HOUSEHOLD PERCEPTIONS AND THEIR IMPLICATIONS FOR ENROLMENT IN THE NATIONAL HEALTH INSURANCE SCHEME AT SEKYERE SOUTH DISTRICT

By

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DECLARATION

I hereby declare that this piece is my own work towards the Master of Business Administration and that, to the best of my knowledge, it contains no material previously published by another person or material which has been accepted for the award of any other degree of the university except where due acknowledgement has been made in the text.

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DEDICATION

To Almighty Allah I say Alhamdulilah. To my uncle Mr.Abdul Karim Mohammed and his wife Mrs. Mariam Suleiman Nketiah. My parent Mr. Ahmed Abdul Mumin and Mrs. Fatimatu Mohammed. To My siblings Abdul Razak Ahmed,Abdul Karim Ahmed, Abass Ahmed and Zakiya Ahmed I say God bless you for your support and encouragement. God richly bless you.

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ABSTRACT

The health status of people indicates the wellbeing of the populace from spiritual being to the flesh. Millions of people in developing countries all over suffer from preventable health problems such as communicable diseases and complication of childbirth because they are simply poor. Healthcare financing in Ghana from 1950 up to 1966 was in line with the socialist philosophy of Dr. Nkrumah. Under the National Liberation Council healthcare was being paid by the individual but currently health care financing in Ghana is the National Health Insurance Scheme. Health insurance is increasingly recognized as a hopeful tool for financing equitable healthcare in low income countries. In addressing financial constraints for the poor and improve equity in access to care, Ghana passed the National Health Insurance law in 2003 which mandated the establishment of District-wide mutual health insurance schemes. The study seeks to assess households' perception and its implication on enrolment in the NHIS. The population of the study comprises of households in sekyere south district who subscribe to the NHIS. The study is conducted on a total 464 households and stratified and purposive sampling techniques are used in selecting respondent. Finding reveals that treatment provided by NHIS is effective for recovery and cure of sickness. There are challenges of inadequate doctors, lack modern medical infrastructure and lack of confidence in the scheme. There is a perception of good and quality service to the people in the district, and accessibility as and when one needs a service. The study recommended intensified education, training for official, drug availability and prompt payment of claims.

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CHAPTER ONE

GENERAL INTRODUCTION

1.1 Background of the Study

Health status of people indicates the well-being of the populace from the spiritual being to the flesh. Millions of people in developing countries all over are suffering from preventable health problems such as communicable diseases, malnourishment, and complication of childbirth because they are simply deprived. Broad contrasts in wellbeing status between poorer individuals and better-off individuals are regularly stoppable and uncalled for, reflecting diverse financial limitations and opportunities as opposed to distinctive individual decisions. Despite the fact that legislatures have gained ground in enhancing general wellbeing in the course of the last number of decades, a large portion of the activities to enhance the strength of the denied individuals have been pointless . Recently, new research has become available on health variations in developing countries. Some of these studies shed light on how the world's underprivileged people are coping, establishing for the most part how persistent and prevalent health inequalities are. Other researchers evaluated a range of methods to reducing health inequalities, which includes alterations in the way health care is funded and organized, advancement in the quality and availability of services and wider community development.

The topic of financing healthcare in Ghana has gone through a extensive and meandering road from the time of colonialism through to the present health insurance regime of healthcare financing which is still seeking refinement to meet the aspirations of Ghanaians. Healthcare financing in Ghana from 1950s up to 1966 was

in accordance with the Socialist viewpoint of Dr. Nkrumah's Convention People's Party Government, and was almost free as was other social services.

After the overthrown of President Kwame Nkrumah, financing of health in Ghana completely changed. During the National Liberation Council (NLC), healthcare was being paid by individual Ghanaians. Since 1981 there have been trials on finding the best permutation of Government-Peoples-Partnership that would help in meeting partly the needs and pockets of both the government and Ghanaians as a whole.

Currently the new healthcare funding regime is the health insurance scheme. The National Health Insurance is been used to finance healthcare in Ghana for the past ten years Out-of-pocket payments create financial barriers that prevent millions of people each year from seeking and receiving needed health service (Preker et al, 2002, Hjortsberg, 2003) additionally, many of the people who seek and pay for health services are confronted with financial misfortune and insolvency (Xu et al, 2003, 2005, Wagstaff & Doorslaer, 2003).

Insuring for health is gradually recognised as an optimistic tool for funding health care to all in low-income countries. In merging resources and risks, it has the capacities to safeguard improved accessibility and offer safeguard against risk of cost of illness to poor households(Bennett et al. 1998;Ekman 2004 Dror and Jacquier 1999;).Cost-recovery strategies are other alternatives available but they have all been condemned on parity grounds as affecting accessibility to health precaution (Gilson et al. 2000). Presently, only two African countries namely, Rwanda and Ghana in the western part of Africa that, have been able to take insuring of health to great lengths through scope and coverage. Whereas there is 91% coverage in Rwanda from 7% in

2003 (MOH Rwanda 2010), there is a 66% coverage in Ghana by the National Health Insurance Scheme (NHIS) since it was founded in 2003 (NHIA 2010). Regardless of such advances, there is evidence that shows that the NHIS is not achieving its goal of fairness, with the poor registering less(Asante and Aikins 2008; Aikins and Dzikunu 2006; Jehu-Appiah et al. 2011; Sulzbach et al. 2005; GSS 2009; Sarpong et al. 2010).

In the 2008 health and Demographic Survey of Ghana, there was a highest quintiles (43%) who are more prospective to be registered in comparison to the (23%) which is lower. Additionally, emergent proof shows a diversity of problems of implementation like the apparent low quality of health care, the absence of trust in the management of the scheme, longer time spent in the NHIS card production and its distribution, the length of time the insured client waits and high rate of dropout of membership (Bruce et al. 2008; NHIA 2010).

Preceding writings has recognized a variety of obstacles and elements recognized to effect registration, the emphasis is on socio-economic and demographic characteristics (Asante and Aikins 2008; Basaza et al. 2008; Buor 2004; De Allegri et al. 2006a; De Allegri et al. 2006b; Dong et al. 2009; Kamuzora and Gilson 2007; Ndiaye et al. 2007;Sinha et al. 2006; Nketiah-Amponsah 2009; Nunes 2008;; Sarpong et al. 2010). The preferences of Communities and perceptions and their impact on decisions to enrol in Ghana have been explored by some researchers (Arhinful 2003; Akazili et al. 2005). De Allegri et al. (2006b) observed that in rural West Africa, understanding end user preferences and incorporating them into how insurance schemes in the community are designed may effect increased rate of participation, make certain there is better access by the poor, but there is a conclusion that, this has

not been given sufficient consideration in prevailing literature. Qualitative works have been done on the subject (Arhinful 2003; De Allegri et al. 2006a; De Allegri et al. 2006b ;Criel and Waelkens 2003;). Even though perceptive, it does not deliver a methodical assessment of the relationship among enrolment and perceptions, and specifically the enquiry of which of the perceptions are of main significance in choosing to register and remain registered on the NHIS. Having the understanding, that is needed for policy development routes and valuable for handling implementation which benefit Ghana and similar schemes in countries with low and middle-income. Contrary, the research adopt a unique procedural method which is quantitative to thoroughly weigh, match and rank the opinions of insured and those not insured individuals as they relates to service providers (staff attitudes, quality of care, service delivery adequacy), insurance schemes (convenience, price and benefits) and community characteristics (peer-pressure and health 'attitudes and beliefs').Additionally, the study discovers the relationship between these perceptions with the decision for households to register and remain with the scheme. With these, the following hypothesis is being tested: perception of households in relation to providers, community and scheme attributes are unevenly related with household's decision to register and remain in the scheme.

The National Health Insurance Scheme (NHIS)

The National Health Insurance law was passed in 2003 to address financial limitations faced by the poor and also improve fairness in accessing of care. (GOG 2003), which mandated the creation of mutual health insurance schemes at the districts. All District schemes are mandated by the Act to collect a lowest premium of US$8 per adult for those without contribution to Social Security and National

Insurance Trust to take care of their premium. Individuals under 18, pregnant women, pensioners and individuals over 70, or those deemed as indigent are exempted from paying premium. In designing the Health Insurance they build in a mechanism that caters for fairness in subscribers paying income-adjusted premiums. Practically, however, those who subscribe are made to pay a rate which is flat because of difficulty in assessing incomes. Beyond the premiums paid, there are no cost-sharing; no any co-payments by members or deductibles. All formal sector employees and some contributors of SSNIT—have their 2.5% SSNIT contribution deducted as premium at a central level via pay-roll deduction which are proportionate to their revenue. Nevertheless, a registration fee is still to be paid at a District Mutual Health Insurance Scheme office so as to obtain NHIS card in order to be registered and have access to NHIS benefits. Registration onto the NHIS is mandatory by the law but is not been complained with, the social policy nature of it makes the law challenging to enforce, as the informal sector is great and lacks database and there is the need for workers in the formal sector who are SSNIT contributors to pay willingly a registration fee to be registered (MOH 2009). Besides these premiums that are locally collected, the National Health Insurance Scheme is funded by the National Health Insurance Levy which is founded by the Government. A value added tax (VAT) of 2.5% is charged on most services and commodities, but there is an exemption on basic products and goods which are consumed largely by the deprived. There is a pre-defined benefit package which is mandated by the National Health Insurance Authority (NHIA) that covers 95% of the diseases that are burdened in Ghana. Administration region that are secured incorporate outpatient counsels, fundamental medications, inpatient mind and shared convenience, maternity care (ordinary and cesarean conveyance), crisis care, dental care and eye care. The District Mutual Heath

Insurance Scheme enter into agreements with providers who have accreditation (private public, and church-based) to render health care to those with memberships and pay them back after they submit claims for services rendered. This arrangement splits the provision and purchasing functions over all stakeholders to intensify its transparency. Presently providers are paid back by the NHIS based on fee-for-service (FFS) for medicines on the tariff list and the Ghana Diagnostic Related Groupings (G-DRGs) (MOH 2009). The National Health Insurance Scheme is regulated by the National Health Insurance Authority at a centralised level which also plays an important part in directing the National Health Insurance Fund (NHIF) managers. The Incomes used for additional coverage for the Mutual Health Insurance Schemes at the districts and premiums for the groups that are exempted comes from the NHIF.

