HEALTH FINANCING IN GHANA: A CASE OF AHAFO ANO NORTH DISTRICT MUTUAL HEALTH INSURANCE SCHEME.

by

Charles, Ofori-Anarfi

Bed. Social Science (Hons)

A Thesis Submitted to the School of Business, Kwame Nkrumah University of Science and Technology in partial fulfillment for the requirements for the degree of

MASTER OF BUSINESS ADMINISTRATION

(BANKING AND FINANCE)

SEPTEMBER 2009

DECLARATION

I hereby declare that I have personally, under the supervision of Mr. J.M. Frimpong of the KNUST, school of business, undertaken this study. And that to the best of my knowledge, it contains no material previously published by another person nor material which has been accepted for the award of any other degree of the University, except where due acknowledge has been made in the text.

Ofori-Anarfi Charles (PG 1879807) 15-10-09

Student Name and ID number Signature Date

"I declare that I have supervised the student in undertaken the study submitted herein and approve it for assessment."

..... 19-10-09

Mr. J.M. Frimpong Date

Supervisor

Certified by..... 19-10-09

Dean of KNUST School of business

DEDICATION

I dedicate this write up to my dear friends, Michael Kontor Yeboah and Anita Amartey.

ACKONWLEDGEMENTS

No great work is accomplished without the help of others. My deepest appreciation goes to the Almighty God who has watched over me all these years. I owe my greatest gratitude to the numerous authors whose literatures I used. I value their thoughts and contributions about their work.

Particular gratitude goes to my supervisor, Mr. J.M. Frimpong, whose encouragement, dedication and care, in spite of his tight schedules helped to conduct this study.

I would like to acknowledge my parents Mr. A.K. Ofori and Madam Janet Nkrumah for their prayers, encouragement and support throughout the work of this project. They deserve special praise and thanks.

I cannot conclude without expressing my deep appreciation to Mr. Abu-Bakr Hussein and all the staff of the Ahafo Ano North District Mutual Health Insurance Scheme for their support and patience and the release of information for my work.

To all I say a big Thank You

ABSTRACT

The study was to find out the possibility of the onetime premium payment which was proposed during the 2008 general election as a campaign promise. The research also seeks to find the challenge that hinders the smooth operation of the schemes, the affordability of the premium and the rate was also investigated.

The research found among other things that will help the running of the health insurance scheme effectively in the country.

This research covered the profile and brief history of the Ahafo Ano North District and the Mutual Health Insurance Scheme. The respondents were taken from the clients and non clients of the scheme, the staff of the scheme and the health facility providers in and around the district.

The study revealed that there are a number of challenges that need to be streamline to for the smooth running of the scheme, the paramount one is the delay in the transfer of subsidy for the payment of the providers. The feasibility of the one time premium payment was questioned by this research work.

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CHAPTER ONE

GENERAL INTRODUCTION

1.0 Introduction

This chapter talks about the general background of the research, the statement of the problem, the objective, justification, scope ,limitation and the organization of the study

1.1 Background of the Study

The issue of one time premium was a campaign promise made by the then opposition National Democratic Congress (NDC) during the 2008 general election. The implementation of this promise has brought about a mixed reaction from all corners of the country. A section of the population believes that one time premium will collapse the scheme but others especially the ruling party and their members thinks otherwise. The NDC upon assumption of office has decided to fulfill its promise to the people. There has been a series of meetings and consultations to come up with a program to implement this one time premium agenda. Health care in developing countries is enmeshed in a crisis that is both profound and prolonged. Some of the reasons are universal and largely economic, others are specific to individual countries: they include national policy, methods of organization, funding and social-cultural values.

In Ghana, the 'Cash and Carry' health financing that made it compulsory for patient to pay money before or after treatment in the hospitals and clinics was not within the means of many people. Many Ghanaians were therefore not attending hospitals and suffering from many diseases. This 'Cash and Carry' system presented a strong barrier to health care access to majority of Ghanaians (Ministry of Health, 2004).

The former government of Ghana (New Patriotic Party), recognizing this necessity, therefore initiated a process of establishing a National Health Insurance Scheme to guarantee access to health care to everyone in the country. An Act was promulgated in 2003 called National Health Insurance Act 2003 (Act 650) which provided the policy framework for working guidelines for the schemes. In 2004, Legislative Instrument (LI 1890) was released as the National Health Insurance Regulations.

