 67 percent of the population of the schemes studied, with about 47.5 percent of the target population enrolled with the scheme. More

so, payment schedule for premiums is considered suitable and appropriate, since payment is allowed by instalment, and registration is done in three phases within a year to allow people to enrol when they are ready within the year. The benefit package is also comprehensive and gives members the opportunity to have access to both out patients' attendance (OPD) and inpatients (admissions) services as and when it is necessary. Thus, it has increases access to health care services to an average of approximately 42.3 percent as assessed from out patients' attendance in the Pru and Bawku- West Hospitals.

According to Preker and Carrin's (2003) typology of financial risk protection rating, the Health insurance scheme is at the stage of established insurance pools after it has moved away form out-of-packed payment and Community Health Insurance pools with a National Health Insurance Fund for re-insurance and a framework for the pool management. Thus according to this rating typology, the National Health Insurance is mid-way through to the achievement of universal coverage.

From the study it is important to note that, the National Health Insurance Scheme Policy has so far had a smooth take off for taking into consideration lessons from experience of other schemes, for a good technical design that includes; formal and informal sectors, public and private participation, coupled with the establishment of subsidy that is supported by a fund from taxation.

However sustainability indicators such as; higher enrolment of premium contributors, effective supervision and monitoring of provider activities, and an effective risk management framework should be enforced to ensure the growth of the scheme, since it is generally accepted by all people as a good policy.

5.6 RECOMMENDATIONS FOR POLICY CONSIDERATION

1. Education and awareness creation should be a continuous and sustained activity throughout the life span of the schemes, in order to improve and maintain the demand for membership. It should be done in a simple language that the people would understand and which would seek to answer most of the questions the people ask about the scheme, with respect to their experience with it. This would also offer the people the opportunity to know their rights and obligations on Health Insurance, and seek to observe them to ensure the smooth implementation and sustainability of the scheme. This should be initiated immediately.
2. With registration being voluntary for the formal sector workers, registration fees (administration fees) should be moderate and not too high so as to serve as a disincentive to people within this sector to renew the membership, since the formal sector serve as the positive pillar, that can be relied on to sustain the scheme with deductions at source which is a reliable and cost effective source of revenue to the scheme. In lieu of this, formal sector contributions should be made mandatory by the beginning of 2009.
3. Fee regulations should be done gradually, at least once in every two years. Such that, it would not be seen to be too high by the poor who constitute about sixty percent (60percent) of eligible / prospective contributors or members of the scheme. This is to ensure an increase in the demand for health insurance and sustained membership of the scheme, for its sustained risk pooling and effective cross subsidization drive.
4. With regards to risk management, the following risk management techniques should be initiated or emphasized to curb or mitigate the present incidence of fraud and abuse;
    - *Social audits;* where a special team would be established within the Mutual Health Insurance Schemes to conduct periodic unannounced visits to health care facilities to identify sampled patients in attendance with their identity cards to avoid fraudulent admissions and out patient visits.
    - *Medical chart audits.* Apart from the usual vetting procedure for claims management adopted, the scheme should employ experts to periodically visit

accredited facilities to cross check samples of medical charts of patients who are members to ensure that they were not over billed. It is only the technical eye that can detect a technical anomaly.

- *Providers should be given proper education* through workshops on the health insurance regulations and the consequences of engaging in any fraudulent act. More so, incentive regimes should be introduced for providers as well as members to check fraud and abuse.
- There should also be the administrative and political will to enforce the National Health Insurance Regulations on fraud and abuse so as to deter perpetrators and prospective actors to refrain.
- *Introduction of co-payments after a given number of visits from a household* monthly could also help reduce abuse. Under this policy a household could be made to pay a percentage of her/his bills after the household members have visited the health care facilities for more than a reasonable number of times within a month. This would serve to reduce the incidence of abuse. In lieu of this, a comprehensive demographic profile, the morbidity rate, the facility utilization rate and regular primary data collection should be a priority for each District Mutual Health Insurance Scheme.

It is advised that these measures are taken as early as possible, at least before the beginning of the year 2009.

1. Mutual Health Insurance Schemes should support Health Promotion Activities within their respective districts as a social responsibility. This has a direct bearing on reducing the incidence of preventable diseases, which constitute the most reported cases at the various health facilities. This would in the long –run help to reduce the high facility attendance and consequently the huge claims paid monthly to improve the revenue mobilization status of the schemes. In this direction, the National Health Insurance Authority should set aside a proportion of the tax revenue from the National Health Insurance Fund for this purpose. This activity should be done in collaboration with the relevant stake holders involved. This could also be organized by the end of the year 2008.