1.2 Statement of the Problem

The objective of the NHIS policy is that, every individual living in Ghana shall belong to a health insurance scheme that sufficiently covers him or her against the need to pay out-of-pocket expense at facilities indicate all together get access to a characterized bundle of worthy quality social insurance within the following five years (MOH, 2004). According to Witter and Garshong (2009), relatively low coverage contributes to poor performance problems such as low revenue generation, and high expenditure on administration and medical bills. These performance problems could threaten financial viability and sustainability of the Scheme. The perception of the individuals towards the benefit of Health Insurance, the convenience of NHIS administration will determine voluntary registration and remain with the Scheme.

The relatively low population coverage of the Scheme means that majority of the population especially the poor and vulnerable (children, women, and the elderly) do not have access to quality and inexpensive health services as stated in NHIS policy framework (MOH, 2004) and are therefore exposed to health risks. Studies by Dror and Jacquier (1999), Jutting (2003), and McCord (2001), show that when individuals are exposed to great health risk, they are lesser likelihood of them taking point of interest of development opportunities, for example, growing organizations or putting resources into new innovation

According Guy et al (2008), up to 13% of family units face budgetary disaster in any given year in light of the accuses related of utilizing wellbeing administrations and up to 6% are pushed beneath the destitution line. Families are considered to endure budgetary calamity on the off chance that they spend more than 40% of their discretionary cashflow on wellbeing administrations. They are frequently compelled to decrease use on other fundamental things, for example, lodging, attire and the training of kids to pay for wellbeing administrations. The study explores how perception of health care provided effect enrolment onto the National Health Insurance. It also wants to understand impact these factors can have on the sustainability of the National Health Insurance.

1.3 Objectives of the study

The general objective of this study is to compare the perceptions of individual households towards National Health Insurance and it impact on sustainability.

The specific objectives are:

1. To compare perceptions of insured households in Sekyere South District on health care being provided
2. To identify the associated factors with enrolment with the National Health Insurance Scheme at Sekyere South District Health Insurance Scheme
3. To assess the effect of perception factors on National Health Insurance Scheme Sustainability in the Sekyere South District

1.4 Research Questions

In order to attain the above objectives drawn from the problem statement, the research seeks to address the following:

1. What are the perceptions of the insured household in the Sekyere South District in regards to health care provided?
2. What are the factors associated with enrolment with NHIS Sekyere South District?
3. What are the effects of the perception factors on the sustainability of NHIS Sekyere South District?

1.5 Justification

The NHIS is a key health division activity to bolster the Ghana Poverty Reduction Strategy (GPRS II) approach goal of guaranteeing economical monetary plans that secures poor people. This arrangement is additionally key to Ghana's fulfilment of the Millennium Development Goals (MDGs) 1, 3, 4 & 5. Therefore, the perception of households to enrol unto the NHIS, since implementation of the NHIS in 2005 can be the barrier to growth of the NHIS. Understanding the perception of individuals is important in designing intervention that will help in careful diagnosing of factors that may undermine it sustainability.

1.6 Limitations of the study

The study was specifically carried out in the Sekyere South District in the Ashanti Region. The targets were the households in the District. The study was concentrated on this district based on factors that included access to respondents and study variables. Access to the respondents was not a problem since individuals living in the district provided data for the study. The intensity which was given to the research work has to be compromised but it has not affected the quality of information that has been gathered.

1.7 Organization of the Study

This study is grouped into five chapters. Chapter one is the introduction which explains the background and historical data of the study. Chapter two deals with the literature review where theoretical or conceptual framework and empirical basis of the study is looked at. Chapter three is about the Methodology which describes the procedures that is adopted in conducting the research. Chapter four explains into detail results of the data gathered about the subject matter. It comprises the organization, description, analysis and interpretation of the results obtained. Finally, chapter five summarizes the study; conclude with recommendations and suggestions for further study by other researchers.

CHAPTER TWO

LITERATURE REVIEW

2.1 Health Financing in Africa

Guy and James (2005) refer to the report of WHO (2005) in describing the current situation of health financing in the WHO African Region and the key challenges confronting countries in the region. In accordance with World Health Report (2005), 44 nations of Africa uses less than 15% of their national budget annually on health; 50% of the total revenue spent on health in 24 countries are sourced from government; 29 governments spend below US$10 per person per year; prepaid health funding mechanisms shield only a small proportion of the populations in the Region; in 31 countries, private spending constitute over 40% of their total expenditure; whereas in 38 nations, direct out-of-pocket spending constitute over 50% of the private health expenditure.

Countries in Africa are challenged with a number of key issues including: 1) low rate of investment in health; 2) lower economic growth rates; 3) unavailability of comprehensive health financing polices and strategic plans; 4) extensive out-of-pocket payments; 5) limited financial access to health services; 6) limited coverage by health insurance; 7) unavailable social safety nets to protect the poor; 8) inefficiency in the use of resource ; 9) ineffective aid; and 10) weak mechanisms for coordinating partner support in the health sector (WHO, 2006).

In trying to address some of the challenges mentioned above, nations have been exploring various financing options, for example, taxes, health insurance for formal

sector employees, social health insurance, private health insurance, community-based health financing (CHF), and external donations.

In the opinion of Preker (2002), some of the financing mechanisms adopted by some nations are expanding government financing for social insurance, limiting the administration of chose wellbeing administrations, and enhancing the focusing of government spending on wellbeing needs of poor people. Wellbeing protection has risen as a component of the change drive in numerous nations, both as a method for increasing assets accessible and as a method for better connecting wellbeing interest to the procurement of administrations.

2.2 Health care financing in Ghana

Financing of health in Ghana has gone through a changeable history (MOH, 2004). Before the attainment of independence, out-of-pocket payment at various service points was predominately used to access to modern health care (Arhinful, 2003). Soon after Ghana gain independence, health services that was provided for the resident was "free" in public facilities. The financing of health care in the public sector was, therefore, exclusively through tax revenue. However, out-of-pocket fees at service points continuous to be used at the private sector health services. It became debatable to sustain this form of funding as the economy began to show signs of weakening and there were competing demands on the same source (MOH, 2004).

This was the circumstance until the administration then, presented the client charges for every therapeutic condition aside from certain predefined transmittable ailments in 1985. This was a piece of the auxiliary modification strategies and got to be known as

„cash and carry". The point of the 1985 client charges was to recoup no less than 15% of intermittent expense for quality enhancement (Agyepong & Adjei, 2008). According to MOH (2001), this aim was achieved. Also, there was improvement in supply of essential medicines and other healthcare products. However, in implementing the „cash and carry" system, there was a utilization problems which created financial obstacle for accessing health especially for the poor (MOH, 2004). In noting these problems related with out-of-pocket payment the government initiated the NHIS policy in 2001 to substitute "cash and carry''.

2.3 Overview of the National Health Insurance Scheme (NHIS) Policy

In line with the Ghana Poverty Reduction Strategy (GPRS), there was a strategy to provide accessible, reasonably priced, and health care of good quality to all Ghanaians particularly the poor and those people at risk (MOH, 2004). The out-of-pocket payment for healthcare popularly known as cash and carry" posed a financial barrier to health care access. Indeed it was projected that out of 18% of the population who required health care at any given time, only 20% of them were able to access it. That is about 80% of 18% of the populace requiring health service do not have the funds to pay out-of-pocket at the service point. This normally results in individuals not seeking health care on time, not complaining with treatment given, and consequently premature death (MOH, 2004).

The NHIS was created out based on philosophies of equity, quality care, risk equalization, solidarity, cross-subsidization, effectiveness of collecting premium, subscriber or community ownership, reinsurance, sustainability and partnership (MOH, 2004). Therefore, there are two main forms of health insurance in Ghana: the

social-type health insurance scheme which is made up of DMHISs and the Private Mutual Health Insurance Schemes, and the Private Commercial Health Insurance Schemes (MOH, 2004). According to the policy framework (MOH, 2004), it is obligatory for every resident of Ghana to enrol with a form of health insurance scheme. Every resident of Ghana shall pay according to their ability, so as to enjoy a package of health care covering over 95% of diseases found in Ghanaians. This is in light of equity solidarity, sense of belongingness and social responsibility in the building of a healthy and successful nation..

2.3.1 Financing Sources

The National Health Insurance Scheme is being financed mainly through taxation and contributions of registered members. Two and half percent is contributed by the formal sector (2.5%) from their Social Security and National Insurance Trust (SSNIT) contributions whiles GH¢7.20 is paid by the informal sector per annum. There is an inbuilt cross-subsidization mechanism in the contribution levels which allows the rich to pay more than the less fortunate, children's own paid by adult, the healthy cover for the sick and rural dwellers pay less than the urban dwellers (MOH, 2004).