By this law, there are three types of Health Insurance Schemes that could be established in the country. These are:

- The District /Municipal/Sub Metro Mutual Health Insurance Scheme
- The Private Mutual Health Insurance Scheme
- The Private Commercial Health Insurance Scheme

The government plays vital role in the running of the district mutual health insurance schemes. Each district has been divided into health insurance communities so that health care could be brought to the doorsteps of all Ghanaians. The health insurance community comprises of any group of adults who reside in the same geographical area and coverage to register and vote at specifically predetermined polling stations in the area (Ministry of Health, 2004).

In each health insurance community, a health insurance committee is formed to oversee the collection of premium and to supervise its deposit in the district health insurance fund.

A health insurance assembly is formed from the insurance committees to draw a constitution to provide general guidelines for the operation of scheme. The health insurance assembly

then appoints a Board of Trustees who appoints management team to administer the running of the scheme.

Since the socio-economic conditions of all Ghanaians are not the same, the criterion for assessing premiums payable to the schemes is 'affordability'. However, a range of minimum and maximum premiums has been set, within which all the mutual health insurance must set their premium charges. There are categories of people who do not pay any premium at all; they are adults who are unemployed or do not receive any identifiable and constant support from elsewhere for survival. In addition, children or dependants below 18 years do not pay premiums (National Health Insurance LI 2004). By the introduction of free maternal care the NPP came out with another policy to cover all pregnant women. This policy gives health care free for every woman who is pregnant which is catered for by the health insurance scheme. Therefore, premiums payable varies from one District Mutual Health Insurance Scheme to another. The government supplements the premiums internally generated by the schemes by transferring 2.5% of proceeds from Value Added Tax collected in the country.

1.2 Statement of the Problem

The hope of the average Ghanaian to have a reliable and affordable healthcare delivery system has brightened with the take-off of the long-awaited National Health Insurance Scheme [NHIS].

Modeled after the practice in developed countries where responsibility for quality healthcare delivery is shared, the Ghanaian version at full implementation would spread health benefits across the primary, secondary and tertiary spectra.

Having every segment of Ghana's variegated population in mind, the National Health Insurance Scheme aims to mobilise resources in a sustainable manner for the provision of accessible, quality healthcare for all irrespective of status.

Health financing has been rising because there has been a continuous increase in the salaries and allowances of health professionals and workers. In addition, many of the logistics, equipment and drugs used by health facility providers are very expensive. These health care facility providers always transfer their huge taxes and production cost to patients because health care is inelastic in demand.

The government of Ghana under the then ruling New Patriotic Party's (Kufour's first term) identifying that a higher percentage of the income of Ghanaians go into the pockets of health financing, came out with a nationwide health insurance scheme to ease this burden from Ghanaians.

However, there has been series of challenges that are been faced by the various schemes, a situation where patients are sent home because of the fact that claims made by the service provider has not been paid. There is evidence that many health facility providers in Ghana have not gone for accreditation to operate under the National Health Insurance Scheme despite the education that goes on everyday on all the televisions and FM stations. The question we must ask is, is the premium paid sufficient enough to pay for the services rendered by the health providers? Do we have effective system that will guarantee the payment of claims to health facility providers? Do we have the capacity with regards to resources to sustain the one time premium payment as it has been proposed by the NDC government?

The study therefore sets out to investigate the possibility of the one time premium payment, the challenges and the measure that can ensure the sustainability of the national health insurance.

1.3 Objectives of the Study

The overall goal of the study is to examine the possibility of the one time premium payment of the national health insurance scheme.

The study has subsidiary objectives which includes the following:

1. To examine the premiums payable to the schemes.
2. To assess the challenges that are involve in the implementation of the scheme
3. To examine what the government has put in place to implement the scheme.
4. To make recommendations to guide the management of the schemes throughout the nation.

1.4 Research Questions

In addition to the above objectives, research questions further provide boundary of the study and give it overall direction. For this study, the following under listed questions have been designed to address the above problem:

- How much premium does a client pay in a year?
- What are some of the challenges facing the implementation of the scheme?
- What are the measures that the government is using in the implementation of the scheme?

1.5 Justification of the Study

"The idea was to replace the old cost-recovery health system in operation since 1985 and known infamously as "cash-and-carry," under which patients were required to pay up-front for health services at government clinics and hospitals.

The new bid to provide care for even the poor and the vulnerable among Ghana's 21 million people was described by one editorialist as "perhaps the biggest social development project undertaken by any government since (Kwame) Nkrumah after Ghana's independence."
Quality health care is the bedrock of every nation. Where the cost of health care is very high, only few of the residents of the nation can afford leaving the majority to meet their premature death.

In view of this, the study will help policy makers to make comprehensive health insurance policies. That is, to make laws to enhance the operations of National Health Insurance Schemes to attract more clients and facility providers.