2. There is also the urgent need for government to provide an increase in the staffing situation and health infrastructure by the next three years. This is to reduce the present delays and pressure at the various facilities which is created by lack of Doctors, Nurses, Midwives, Laboratories and Dispensary Technicians and other supporting staff. More so, there is also a need to expand and increase the capacity of health facilities throughout the country so as to accommodate the increase in health care utilization created by the introduction of the National Health Insurance Scheme. This is also to improve the quality of health care services in order to build confidence in the scheme.
3. The various schemes should create viable and pro-active information management systems that would not only be keeping demographic characteristics of membership of the schemes , but also to design and operate a feed back system that is capable of collecting primary information about complains and problems faced by the scheme, and getting management informed about them for solutions to be found. The Information management system should be a research unit of the scheme, a pivot around which new policies and policy changes should be generated to face challenges of the scheme. In view of this, the schedule officers for the management information systems should be people who have knowledge in research and pro-active. It is suggested that action be taken on this before the beginning of 2009.
4. The National Health Insurance Authority should with a matter of urgency establish a well defined and comprehensive Human resource policy by next year 2009, which should spell out the condition of service, scheme of work, promotion and salary scales. It should also include a conflict resolution and management code. The authority should also design a comprehensive training programme for its staff, to give them the necessary skills and knowledge of health insurance. Such a training programme could a sandwich one.
5. The achievements of the Millennium Development Goals four (4) and five (5) is very crucial for improving the health status of most people especially the rural poor. Thus, its recent inclusion on the list of the benefit package. However, in order not to compromise with its population implications, co-payments could be introduced within the post natal stage.

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APPENDICES

APPENDIX 1

QUESTIONNAIRE FOR HOUSEHOLDS

A) PERSONAL INFORMATION OF RESPONDENTS

1) Age [ ]

2) Sex: Male [ ] Female [ ]

3) Religious affiliation: (a) Christian (b) Moslem (c) Traditionalist (d) None

4) Employment status: i) (a) Employment (b) Unemployed

ii) If employed which sector? (a) Formal (b) informal

5) Are you a member of the Health Insurance Scheme? (a) Yes [ ] (b) No [ ]

If 'Yes' why did you decide to register?.....

If 'No' why did you not register? .....

* If not registered, proceed to 22-27

B) TECHNICAL CHARACTERISTICS

6) How are premiums fixed? [*Choose the appropriate application*]

a) Fixed by management

b) By people of the community

c) By management with consultation with community members

d) By government

7) Are you forced to register with the scheme? (a)Yes [ ] (b) No [ ]

8) Which benefit packages does the scheme offer?

(a)Only OPD (b) Only admission (c) Both OPD and admissions

(C) MANAGEMENT CHARACTERISTICS

9) Does the scheme organize meetings to solicit your views about management?

(a)Yes [ ] (b) No [ ]

10) Does the management of the scheme consult you when they went to change the premium? (a) Yes [ ] (b) No [ ]

11) Do you have a representative from your community who collects premiums from you and gives you information from the scheme? (a) Yes [ ] (b) No [ ]

12) How do you get your information about the scheme?

a) Radio broad cast b) Local announcements

c) Television d) From the church or mosque

e) From other people within the community

ORGANIZATIONAL CHARACTERISTICS

13) I) Do you have everybody in your house registered? Yes [ ] No [ ]

ii) If 'No' why? .....

14) Do you have to pay premium for every member of your household? Yes [ ] No [ ]

ii) If 'YES' why .....

iii) If 'No' which category of your household are exempted?.....

15) How are you allowed to pay your premium? (Tick those that apply)

(a)In kind b)In cash (c)By instalment (d) In full

16) Where do you go for treatment when sick?

a) Hospital (b) Health centre (c) Clinic (d) Private drug store

17) How far is the facility (Hospital or clinic) from your community (House)? .....

18) How many times do you or any member of the house hold attended hospital or clinic in the passed week? (a)once (b)two times (c)three times (d)more than three times

E) INSTITUTIONAL CHARACTERISTICS

19) The people in the district have much control of the activities of the scheme than the government (a) Strongly agree (b) Agree (c) not aware (d) Disagree (e)Strongly disagree.

20) Does the scheme allow members to seek treatment from private clinics of their choice? (a)Yes [ ] (b) No [ ]

21) Do you pay any money directly at the hospital when you go for treatment?

(a) No [ ] Yes [ ]

F) GENERAL PERCEPTION ABOUT THE SCHEME

(What is your opinion about the follows issues on the scheme?)

22) The premium are; (a) Too low (b) Low (c) moderate (c)High (d)Too high

23) The period allowed for the payment of premium is suitable;

Strongly agree (b) Agree (b) Fairly agree (c) Disagree (d) strongly disagree

24) The time spent at the Hospital as an insured member is;

(a)Normal (b)Little (c)Longer

25) The quality of services (treatment) at the facilities (hospital/clinic) is;

(a) Very good (b) Good (c) Fair (d) Bad (e) Very bad

26) The attitude of Health workers (doctors, nurses) to patients is;

(a) Cordial (b) Normal (c) Not cordial

27) The waiting period for the collection of ID cards after registration is ;

(a) Too short (b)Short (c)Alright (c)Long (d)Too long

APPENDIX 2

QUESTIONNAIRE FOR MANAGEMENT

Name of Scheme: .....