Because of anticipated that teething issues related would antagonistic and hazard determination issues, and low salaries, the approach structure set up a store to give financing to sponsor the expense of giving social insurance administrations for members of DMHISs licensed under the Act 650. The fund tacitly subsidizes families by exempting children (under 18 years of age) whose parents fully pay their annual premium. A further aspect of exemption under the policy is entrenched in its approach

of generating funds, which is through a levy on consumption of goods and services that are believed to be patronized less often by the poor (NDPC PM&E, 2008).

The NHIS replaces out-of-pockets fees payment at the service point but not abolish cost recovery. This means that persons will still have to make payment for services consumed but it will be in a more compassionate manner as the individual does not have to bear the problem of health alone. This emphasises that it compulsory for every resident in Ghana to part of a health insurance scheme of his/her choice (MOH, 2004).

2.3.2 Leadership and Governance

In line with WHO health system framework for action (WHO, 2007), the NHIS has a regulatory body (NHIA) which provides leadership and governance function. The regulatory body oversees and guides the establishment of NHIS on a national scale. It is an act of parliament with an executive body that has the direct day to day responsibility of ensuring policy decisions taken by NHIA are implemented effectively and they are autonomous in nature. The NHIA reports through the Ministry of Health to the President of the Republic of Ghana. As part of the procedure of reporting to interested party, the NHIA ensures preparation of an annual report describing the state of the NHIS (MOH, 2004).

There are four units that assist the NHIA to effectively execute its leadership and governance functions, namely: 1) Administration, Management Support and Training, 2) Licensing and Accreditation, 3) Policy Planning, Monitoring and Evaluation, and 4) Fund Management and Investment (MOH, 2004). These units perform various

functions to make sure that the objective of government in introducing a National Health Insurance programme is achieved. Some of these functions are analysis and review of policy options and formulation of policies related to NHIS, regulating and licensing of all schemes in the country, seting of tariffs for payment to accredited providers giving accreditation to providers of health care, and financially analysing the state of the schemes. Others are monitoring and evaluating operations of all the schemes in the country, and providing funds to support DMHISs to cover the poor and vulnerable groups.

2.3.3 Information

The era and vital utilization of data, insight and exploration on wellbeing and heath frameworks are an indispensable piece of the initiative and administration capacity (WHO, 2007). A well-working health data framework is one that guarantees the creation, investigation, spread and utilization of solid and important wellbeing data framework, both on a regular basis and in emergencies.

In accordance with the NHIS policy framework, the NHIA has a policy, planning, monitoring and evaluation unit which is responsible for providing information on how the DMHIS are performing. There is a data management and research section which is responsible for receipt, compilation and data analyses on an agreed set of variables from all health insurance schemes which are operating in Ghana as part of the procedure of monitoring, harmonisation and assessment of their performance is in this unit. The data centre compiles national annual reports.

2.4 Implementation of the NHIS Policy

The policy is implemented through the Legislative Instrument, LI 1809 (Republic of Ghana, 2004), and the National Health Insurance Act, Act 650 (Republic of Ghana, 2003), NHIS was established with the point of expanding access to social insurance and to enhance the nature of essential human services administrations for all residents, particularly the poor and helpless (NDPC PM&E, 2008). It is imagined under the GPRS II that entrance to quality human services will enhance with the foundation of moderate social insurance financing framework, while making the essential environment for the accomplishment of the MDG 4 and 5 to be specific, the annihilation of destitution and yearning, the lessening in tyke and maternal mortality, and the fighting of HIV/AIDS, jungle fever and different illnesses.

According to the NHIS progress report for 2008, the total registered members have increased from 1,797,140 in 2005 to 12,518,560 as at end of 2008, representing 61.3% of the population (NDPC PM&E, 2008). Nevertheless, only about a third of these individuals are contributing financially to the scheme. This creates a problem of sustainability, in that funds is decoupled from membership growing. Additionally, the National Health Insurance Scheme offers a wide-ranging benefits package, inadequate gate-keeping, with no co-payments and also faces cost increase associated with its new system of payment and the growing level consumption by members. These features contributed to a growth in distressed schemes and failure to pay outstanding facility claims in 2008 (Witter & Garshong, 2009).

According to NHIS at their 10^{th} anniversary, they have 8.8 million active subscribers. 3500 health care providers both private and public providers and 85% of service

delivery income of private and public providers are from the National Health Insurance.

2.5 Key Performance Indicators

According to Churchill (2006), Health Insurance is regarded as a mechanism that the poor use in managing risk so as to compensate for the lack of appropriate state-sponsored social protection programmes. All health insurance programmes should aim at becoming financially sustainable since national subsidies or donors of funds are not permanent or unavailable. Short of these subsidies, they will be faced with the same economic and market forces as faced by any other businesses, which requires them to be professionally managed.

The objectives of management, however, are not attainable without continuous transparent measurement and monitoring of performance. Mutual health insurance schemes are restricted in which budgetary and social security administrations can be given and the dangers of wellbeing viably oversaw. It is thusly essential that the execution of wellbeing protection plans be painstakingly checked and assessed (Tabor, 2005).

2.5.1 Coverage Ratio

Garand and Wipf (2008) argue that coverage ratio is an indicator of marketing effectiveness and for a scheme to be sustainable in the long-term, coverage ratio is an important requirement. On a social basis, a high level of coverage is an indication of a wide acceptability of the programme, where scarce resources are readily pooled by members to seek some level of protection from risks.

It is a laudable idea to achieve a universal financial protection for health in a low-income country like Ghana, but challenging and technically difficult. There is no low-income country that has been able to achieve universal health insurance coverage. Thailand is the only lower middle-income country, that has been able to achieve universal coverage since 2001 using a big bang approach (Agyepong and Adjei,2008; Tangcharoensathien & Jongudomsuk, 2004), nations which are wealthier such as Canada, South Korea, Japan and those in Western Europe have been able to achieved universal coverage. They have done as such over the long as opposed to short term. Identified with wage, the structure of Ghana's economy, with numerous residents utilized in the casual area and living in rustic groups and residential communities with poor street access, information transfers and wellbeing administration access, is a noteworthy test.

2.5.2 Annual Revenue

Guy (2002) states that, it is very difficult to define an absolute income threshold below which it would be very hard for a social health insurance to progress. However, income growth will facilitate health insurance development. The emphasis of the study is that, the level of income of target population especially the informal sector group is an important determinant in payment of health insurance contributions. Thus, with more income, their ability to pay health insurance contributions also increases. Inconsistencies in the number of members also influence contribution revenue. The challenge for health insurance schemes is both to attract members and to retain them over long periods during which they consume no or few services (Dror, 2007).

2.5.3 Annual Expenditure

Evaluation studies of mutual health organizations conducted in the northern and southern

Ghana by Lem et al (2006) and Baku et al (2006) respectively concluded that a higher administrative expenditure brings about low efficiency. A scheme spending a higher percentage of income from premiums on administration than on medical bills (claims) is not financially sustainable. A study by Muiser (2007) also shows that administrative expenditure higher than 7% is indicative of administrative inefficiencies.

2.5.4 Promptness of Claims Settlements

The promptness of settling of claims is the time spent by the mutual health insurance scheme in resolving all issues that are concerned with the benefits incurred by the insured. According to the NHIS Act, Act 650 (Republic of Ghana, 2003), all claims are to be paid within four weeks upon receipt. To be able to promptly settle claims is an important feature of service value. Not paying claims on time weakens the worth of the NHIS and in certain circumstances it may even heighten the healthcare provider's circumstance and situation (Garand & Wipf, 2006).

2.5.5 Renewal Rate Ratio

The rate of renewal helps determine how satisfied the insured members are, and is an important indicator of the viability and sustainability of the scheme. (Lem et al, 2006). A very high rate such as 90% or more may signify that 1) the needs of the target population is well understood; 2) there is a general acceptability of the price by the

target population; 3) reasonable services are been rendered; and 4) the community value the benefit derived highly.

Garand & Wipf 2008, argues for the truth in the opposite that schemes with voluntary membership, poor claims payment, low renewal rate is often indicative of client dissatisfaction, possibly due to poor communication, unacceptable service value and so on.

2.5.6 Membership Growth Ratio

The growth ratio shows the growth of activity from one period to another. The trend of the growth is generally an essential determinant of how successful an activity is over period in question. The growth ratio indicator can be generalized under certain circumstances. For example, smaller and newer schemes will usually have higher growth ratio because of it lower base. Secondly, there will be a reduction in growth ratio over time as the membership rate approaches 100% (Garand & Wipf, 2008).

2.5.7 Expense Ratio

The expense ratio reflects how efficient the delivery of health insurance is to the people. The level of the expense ratio is an indication of efficiency in service delivery to the poor. The cost burden is reduced through efficient delivery, which will be as a result of a general satisfaction among the insured population. On the other hand, if the service quality is insufficient and lacks satisfaction, then there should be more investment in service improvement. When expense ratio is high it might also be reflecting that, Manager of the scheme may be enjoying high level salaries and great benefits whiles the poor suffer (ADA et al, 2009).

2.5.8 Claims Ratio

The ratio of claims is an indication of how valued is the NHIS programme to the members. For a sustainable programme, when the claims ratio is high it proves to consumers that they are receiving good value on the premiums paid. However when a ratio is too high, it might indicate the failure of the programme, eventually causing reduced value and social protection to the insured. When the claims ratio is very low it could be seen as exploiting clients situation; though, this is dependent on the kind of programme and conditions (ADA et al (2009).

According to Garand and Wipf (2008), the claims ratio for health insurance will generally rise if the medical services are inflated or there is a increase in level of awareness and consumption. To decrease a heightening cases proportion may oblige activities, for example, changing the advantage structure, presenting co-installments, presenting holding up periods, or forcing sub-limits on specific methodology.