In addition, stakeholders can use the study to educate and encourage the public to join the scheme because a small premium is paid to receive bigger benefit package.

The clients will know from the study that the benefits they enjoy are not limited to only the facilities in the districts where they register but can transfer from their district to any part of the country and still benefit from the health facilities there if they know that they are going to stay there for a longer duration. The results of the study will also be the basis for government decision on the measures to improve the services provided by the various schemes to the public. It is also for the proximity of the case study and accessibility of information. Again it will contribute to the knowledge in the field related. Finally it will also fulfill the requirements for the award of the MBA degree at KNUST School of business.

1.6 Scope of the Study

The study is limited to the health facility providers and residents of Ahafo Ano North District and a few health facility providers who are close to the borderlines of the district because many of the district dwellers patronize those health facilities for health care.

The study covered the NHIS accredited health facility providers on one hand and the unaccredited health facility providers on the other hand. The study focused on the operations of insurance scheme with particular emphasis on the payment of clients' premiums, claims to healthcare providers and the cash and carry health financing of the unaccredited health facility providers. Also the issue of one time premium proposed by the ruling NDC government was investigated to find out its possibility.

1.7 Limitations of the Study

The ideal situation of the study is to cover a reasonable number of district mutual health insurance. However, due to financial and time constraints, a sample size was chosen in relation to the entire population under study. Some administrators of private health providers were not willing to disclose information to anyone for fearing that either their competitors might get their secrets to outwit them or they might be exposed to the Internal Revenue Service to demand bigger taxes from them. Upon several assurances that information collected would be treated as secret and confidential, the researcher managed to retrieve some pieces of information for the study The trust of respondents and interviewees cannot be verified to be sure of the truthfulness or otherwise of information given. There is always an element of error in such analysis since the models used are based on certain assumption that may not be practicable in real case. As Ahafo Ano North district is a least developed area, some of the road networks linking to the hinterlands were not good so it was difficult to get cars to visit these areas. The researcher however had to walk on foot for about four kilometers at times to and fro to collect data. Again, it was not everyday that the inhabitants of the district stayed home. Since the area is a farming community, most of the days of the week were spent on their farms. One could meet an entire village virtually empty. The researcher visited these communities on their taboo and resting days. Another limitation is the lack of time. For such a study the allowable period for submission is woefully inadequate. Finally the researcher's limited financial resources will also inhibit the undertaken.

1.8 Organization of the study

The study is divided into five (5) chapters. Chapter one deals with general background of the research, the statement of the problem, the objective, justification, scope, limitation and the organization of the study. Chapter two reviews the relevant literature on the main concepts and operational words on working capital management. On the other hand chapter three considers the methodology of the research; whiles chapter four analyses and evaluates the data collected using correlation and other descriptive statistics. Finally, chapter five dwells on the findings, summary, conclusion and recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

Insurance is a risk transfer mechanism by which an individual or organization can exchange his or its uncertainty for certainty (Akakpo, 2004). Larsen (2000) writes that insurance does not prevent risk from happening but provides the means by which individuals and entities exposed to risk can transfer the financial consequences of the risk to the insurer in return for the payment of a premium.

Anderson (1980) adds that insurance is the creation of a pool in the form of premiums against risk. He continues that it works well on the principle of numbers because the few who suffer the loss are compensated from the contribution of the many. Gee (1985) differentiates between 'assurance' and 'insurance' contracts, the former being confined to life assurance business, the latter denotes insurance contracts covering events which may or may not happen. He adds that insurance contract is a contract of indemnity against a contingency.

Akakpo (2004) says all assurance or insurance contracts are known as 'uberrimae fidei' contracts. In that, unless the insured discloses every material fact of which he has knowledge and which may affect the insurance contract to the insurer, the contract will be void and has no effect.

In order to affect the insurance, the insured has to complete a proposal form which then becomes the basis of the contract between him and the insurance firm. A contract of

insurance is completed when the insurance firm issues a policy to the insured (PNDC Law 227, 1989)

From the above it can be said that insurance in general provides a cover against an event which may happen or not in an individual's or an entity's life.

Health insurance is a risk pooling arrangement by which the cost of healthcare to single individual becomes a collective responsibility of all the people in the society (Narayan, 2007)

2.1.0 Theoretical Framework

2.1.1 Premium

According to Anderson (1980), the amount of money payable by the insured on acceptance by insurance firm of the proposal is known as the 'first premium', subsequent premiums are termed as 'renewal premiums'.