Date Scheme stated operation: .....

TECHNICAL CHARACTERISTICS

1) What is the level of prepayment of the scheme? (a)Co-payment (b) Risk sharing

2) What is the nature of premium?

Flat rate

Discriminatory according to level of employment

Discriminatory according to income levels

Option a & b

Option a & c

Options b & c

What is the level of Coverage? a) Only formal sector employment

(b) Only informal sector c) Both informal and formal sectors

4) Are there any exemptions under the scheme? Mention them

.....

What is the pooling and risk sharing arrangements of the scheme?

Who is qualified to enjoy the benefit package of the scheme?.....

What constituters the benefit package of the scheme?

a) Out patients treatment only (b) Impatient treatment only (c) Both out and in patients

How is the benefit package determined? .....

8) What is the purchasing arrangement between the scheme and providers?

State .....

MANAGEMENT CHARACTERISTICS

10 Is the community involved in the management of the scheme? Yes [ ] No [ ]

11) If "yes" how is it done? .....

Do you have qualified technical staff? Yes [ ] No [ ]

Are the staffs permanent or voluntary?.....

Is the staff capacity adequate? Yes [ ] No [ ] if 'No' How is their capacity being built?.....

ORGANIZATIONAL STRUCTURE

15) i) What is the form of contractual agreement between the scheme and providers?

ii) What is the provider payment arrangements used by your scheme?.....

16) What is the nature of the schemes integration?

Horizontal Vertical

17) What is the nature of the referral system?.....

18) How are claims of the scheme managed?.....

INSTITUTIONAL CHARACTERISTICS

What are the levels of control of the schemes in terms of its operation?

(a) Local community (b) Central government (c) National Insurance system

20) What is the scheme's ownership and governance arrangement (management boards, committees etc.)

21) Is the scheme competing with others in the insurance market? Yes [ ] No [ ]

i) If 'Yes' what is the nature of competition?.....

21) How does this competition affect the scheme?.....

22 i) Do you identify the following issues in the operation of the scheme? (Please tick those that apply)

Moral hazard [ ] Adverse selection [ ] Provider fraud [ ]

ii) What is the evidence of such behaviours?.....

Please fill in the appropriate information on the tables provided below

25) Drop out rate

Year	**2003**	**2004**	**2005**	**2006**	**2007**	**2008Total**
No Registered						
No Renewals						

26) Source of funding; fill in the Name of source and tick the appropriate nature of source

A)

Name	**Nature of source**	
Government / Dist. Assembly, N G Os etc.	Short-term	Long-term
……. …….. ……		

B)

Year	**2003**	**2004**	**2005**	**2006**	**2007**
Income from premium					
Income from others					
Expenses Admin.					
Expenses claims					
Any other					

27) Do you think the scheme is sustainable? Give two reasons for your answer

.....

28) What are the main challenges in the implementation or operation of the scheme?

.....

APPENDIX 3

QUESTIONNAIRE PROVIDERS (MANAGEMENT)

I hereby present to you this questionnaire to help collect available information for a thesis project entitled "the implementation and challenges of risk pooling in health care financing". The purpose of this study is purely academic and all information provided would be kept as confidential as possible.

Please respond to the level to which you agree or disagree with the following statements, by circling the one that applies

The responses are arranged as follows; strongly agree agree disagree strongly disagree

[4] [3] [2] [1]

1) The introduction of the scheme has made your work cumbersome; 1 2 3 4

2) The scheme has improved revenue mobilization in your facility; 1 2 3 4

3) Referrals of cardholders from the clinic to the hospital is encouraged 1 2 3 4

By the scheme;

4) The scheme encourages the prescription of quality dugs to card holders; 1 2 3 4

5) Prescribers are allowed to direct patients who are cardholders to buy drugs

From private drug stores when, they are not available in their facilities; 1 2 3 4

6) Workshops and seminars are organized by the scheme to keep you and

Your workers abreast with the schemes operations and guidelines; 1 2 3 4

7) The scheme periodically supports preventive health programs in the

District; 1 2 3 4

8) In which specific areas does your outfit have contractual agreements or collaborations? Please state them.

.....

Please state the challenges your institution encounter with the introduction of the Mutual Health Insurance Scheme. .....

Is the health insurance scheme sustainable? YES[ ] NO [ ] Please state the reasons to your answer.....

12) Please provide information on the following items in your district and sub-districts.

ITEM COMMUNITY						
availability of a facility						
Status of the facility						
Number of doctors						
Number of med-assistants						
Number of midwifes						
Number of lab-technicians/assist.						
Number of dispensers						
Supporting Nurses						

Thank you for your co-operation.