CHAPTER THREE

METHODOLOGY AND ORGAINSATIONAL PROFILE

3.1 Introduction

The rationale of this study is to analyze and appraise household perception on enrolment of the National Health Insurance in the Ghana and more specifically, at the Sekyere South District in the Ashanti Region. To demonstrate the theoretical understanding to the topic in study, literature review was conducted prior to the design of the research. In an attempt to achieve the research objectives, data sources both primary and secondary data were gathered through administration of questionnaires, interviews and documentary analysis. It also provided information on how individuals perceive National Health Insurance and the care they are given when they attend hospital.

3.2. Population Distribution

The district has a projected population of 117,568 at the beginning of the year 2012. There are 48 towns and villages in the district. The District has been divided into 4 Sub-districts namely Agona, Kona, Jamasi, and Wiamoase. The NHIS office is situated at Agona the district capital. There are ten (10) health facilities in the District; five (5) government/public facilities, five (5) mission facilities.

3.3 Design of the Study

The study is designed in such a way to evaluate the various perceptions of households towards National Health Insurance in Ghana and its actual influence on enrolment on the scheme, particularly within the Sekyere South District. To achieve this purpose both interview and questionnaires is used to obtain the necessary information to assist

in the analysis and draw conclusions. Information obtained from the questionnaires and interviews are qualitative in nature. To avoid bias, both open ended and close ended questions are asked in using both techniques of unstructured interview and questionnaires. Close ended questions are those inquiries, which can be addressed limitedly by either "yes" or "no." Also known as dichotomous or immersed sort inquiries, close ended questions can incorporate assuming, examining, or driving inquiries. By definition, these inquiries are prohibitive and can be replied in a couple words.

Shut finished inquiries farthest point respondents' responses to the study. Along these lines respondents are permitted to look over prior arrangement of dichotomous answers, for example, yes/no or various decisions with a possibility for "other" to be filled in.

The study chooses to use closed-ended questions as they are more easily analysed. Every answer is given a number or value which allowed for the assessment of statistical interpretation. The study used computer analysis which is better allowed by closed-ended type of questioning. In the event that open-ended questions are to be investigated quantitatively, the subjective data is lessened to coding and answers have a tendency to lose some of their introductory significance. As a result of the straightforwardness of shut finished inquiries, this sort of misfortune is not an issue. Additionally shut finished inquiries can be more particular, hence more inclined to impart comparative implications. Since open-ended questions permit respondents to utilize their own words, it is hard to analyze the implications of the reactions. It took

less time to administer the questionnaires from respondents, response rate were also higher and so it was much less expensive method of survey.

An open-ended question is aimed to encourage the respondent to give meaningful answer using their knowledge or feelings whereas a closed-ended question encourages a single-word or short answer.

This kind of questioning did not give respondents answers to choose from, but rather are phrased so that the respondents are encouraged to explain their answers and reactions to the question with a sentence or a paragraph. Though open-ended questions can be time consuming, it develops trust, is perceived as less threatening, allows an unrestrained or free response, and may be more useful with articulate users. Open-ended questions allowed respondents to include more information to the subject. The study was able to better access the respondents' feelings and understanding of issues related to the subject matter. It allowed respondents the opportunity to express diverse opinions on the issues discussed as the questions asked offered them the chance to express themselves satisfactorily.

Because open-ended questions are used, it allowed the study to obtain extra information such as demographic information (current employment, age, gender, etc.), from respondents, the study can be used more readily for secondary analysis by other researchers.

3.4 Research Sample

In all, research population size is made up of five hundred (500) households; one hundred and fifty (150) each from Agona and Wiamoase households because they have larger population and one hundred each from Kona and Jamasi,

The sample is chosen because if the sample size is too small, the study is not going to be a true representative sample of the population as a whole. If the sample is too large, the information obtained will be unwieldy and the research will become very expensive as more time and resources will be needed.

The main objective in developing the sampling plans is to obtain unbiased samples that are representative of the entire populations of interest.

The research is also aware of differences that exist among various cultural groups. Additional demographic characteristics that were considered when designing the sampling plans are the age, gender, education backgrounds, and socioeconomic levels of the population.

3.5 Research Instrument

Both questionnaires and interviews are employed to gather data for the study. In administering questionnaires for the community folks, data was collected on sex, age, occupation, education, religion, perceive health status and perceptions. A seven-point Likert Scale ranging from ‘1=absolutely disagree’ to ‘7=completely agree’ are used by respondent to express their opinions on statements related to providers’ quality of care.

3.6 Sampling and Sampling Procedure

Both purposive and stratified random samplings are used for the study. The purposive is used because it allows the use of judgment to select cases that will best enable you to answer your question(s) and to meet your objectives (Saunders et al., 2007). This form of sampling is often used when working with very small samples such as in case study research and when you wish to select cases that are particularly informative (Neuman, 2000). Stratified random sampling is used to obtain data from individuals in the community. The stratification achieved greater precision because members chosen from the strata are with similar characteristics of interest.

3.7 Method of Data Analysis

In order to assess the impact of household perception on enrolment of NHIS and how it affect the individual retention rate with the scheme particularly in the Sekyere South District. Primary data in the form of questionnaires are subjected to detailed analysis. Data gathered by the questionnaires are qualitative in nature.

The various perceptions of individual households and their impact on enrolment is statistically analysed with the aid of SPSS.

Also measurement tools of validity and reliability are used to determine how stable, dependable, trustworthy and consistent the information gathered from respondents is. The validity of the information is measured to determine whether information gathered from the respondents actually bring out clearly the purpose of the study based on the representativeness of the sample. Inferences about responses from all the respondents are dependent upon the representativeness of information gathered from these people.

The reliability of the data gathered is measured by comparing responses from all the respondents as they are consistent for conclusions to be drawn. People that are chosen randomly from the district are also grouped and so they are of different backgrounds which proved a true representation of the population of the study. This is also a measure of reliability of the information provided in responding to questions of the study for analysis and conclusions.

3.8. The Background of Sekyere South District

The Sekyere South District is one of the Thirty 30 districts of the Ashanti Region. The district is located in the north – eastern part of the Ashanti Region. The district shares boundaries with four districts. In the south by Kwabre, north by Mampong Municipal, east by Sekyere East and west by Afigya Kwabre districts respectively.

Agona, the District Capital, and also the seat of the District Administration is 34 kilometres from Kumasi on the Kumasi – Mampong trunk road. Agona also seats the shrine of the famous Okomfo Anokye (conjuror of the famous Ashanti Golden stool).

The predominant tribe is Ashanti, with other minors especially from northern Ghana.

The vegetation is partly forest and savannah. There are two forest reserves namely the Offin Forest Reserve and Gye Anoma Forest Reserve. The River Offin meanders across the length and breadth of the district. Notably the district can boast of cocoa, timber and other crops like maize, cassava, plantain, oranges, and vegetables.

It is also worthy of note that majority of the inhabitants are peasant farmers with very low income.

Some of the important tourist attractions in the district are

- The famous Okomfo Anokye shrine at Agona.
- Kente weaving and craft carvings at Kona, Jamasi, and Bepoase.

Some of the major endemic diseases are Malaria, HIV/AIDS, Yaws, Onchocerciasis, Schistosomiasis and intestinal worms.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS

4.1 Introduction

This chapter presents the information on the data collected from the respondents on the household perceptions and their implications for enrolment in the National Health Insurance Scheme in Ghana, case study of Sekyere South District. The chapter presented the findings base on the objectives set for the study. The study explored demography of the respondents, understanding of national health insurance, perception factors, service delivery adequacy, benefit of NHIS, convenience of NHIS, price of NHIS, provider's attitude and peer pressure and the effect of perception factors on the sustainability of NHIS in Ghana. The data was presented in tables, and other statistical tools. The survey was conducted on a total of five hundred (500) out of which four hundred and sixty-four (464) responses were received representing 92.8% response rate.

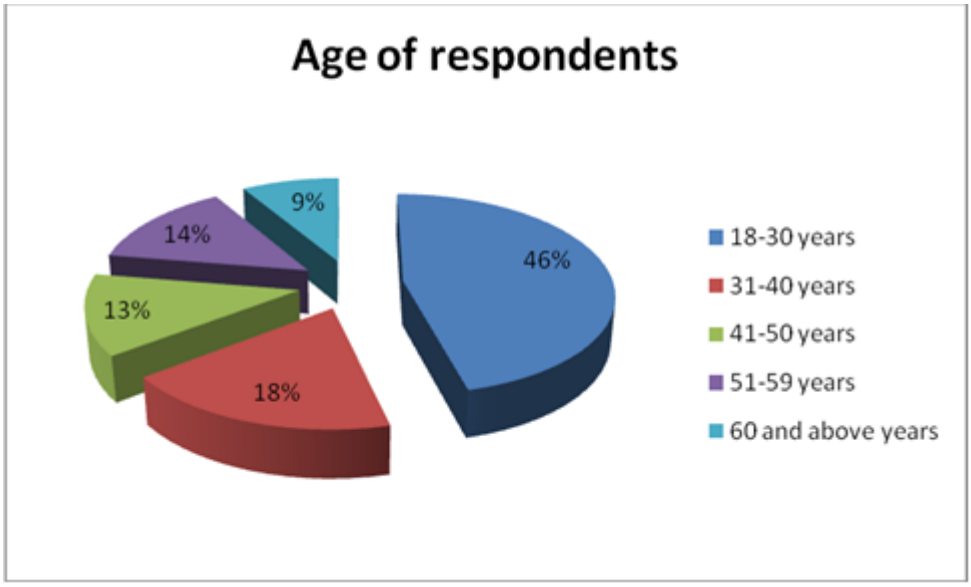
4.2 Demography of respondents

The study discusses background information about respondent's gender, age educational level, marital status and number of total number of years of schooling, occupation and home ownership of enrolling with NHIS.