Generally, premiums are payable annually in advance but semi-annually, quarterly or monthly premiums are accepted by some insurance firms.(Gee, 1985). Apart from life assurance premiums which are continuous in nature, other insurance premiums expire as soon as the period is over (Garbutt, 1989)

Insurance firms reinsure part of the risk they undertake with larger firms and pay premiums to them. The acceptance of risk because of reinsurance gives rise to reinsurance premium inwards. The placing of risk through reinsurance is termed as reinsurance premium onwards (Chasten, 1992)

Insurance premiums represent the turnover of the insurance firm. They can arise from direct business (that is, the insured has direct contractual relationship with the business). Indirect premiums emanate from reinsurance agreements (Akakpo, 2004).

Garbutt (1989) says that unearned premiums are the portion of written premiums that relate to a period of risk after the accounting date so they are deferred to subsequent accounting period.

2.1.2 Claims

Anderson (1980) highlights that claim is the amount payable under a contract of insurance arising from the occurrence of an insured event. Chasten, (1992) adds that the amount included in claims are expenses incurred by an insurance enterprise which are incidental to the handling of claims.

Larsen (2000) writes that claims arising out of the event which have occurred by the end of accounting period but have not been reported to the insurance enterprise by that date are called claims incurred but not reported (IBNR). He continues that claims outstanding are the estimated final cost of settling claims arising from the events that have occurred by the end of the accounting period.

2.1.3 Deferred Acquisition Costs

Gee (1985) says there are expenses relating to the unexpired period of risk which are carried forward from one accounting period to the next period. Most insurance firms employ agents who market their products to individuals and concerned organizations. These agents are rewarded by means of commission (Larsen, 2000). He adds that these commissions are

spread over the lives of the policies to which they relate and are carried forward as deferred acquisition cost.

2.2.0 Empirical Review

George Schieber (2006) in his article health financing in developing countries said, Major changes in global health policy, financing modalities, and financing instruments have occurred over the past ten years resulting from the global focus on poverty reduction, new global health threats from HIV/AIDS, SARS, and avian influenza, and the international community's commitment to the Millennium Development Goals (MDGs). As a result of these factors global health policy has now become a foreign policy, national security, and humanitarian issue for all countries, and significant amounts of increased resources for development assistance, much of it targeted to health, have been committed. International health is on the global agenda as it never has been before, and it is incumbent on the global community and governments to effectively deal with this enormous humanitarian, social, and economic challenge

The mounting costs of health care, increasing out of pocket expenditure and its catastrophic impact on family finances demand an innovative and risk pooling mechanism to provide a security for the poor (Narayan, 2007). He adds that in public hospitals, costs are incurred for transport, accommodation, board for patients and attendants, diagnostic investigations and purchase of drugs unavailable at hospitals. As a result, 40-60% of hospital patients borrows heavily at high interest and end up slipping below the poverty line.

Capon (1982) stresses that health insurance is to strengthen preventive and public health systems to obtain value for the money spent, reduce the disease burden and promote overall health. Therefore excessive reliance on health insurance as a means of health care delivery is neither prudent nor cost effective. Bailit et al (1985) add that health insurance only addresses the symptoms of health care failure without reducing the disease burden. This failure of preventive health care can escalate costs of curative medicine, which can eat up all the money for the health care.

2.2.1 Funding of the Health Insurance Schemes

All over the world, the government supplements health insurance premiums because the health of human capital is paramount to the national development. Organization for Economic Co-operation and Development (OECD) (1987) highlight in their comprehensive work on health financing that the premiums in Israel are scaled according to the income levels. The government therefore supplements the premiums by transferring some money from the national coffers. The Israel Health Insurance Authority collects part of their parallel tax (taxes paid by employers on behalf of employees) to support the operations of the health insurance.

Schieber and Poullier (1986) did a similar on health financing in the United States of America and found that health insurance premiums are deducted from the salaries of employees and are then transferred into the account of the health insurance companies. The total premium is spread over the months to ease payment for employees. The indigents: the people who do not receive any identifiable and constant support form elsewhere for survival and the aged above 70 years do not pay anything. The central government transfers money

to help the various states based on the number of clients registered under the health insurance scheme.

In Ghana, the indigents (adults who are unemployed and do not receive any identifiable and constant support from elsewhere) and dependants below 18 years whose parents or guardians register under the scheme do not pay premium. Premiums differ from one district mutual health insurance to another because they are charged on the ability to pay and the economic activities in the area. There is a range within which all-mutual health insurance schemes must fix their premiums (the minimum is seven Ghana Cedis twenty Ghana Pesewas and the maximum is forty-eight Ghana Cedis per person). Social Security and National Insurance Trust contributors pay only the administrative part of the premium, which is one-third of the total premium amount and the government pays the remaining two-thirds. The central government transfers 2.5% of Value Added Tax income to the National Health Insurance Authority, which then shares the funds among the schemes to supplement their operations (National Health Insurance Regulations LI 1809, 2004)

2.2.2 Funding of the Health of the People

All over the world, countries are trying to operate health insurance schemes for the citizens to reduce some of the health care cost borne by the residents. Abrams and Hessel (1987) emphasize that countries should be divided into states and districts or according to the special needs of its population for better supervision, efficiency and standardization of services between the country and its periphery.