4.2.1 Age of respondents

The age distribution reveals distributed respondents. 214 respondents are between the ages of 18-30 years, 86 respondents between the ages of 31-40 years, 60 of them are between 41-50 years, 64 of them are between 51-59 years whiles 40 of them are 60 and above years. This information is presented in figure 4.2 below.

Figure 4.1 Age of respondents

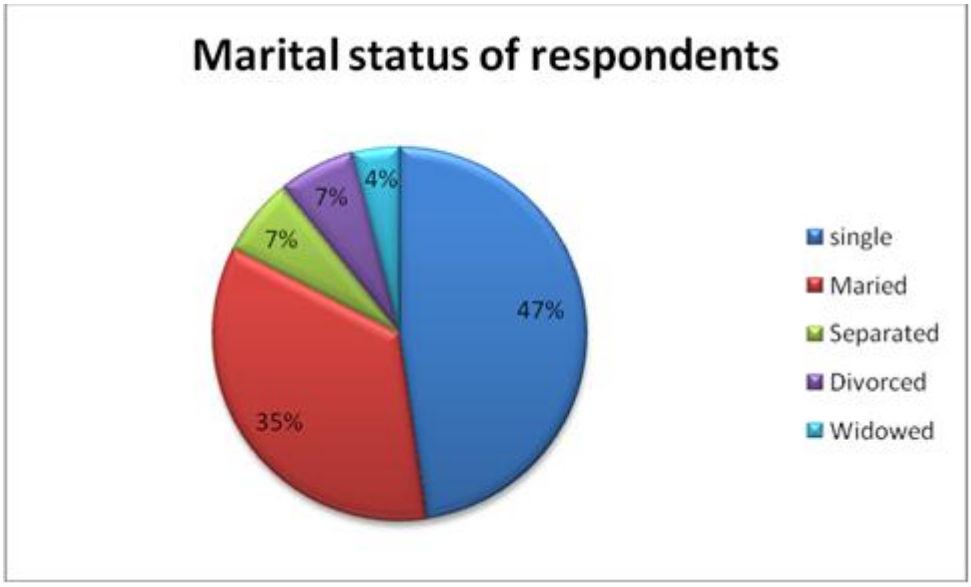


Source: Researchers field work, 2015

4.2.2 Marital status of respondents

The survey is conducted on a total of 464 respondents at Sekyere District in Ashanti region. The marital status of respondents reveals 221 of them are single, 162 are married,3 1 of the respondents separated and divorced respectively, whiles 19 of them are widowed which gives a summed total of 464 respondents and a 100 percent valid percent. This information is represented on figure 4.2 below.

Figure 4.2 Marital status of respondents

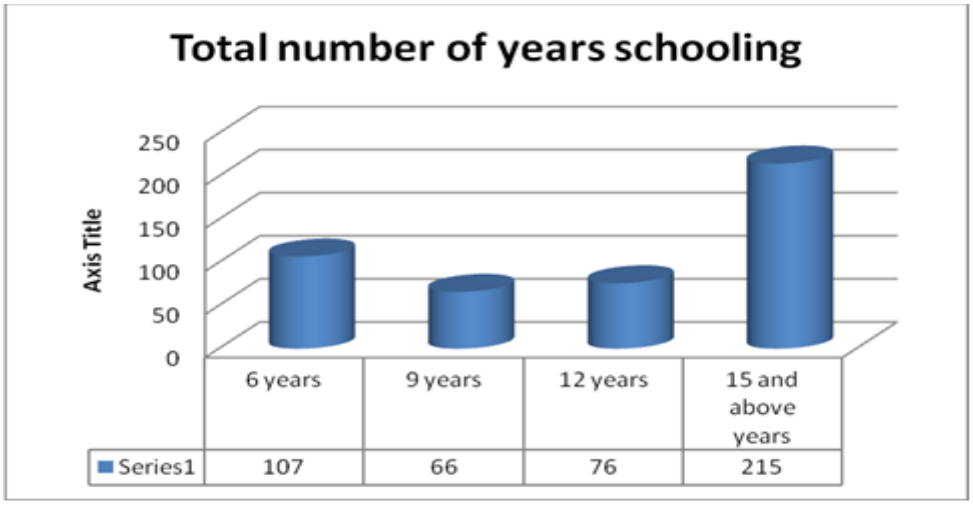


Source: Researchers field work, 2015

4.2.3 Total Number of years of Schooling

The study also wants to assess the total number of years schooling of respondents at Sekyere south district. Findings reveals 107 respondents schooled for 6years, 66 of them attended school for 9years, 76 of them 12years whiles 15 and above the total number of years schooling is 215 representing the highest figure and a highest percentage figure of 46.3%. This implies that the greater percentage of respondents spent high number of years in schooling. The number of years of schooling is presented in figure 4.3 below

Figure 4.3 Total number of years schooling

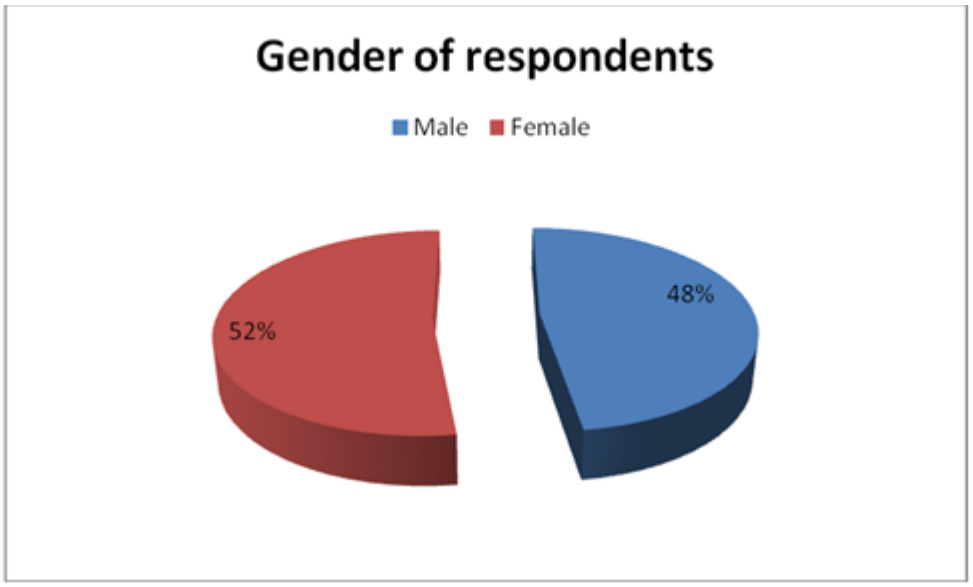


Source: Researchers field work, 2015

4.2.4 Gender of respondents

The study is conducted on a total of 464 respondents out of which 242 respondents representing 52% were female and 222 representing 48% were males. This information is presented in figure 4.4 below.

Figure 4.4: Gender of respondents



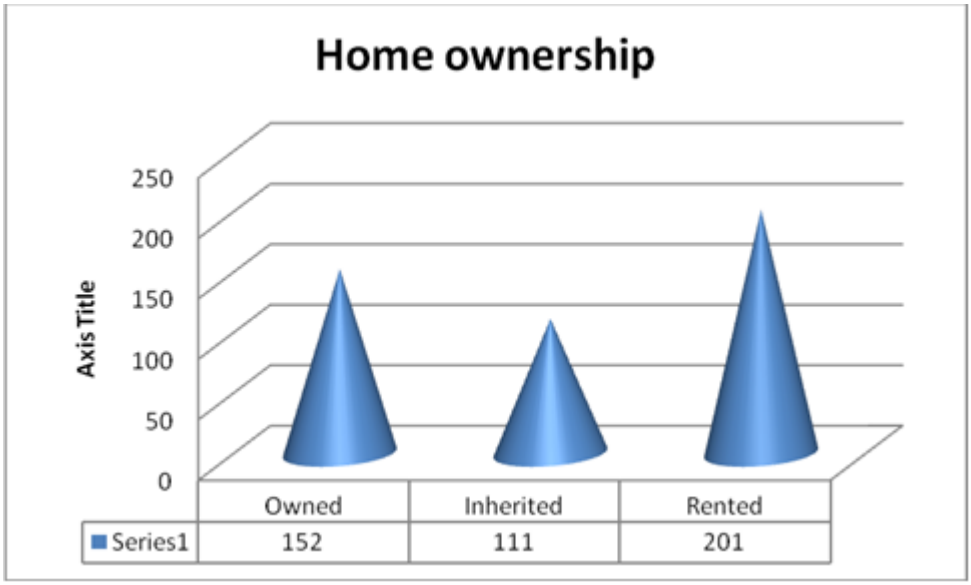
Source: Researchers field work, 2015

4.2.5 Home ownership of respondents

The survey wants to assess the home ownership of respondents as to whether they own the

House, inherited it or it is rented. The study reveals that 152 of the respondents owned their home, 111 of them inherited the home whiles 201 of them representing the highest number is through renting with the highest percentage rate of 43.3%. This information is represented in figure 4.5 below

Figure 4.5: Home ownership of respondents



Source: Researchers field work, 2015

4.3 Compare perceptions of insured households in Sekyere south district on health care being provided.

To compare perception of NHIS beneficiaries in the Sekyere south district on health care being provided, technical quality of health care, service delivery adequacy, convenience of NHIS, price of NHIS, provider's attitude and benefit of NHIS were compared. These are discussed below:

4.3.1 Perception of Technical Quality of Care

With respect to the perception of NHIS insured households, treatment provided for recovery and cure, drugs supply, diagnosis, clinical examination and accessibility are assessed by insured households. Table 4.1 shows the mean and standard deviation for the variables used to assess perception of technical quality of care on a scale of 1-7 of absolutely disagree to completely agree.

Table 4.1 Perception of Technical Quality of Care

Technical Quality of care	Mean	standard deviation	Percentages	Frequency
Effective treatment recovery and cure	3.72	1.887	53.1	464
Supplying quality drugs	3.72	2.011	52.6	464
Good diagnosis	4.2	1.797	47.4	464
Clinical examination by doctors are high	4.3	1.8	61.4	464
Immediate access to health care	4.03	1.881	57.5	464
The service providers are good	4.1	1.818	58.1	464
There are enough Doctors for women	3.97	1.947	41.5	464
NHIS help saves money	4.89	1.863	69.8	464

Source: Researchers field work, 2015

The survey conducted in the table above wants to critically assess the technical quality of health care provided by NHIS at Sekyere south district. The credibility of the quality of care provided in relation to health care system is a decisive factor in the way insured households are perceiving health insurance in the district. From the table 4.1 above, 3.72 of the respondents which represent a percentage rate of 53.1% believed that the treatment provided by NHIS in the district is effective for recovery and cure. The reasons for this perception may be attributed to several reasons, and paramount among these reasons is the fact that doctors allow patients to conduct lab before any possible treatment is affected. The perception that low quality drugs are

given to patients when using NHIS cards is proven wrong in the district since quality drugs are given to them upon a prescription given by doctors. 53.1% of the insured households also believed that they receive equal treatment and cure even with all manner of sickness without any exemption. Whiles the remaining 46.9% of the insured households also perceived that the treatment provided by NHIS in the district is not effective for recovery and cure since doctor to patients' ratio in the district is poor, facilities in the district is inadequate and mistrust of confident in the scheme.

With respect to whether drugs supplied by NHIS are of quality, a mean of 3.68 of the insured households which constitute a percentage rate of 52.6% attest to the fact that the drugs supply by NHIS in the district are of quality based on the satisfaction the respondents obtained from the drugs used. Again, according to the respondents the drugs are of quality because of the storage facilities available in the district to keep the drugs from possible damage. On the contrary, 47.4% of the insured households have a different opinion about the quality of the drugs. This according to them is as a result of inefficacy of the drug in most cases, low standard drugs supply to the district and also in most cases patients are given prescription to buy their own drugs outside the hospital.

Again the study wants to find out whether the diagnosis that is given by providers is good. The result indicated that a mean of 4.20 of insured households with a percentage rate of 59.9% perceived that diagnoses given by providers are good. This is as a result of services provided by quality doctors, quality drugs prescribed to patients and frequent health education carried out in the district. Research is conducted on whether clinical examination by doctors in the district is of high quality,

and result indicated that 4.30 of the insured households with a percentage rate of 61.40% maintained that clinical examination by doctors are of high quality. According to the insured households, qualify lab technicians are in Sekyere district hospitals that conduct various lab test before treatments is carry out. Another reason assigned to this is availability and quality lab equipment. But the remaining 38.6% of the insured households perceived that clinical examination by doctors in the district are of high quality by disputing the reasons stated above. The research was also conducted as to whether respondents get immediate access care when needed, and it was revealed that 4.03 of the insured households which constitute 57.5% pointed out that they get immediate assess care when needed because hospitals and clinics are available in the district to assess health care, doctors and nurses are always available and accessible to deliver services to patients if the need arise. But 42.5% of the respondents disagree with the reasons that assessing health care in terms of transportation to health centers is a major challenge to them. Again insured households argued that the health workers at the district hospitals close too early and this deny others of assessing health care.

4.3.2 Perception of Service Delivery Adequacy

With respect to the perception of service delivery adequacy of NHIS insured households, the excellent nature of service providers and adequacy of doctors are assessed by insured households. Table 4.2 shows the mean and standard deviation for the variables used to assess perception of service delivery adequacy on a scale of 1-7 of absolutely disagree to completely agree.

Table 4.2 Service delivery adequacy

Service delivery adequacy	Mean	Std. Deviation	Percentages	N
The service providers are good	4.10	1.818	58.5	464
There are enough Doctors for women	3.97	1.947	41.5	464

Source: Researchers field work, 2015

The study is conducted in Sekyere district to ascertain the service delivery adequacy, and it was pointed out that 4.10 of the insured households with a percentage rate of 58.5% agreed with the perception that service providers in the district are good based on their interpersonal relations with the patients and co-workers, professionally service providers are good and competent. Meanwhile, 41.5% of the insured households perceive otherwise and this is partly because the services received from the NHIS officials in the district did not meet their expectation and also in most cases service providers engage in discrimination or favoritism.

The perception as to whether there are enough doctors for women, it was found out that 56.7% of the insured households agreed and this is partly because, a significant number of doctors are assigned on daily bases to give needed attention to women especially in maternity wards. Again, women with special medical problems are given priorities to have a special doctor with the needed expertise to attend to them when it becomes necessary. Whiles the remaining 43.3% of the insured households also disagree with the above assertion and pointed out that even if there are enough doctors. This implies that both the officials and the doctors are not performing their duties diligently to prove that there are enough doctors for women.

4.3.3 Perception about the Benefit of NHIS

With respect to the perception of NHIS insured households about the benefit of the scheme, cost saving is assessed by insured households. Table 4.3 shows the mean and standard deviation for the variables used to assess perception of benefit of NHIS on a scale of 1-7 of absolutely disagree to completely agree.

The research is further conducted to know the benefit of NHIS to insured households in the district and it is found out that 4.89 of the insured households which constitute 69.8% perceive NHIS as helping to save money. Because the insured households spent a small fraction of their income in renewing their health insurance cards in assessing health care delivery. Again with the help of NHIS, insured households explains that their hospital bill has reduced drastically and the renewal is done yearly which according to them help saves money. Whiles 30.2% of the respondents think otherwise and perceive they rather spend money in renewing the cards, they spend money in buying most of the drugs even with the NHIS cards. Some argue strongly that though cards are been renewed, most of them did not use the cards in attending hospitals hence consider it waste of money. Nevertheless, premium received by the NHIS officials helps save substantial money in aid of prompt settlement of claims. The scheme's ability to Pay claims promptly is an important feature of good value and service and not paying claims timely diminishes the value of the NHIS in some cases may even worsen the healthcare provider's situation and conditions (Garand & Wipf, 2006).

4.3.4 Perception of convenience with NHIS

With respect to the perception of NHIS insured households about convenience with NHIS, location of District Mutual Health Insurance Scheme, operating hours, production and insurance cards are assessed by insured households. Table 4.4 shows the mean and standard deviation for the variables used to assess perception of convenience with NHIS on a scale of 1-7 of absolutely disagree to completely agree.

Table 4.3 Convenience of NHIS

Convenience	Mean	Standard Deviation	Percentages	Frequency
Convenient location of the NHIS office	4.41	1.776	62.97	464
Convenient opening hours	4.23	1.976	60.4	464
collection of insurance card is convenient	3.39	2.097	39.6	464

Source: Researchers field work, 2015

The study is conducted to ascertain the convenience of NHIS in finding whether the office of district mutual health insurance scheme is convenient to the insured households. Findings reveal that 4.41 of insured households which constitute 62.97% with a standard deviation of 1.776 suggested that the office of district mutual health insurance scheme is actually convenient to them. This is because most of the insured households can conveniently access the office of the NHIS with ease without any struggle and the location is situated at where each single individual can visit at any point in time. The remaining 37.03% of the insured households also think otherwise.

With convenient of NHIS with respect to opening hours, a mean of 4.23 of the insured households with a percentage rate of 60.4% perceive that the district scheme office opening hours which start from 8am-5pm is convenient to them. This is because it enables the insured households to visit there at any time it pleases them, Due to the long period of opening hours, it help reduce long queue awaiting to be attended to thereby reducing pressure on the workers and the insured households as well. Again the extended hours assist the workers at the various offices to work effectively and efficiently since they work under less pressure. But the remaining 39.6% of the respondents hold the view that the office opening hours is not convenient to them especially during weekends. Again they hold the view that due to the long hours of operation, workers in the various offices in the district work at a slow pace which leads to low productivity in the long run.

The research conducted on whether the production and collection of insurance card is convenient, it was found out that 3.39 of the insured households which constitute a percentage rate of 48.4% came out with the view that both production and collection of NHIS cards convenient to them. Reasons assigned to this include, prompt and timely delivery of the cards after been processed, renewals of the cards after expiry is done with urgency and needed attention to meet insured households requirements. The rate of renewal helps determine how satisfied the insured members are, and is an important indicator of the viability and sustainability of the scheme (Lem et al, 2006). If the renewal rate is as high as 90% or more, it may suggest that the needs of the target population is well understood, reasonable services are been rendered and the benefit is highly valued by the people in the Sekyere district. Again, NHIS agents are allowed to distribute the processed cards to the beneficiaries. But 51.6% of the

respondents revealed that, production and collection of NHIS cards are not convenient to them and this is because majority of the respondents either receive their cards late or have their cards missing due to administrative lapses. Officials of NHIS in the district usually engage in petty politics in production and distribution of cards to the respondents since the policy is a government initiative and intend to work in the interest of sympathizers of the government. When schemes have low rate of renewal, voluntary participation it is often sign of dissatisfaction by client, which is possibly because of poor communication, unsatisfactory claims payment unacceptable service value (Garand & Wipf, 2008).

4.3.5 Perception about Premium of NHIS

A research is conducted on whether the premium charge is too high for the insured households and it was revealed that 3.59 of the insured households which constitute 51.27% actually agreed that the premium charge is too high for them. Hence in the opinion of Preker (2002), suggested that some of the financing mechanisms adopted by several countries are increasing government funding for health care, localizing the management of selected health services, and targeting of government spending on health needs of the poor. This is because it is usually done on yearly bases and according to them the interval is too short. Again, the premium charged on infant or children is also too high for them. Due to expected teething problems related to adverse and risk selection issues, and low incomes, the policy framework established a fund to provide financing to subsidize the cost of providing health care services for members of DMHISs licensed under the Act 50.

However, the remaining 48.73% have a different view on the premium charge and according to insured households; the premium charge is too small to keep the insurance scheme in full operation and active. The 48.73% of the respondents again believe that the premium charge is too small because the insurance officials will find it difficult to pay claims to service providers. This argument was supported by the fact that, in implementing the "cash and carry" it was compounded with consumption problems by creating financial obstacle to health care access especially for the poor (MOH, 2004). Hence the government noting the problems associated with the "cash and carry" system initiated the NHIS policy in 2003 to replaces this out-of- pocket payment at point of service for health care.

4.3.6 Perception about Providers attitude

The research is further conducted to ascertain as to whether the attitude of health staff improve and it was revealed that 4.20 of the insured households with a percent rate of 59.97% of the insured households in the district actually agreed that attitude of health staff really improved. This is because health staff workers now have a cordial and working relation with the respondents in the district and also, health staff workers now work with so much passion devoid of laziness and lukewarm attitude. However, 40.03% of the insured households still hold the view that the attitude of health workers in terms of responds to complain launched by insured households, lateness to work and personal dedication to work by staff is truly not encouraging to help in improve the NHIS in the district.

4.4 Associated enrolment factors with NHIS at Sekyere South District Health Insurance Scheme

Drug availability to cure sickness is a factor that encourages enrolment in the NHIS at Sekyere South district health care. The study recorded a mean of 5.33 on a scale of 1 to 7 of the insured households with a percentage of 76.1% overwhelmingly confirm that indeed there should be more drugs to client in the district. Various reasons were assigned to this and among such reasons include the fact that availability of drugs inject more confidence and trust in the scheme, it also increase the patronage of the scheme in the district and last but not the least, it assist the insured households to buy a specific drug at any point in time without any difficulties. But the remaining 23.9% of the respondents hold a different view. And insured households also believe that when drugs are available in the district, majority will take advantage of that and misuse the system.

Community leaders also influence people to enroll on the NHIS at Sekyere South District health care influence. Research was further conducted to know whether the community leaders influence the decision of the insured households in the district and it was found out that 1.58 of the insured households which constitute 22.56% of the insured households agreed that the community leaders influence their decision because they feel reluctant in visiting the NHIS office in the district. Some of the insured households did not see the benefit of the scheme since according to them they still pay for the drugs given to them, besides quality drugs are usually prescribe to them to go and buy instead of the hospital paying for them. The 22.56% of the insured households believed that their enrolment was influence by the community leaders. Whiles the highest percentage of 77.44% believed that their decision was not

influence by the community leaders because they know the health benefit of NHIS, it shows patriotism and moreover it is their civic responsibility.

4.5 To assess the effect of perception factors on NHIS sustainability in Sekyere south district.

In assessing the effect of perception factors on NHIS, the study adopted regression analysis to assess the impact of independent variables on the dependent variable. The independent variables used include technical quality of care, service delivery adequacy, convenience of NHIS, price of NHIS, provider's attitude and benefit of NHIS. The dependent variable employed was sustainability of NHIS. The table below shows the summary of regression output.

Table 4.4 Regression Results

	Unstandardized coefficients. B (S.E)	T	Sig.	Beta
(Constant)	1.466 (.117	12.506	.000	
Technical Quality of Care	-.038 (.023)	-1.653	.0.99	.094
Service Delivery Adequacy	.015 (.019)	.831	.406	.045
Convenience of NHIS	-.037 (.021)	-.782	.075	.089
Price of NHIS	.016(.021)	.766	.444	.037
Providers Attitude	.022 (.017)	1.335	. .183	.066
Benefit of NHIS	-032 (.013)	-.121	.016	.121
R	.196			
R Sq.	.039			
Adj. R. Sq.	.026			
F Statistic	3.039***			

Source: Authors (2014)

From the analysis above, it was realized that perception factors of NHIS had a weak relationship with sustainability with NHIS. The correlation or relationship value was 0.196 (when the correlation value falls under 0.3 it is considered a weak relationship). The R2 value indicates that 3.9% (.039) of sustainability of NHIS (dependent variable) could be explained using the independent variables (perception factors).

The analysis indicates that, the coefficient value for technical quality of care is -.038 showing a negative or inverse relationship to sustainability of NHIS. This means that all things been equal when the other independent variables (service delivery adequacy, benefit of NHIS, convenience of NHIS, price of NHIS and provider's attitude) are held constant, sustainability of NHIS would decrease by 3.8% if there is 100% technical quality of care delivered by NHIS. Technical quality of care was statistically not significant and the variable is not making any unique contribution to the prediction of sustainable NHIS because it has a significant value of 0.099 which is greater than 0.05.

This analysis indicates that the coefficient value for service delivery adequacy is .015 showing a positive relationship to sustainability of NHIS. All things being equal when the other independent variables (technical quality of care, benefit of NHIS, convenience of NHIS ,price of NHIS, provider's attitude) are held constant, sustainability of NHIS would increase by 1.5% if there is 100% service delivery adequacy delivered by NHIS. Service delivery adequacy was statistically not significant and the variable is not making a unique contribution to the prediction of sustainable NHIS because it has a significant value of 0.406 which is greater than 0.05.

The analysis indicates that the coefficient value for convenience of NHIS is -037 showing negative or inverse relationship to sustainability of NHIS. This implies that ceteris paribus when the other independent variables (technical quality of care, service delivery adequacy, price of NHIS, provider's attitude, benefit of NHIS) are held constant, sustainability of NHIS would decrease by 3.7% if there is 100% convenience of NHIS by national health insurance schemes' convenience was statistically not significant and the variable is not making any unique contribution to the prediction of sustainable NHIS because it has a significant value of 0.075(.075.>.05)

This analysis indicated that the coefficient value for price of NHIS is .016 showing a positive relationship to sustainability of NHIS. This means that all things been equal when the other independent variables (technical quality of care, service delivery adequacy, provider's attitude, benefit of NHIS) are held constant, sustainability of NHIS would decrease by 1.6% if there is 100% price of NHIS by national health insurance schemes' price of NHIS was statistically not significant and the variable is not making any unique contribution to the prediction of sustainable NHIS because it has a significant value of 0.444 (.444>.05)

The analysis indicates that the coefficient value for provider's attitude is .022 showing a positive relationship to sustainability of NHIS. This means that all things been equal when the other dependent variables (technical quality of care, service delivery adequacy, price of NHIS, benefit of NHIS) are held constant, sustainability of NHIS would increase by 2.2% if there is 100% provider's attitude delivered by NHIS. Provider's attitude is statistically not significant and the variable is not making any

unique contribution to the prediction of sustainable NHIS because it has significant value of 0.183(.0183>.05).

The analysis indicates that the coefficient value for benefit of NHIS is -.032 showing a negative or inverse relationship to sustainability of NHIS. This means that all things been equal when the other dependent variables (technical quality of care, service delivery adequacy, price of NHIS, provider's attitude) are held constant, sustainability of NHIS will increase by 3.2% if there is 100% benefit of NHIS delivered NHIS. However benefit of NHIS was statistically significant and the variable is making a unique contribution to the prediction of sustainable NHIS because it has significant value of 0.016 which is less than 0.05.

In comparing the contribution of each independent variable (technical quality of care, service delivery adequacy, convenience of NHIS, provider's attitude, price of NHIS, benefit of NHIS) on sustainability of NHIS, the beta values are used ignoring the negative sign. Technical quality of care, service delivery adequacy, convenience of NHIS, provider's attitude, price of NHIS and benefit of NHIS have beta values of .094, .045,.089,.037,.066,.121 respectively . In this case, the largest beta value is .121, which is benefit of NHIS meaning that this variable makes the strongest contribution to explaining the dependent variable (sustainability of NHIS) when the variance explained all other variables in the model is controlled for.

CHAPTER FIVE

SUMMARY OF FINDINGS, RECOMMENDATIONS AND CONCLUSION

5.1 Introduction

In this chapter, the study explored the summary of findings, recommendations that are stated based on the study and conclusion of the study. The summary of findings is captured under objectives which are stated below.

5.2.1 Perceptions of insured household in Sekyere south district on health provided on NHIS.

It can be explained that, insured household in Sekyere district point to the fact that, the treatment provided by NHIS in the district is effective for recovery and cure of sicknesses. And this is because, trained and qualified doctors are posted to district and patients are allowed to conduct lab before receiving treatment. But there are few challenges which include inadequate number of doctors in the district, lack of modern medical infrastructure, mistrust and lack of confidence in the scheme through attitude of some service providers. The overall perception of insured household in the district is that health care delivery in the district is good, the available doctors and health workers are qualified and exhibit high standard of professionalism. There is a total improvement in the attitude of health staff workers towards the people in the district through cordial and interpersonal relations that exist between them. Drugs are also available for insured household upon receiving of treatment and on premium majority of the household perceived that the premium charge is moderate and considerate.

5.2.2 To determine the factors associated with enrolment with NHIS at Sekyere South District Health care

The research emphasized on factors such as quality treatment provided by NHIS, quality drugs supplied by NHIS, good diagnosis are given by providers through clinical examination by doctors. Service providers are good and render quality services to the people in the district, the people in the community get immediate access care when needed and there are also enough doctors for all categories of people especially women. Also the location of district mutual health insurance scheme is convenient hence serving as enrolment factor. The insured household in the district shows much interest and involvement in the enrolment process of the NHIS in that a significant number of renewals and growth rate of the scheme was recorded. The community leaders in the Sekyere south district shows high level of involvement by influencing a percentage of respondents in the district to enroll in the national health insurance scheme since a substantial number of respondents did value the scheme and did not see its benefit. In determining the renewal rate of the people in the district, it was noted that the renewal rate is high since the premium charge for renewal and processing is low and majority of the respondents can afford it, and cards are often done with urgency and needed attention after expiry. And since new registration and renewals of cards keep increasing, automatically the growth rate of the scheme also attains a significant growth. The trend of the growth is usually an important determinant of the success of the activity over the period.

5.2.3 To ascertain the effect of perception factors on sustainability of NHIS

Perception factors of NHIS had a weak relationship with sustainability with NHIS. The correlation or relationship value was 0.196 and 3.9% of sustainability of NHIS

could be explained using the perception factors. Technical quality of care has an inverse relationship to sustainability of NHIS and it was not statistically significant. Service delivery adequacy has a positive relationship to sustainability of NHIS and it was not statistically significant. Value for price of NHIS shows a positive relationship to sustainability of NHIS and it was not statistically significant. Provider's attitude shows a positive relationship to sustainability of NHIS and it was not statistically significant. Benefit of NHIS shows an inverse relationship to sustainability of NHIS and it was statistically significant. Benefit of NHIS makes the strongest contribution to explaining to the sustainability of NHIS when the variance explained all other variables in the model are controlled for.

5.3 Conclusion

Looking critically at the findings of the study, National health insurance scheme in the Sekyere south district is of immense benefit to the populace since it has replaced the old system of cash and carry system and helps alleviate the plight of the poor. National health insurance has received an overwhelming endorsement from the people of Sekyere south district and the general public at large for its immense contribution in accessing health care delivery. The ability of the scheme in assisting the general public to access health care is of significant important. The purpose of the study was to assess the effect of perceptions factors on NHIS sustainability and there is also a strong desire of the people of Sekyere south district to support the activities of NHIS because it helps improve their health condition in the district. There is therefore the need for the Health insurance stakeholders to help maintain the scheme.

5.4 Recommendations

The following recommendations worth considering

One important recommendation is that the opinion leaders in the district should embark on intensive education or public awareness of the health benefit of the NHIS. From the analysis it was revealed that most of the respondents are ignorant about the health benefit of NHIS hence their reluctant to enroll with the scheme.

On the issue of convenience, the production and collection of NHIS cards should be done with ease without the people in the district going through hustling and pains before receiving their cards.

There should be constant training for workers so as to bear with patients. It is further recommended that since the analysis indicated that the attitude of health workers has improved, the authorities should put adequate measures in place to either maintain the trend or even improve further because such attitude can enhance sustainability of the scheme

Again, since the research conducted indicated that there are more doctors for women, it is then recommended that there should be enough doctors for men and children as well to bridge the gender disparity.

Another important recommendation put across is that there should be more drugs available to the people in the district as it was evidenced in the analysis that 5.33 of the respondents with a percentage rate of 76.1% overwhelmingly confirm that indeed there should be more drugs to the people in the district.

5.4.6 Prompt payment of claims

Again, payment of claims to service providers should be done promptly to enhance the effectiveness of the scheme. This recommendation is very crucial because the survival and effectiveness of the scheme largely depend on prompt payment of claims to service providers.

5.5 Recommendations for further studies

The following recommendations are suggested for other researchers to explore. Firstly, household perception and their implication for enrolment in the national health insurance scheme in other districts should be investigated. Secondly, household's attitudes towards national health insurance scheme should be studied. Challenges affecting smooth implementation and payment of claims should be investigated.

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APPENDIX I

QUESTIONNAIRE

SECTION A: DEMOGRAPHIC DATA

1. Age: [ ] 18-30 [ ] 31-40 [ ] 41-50 [ ] 51-59 [ ] 60 and above

2. Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [] Widowed

3. Total number of years of schooling [ ]6 [ ]9 [ ]12 [ ]15 and above

4. Occupation: ……..

5. Gender [ ]Male [ ]Female

6. Home ownership [ ] owned [ ] Inherited [ ] Rented

SECTION B: UNDERSTANDING OF NATIONAL HEALTH INSURANCE

1. Are you a member of any of the health insurance scheme? [ ]Yes [ ] No

b. If yes, when did you join the scheme? 0-2years 2-3years 4years & more

c. If no why?.....

2. Do you think health insurance is good? [ ]Yes [ ] No

3. Before the introduction of health insurance how do you rate healthcare delivery when you attend hospital? [ ] Poor [ ] Average [ ] Good

4. How do you rate healthcare delivery now when you attend hospital? [ ] Poor [ ]Average [ ]Good

5. Which of the following do you prefer? [ ]Health insurance [ ] cash and carry

   b. Why do you prefer it?.....

6. Have u renew your NHIS before? Yes [ ] No [ ]
7. If no why? ……

8. What challenges do you think health insurance is confronted with? lack of satisfaction from providers [ ] lack of confidence in the scheme [ ] lack of funds [ ] location of scheme [ ] co- payment [ ]

SECTION C: PERCEPTION FACTORS

TECHNICAL QUALITY OF CARE

1. Treatment provided by NHIS is effective for recovery and cure.
   Absolutely disagree [ ] Strongly disagree [ ] Disagree [ ] Indifferent [ ] Agree [ ] Strongly Agree [ ] Completely Agree [ ]

2. Drugs supplied by NHIS are of high quality. Absolutely disagree [ ] Strongly disagree [ ] Disagree [ ] Indifferent [ ] Agree [ ] Strongly Agree [ ] Completely Agree [ ]

3. Diagnosis that are given by providers are good. Absolutely disagree [ ] Strongly disagree [ ] Disagree [ ] Indifferent [ ] Agree [ ] Strongly Agree [ ] Completely Agree [ ]

4. Clinical examination by Doctors are of high quality. Absolutely disagree [ ] Strongly disagree [ ] Disagree [ ] Indifferent [ ] Agree [ ] Strongly Agree [ ] Completely Agree [ ]

5. You get immediate access care when needed Absolutely disagree [ ] Strongly disagree [ ] Disagree [ ] Indifferent [ ] Agree [ ] Strongly Agree [ ] Completely Agree [ ]

SERVICE DELIVERY ADEQUACY

1. The service providers are good. Absolutely disagree [ ] Strongly disagree [ ] Disagree [ ] Indifferent [ ] Agree [ ] Strongly Agree [ ] Completely Agree [ ]

2. There are enough Doctors for women. Absolutely disagree [ ] Strongly disagree [ ] Disagree [ ] Indifferent [ ] Agree [ ] Strongly Agree [ ] Completely Agree [ ]

BENEFIT OF NHIS

1. NHIS help saves money. Absolutely disagree [ ] Strongly disagree[ ] Disagree[ ] Indifferent [ ] Agree [ ] Strongly Agree [ ] Completely Agree [ ]

2. What are some of the benefit of NHIS……

CONVENIENCE OF NHIS

1. Where the office of District Mutual Health Insurance Scheme is convenient. Absolutely disagree [ ] Strongly disagree [ ] Disagree [ ] Indifferent [ ] Agree [ ] Strongly Agree [ ] Completely Agree [ ]

2. The district scheme office opening hours are convenient.
   Absolutely disagree [ ] Strongly disagree [ ] Disagree [ ] Indifferent [ ] Agree [ ]
   Strongly Agree [ ] Completely Agree [ ]

3. The production and collection of Insurance card is convenient. Absolutely disagree [ ] Strongly disagree [ ]Disagree [ ] Indifferent [ ] Agree [ ] Strongly Agree [ ] Completely Agree [ ]

PRICE OF NHIS

1. The premium charged is too high. Absolutely disagree [ ] Strongly disagree [ ] Disagree [ ] Indifferent [ ] Agree [ ] Strongly Agree [ ] Completely Agree [ ]

2. The processing fees for NHIS card are too high. Yes [ ] No [ ]

PROVIDER'S ATTITUDE

1. The attitude of health staff improve. Absolutely disagree [ ] Strongly disagree [ ] Disagree [ ] Indifferent [ ] Agree [ ] Strongly Agree [ ] Completely Agree [ ]

2. There should be more drugs available for client.

Absolutely disagree [ ] Strongly disagree [ ] Disagree [ ] Indifferent [ ] Agree [ ] Strongly Agree [ ] Completely Agree [ ]

PEER PRESSURE

1. What attracted your decision to enrol with NHIS?

   ……

   ……

2. Did the community leaders influence your decision to enrol? Yes [ ] No [ ]

3. If yes which of these community leaders influence your decision?
   Assembly man [ ] Church leader [ ] Imam [ ] Chief [ ] Queen mother [ ] Health worker [ ]