Brook et al (1983) add that health insurance should be compulsory and backed by a national law to guarantee specific health care for services for every resident. The scope of the national health insurance should be comprehensive to cover even the indigent.

Ellencweig (1988) writes that in Israel the National Health Authority, that is, the supervisory body of the national health insurance has taken over some of the functions of their health ministry. It now plans and coordinates health care within the regions and districts, controls standards, ensures proper availability of health facilities and accessibility to the residents. Narayan (2007) reiterates that in India each district health insurance scheme is an autonomous body that runs independent cost centre independent budget and provide independent audited financial statements.

From the above, Ghana organizes her health insurance in line with what pertains in other countries such as Israel, India and the United States of America. According to Act 650 (2003), each district mutual scheme is an autonomous body that prepares its own accounts, appoints its own external auditors, appoints its board members, and employs its workforce. The National Health Insurance Authority supervises the district schemes through its regional head offices. Each district mutual health scheme sends quarterly report to the Authority through the regional offices.

2.2.3 Equality in the health care delivery and payment to facility providers

There is evidence in the United States of America that people have perception that health care provided at the private facility offer better services and quality drugs than the public ones because they are there to make profit (Reinhardt, 1992). Western (1982) debates that equal care should be given to the clients of health insurance. Facilities of the public health

providers should be upgraded to match that of the private ones. In addition, quality drugs should be given to patients who attend the public health facilities. He concludes that there should be a mechanism to guide uniform payment for non drug and drug charges.

According to Epstein (1993), some public health facilities have special wards where better drugs and services are offered at higher cost than the charges at the ordinary wards. He therefore argues that health insurance clients have right to attend health care facilities so there should not be any discrimination of treatment against any one of them by the same facility.

National Health Insurance Regulations LI 1809 (2004) says the National Health Insurance Authority reviews the tariff structure for payment of drugs and services to guide the mutual health schemes in vetting and paying claims. The tariff structure charges drugs based on the generic names but not on brand names. It also caters for the charges for each operation and consultation.

The Health Insurance Regulations add that the regional and teaching hospitals are for referral cases so if a client attends such facility without a referral note from an accredited facility the medical bill cannot be borne by health insurance because their charges are higher.

2.2.4 Nationwide Coverage of Health Insurance Identity Cards

In Israel the operations of the health insurance is decentralized but clients can transfer their insurance policies and choose the physicians and services (hospitals, laboratories, etc) that

they want which may be outside the operations of their districts and regional health insurance coverage (Baruch, 1987).

According to the National Health insurance Regulation LI 1809, (2004) clients of the district mutual health insurance schemes can apply for transfer from one district to another and register with the transferred documents in the new district before they can access the accredited health facilities in the new area. The recipient district then issues a special identity card to the transferred client, pays all his bills, and demands a refund from the district where the transferred client paid his premium.

The New Patriotic Party administration's budget proposal for 2008 discloses that by the end of the second quarter of 2008 they would have networked all the district mutual health insurance schemes in the country so a client can access any accredited health facility without any problem in the country.

2.2.5 Payment of Tariffs to Health Care Facilities

The payment to the health facility providers is made by either capitation or fee for service. Capitation is a payment mechanism in a written agreement by which a fixed rate of payment for a fixed period is negotiated with representatives of health care providers to deliver health care service to the clients of the health insurance schemes. The fee for service system is where the facility provider attaches a cost statement of how he treats the client with documents from the client that he has health insurance policy. (Reinhardt, 1992).

The payment of National Health Insurance claims adopts the above two payments mechanisms. The National Health Insurance Authority (formerly National Health Insurance

Council) sits down with representatives of facility providers and the employees of the schemes and come out with the tariff structure to guide the facility providers and the schemes in charging and vetting claims. Any submitted claims without detailed cost statement cannot be paid (Act 650, 2003).

2.2.6 Claims

Claims are payment demands made by the health care facility providers. Claims payments usually have two components: payment of services offered and drugs given to clients. Claims are not paid to clients but to facility
providers (Manning et al, 1985).

Claim for payment submitted is paid within four weeks after the receipt of the claim from the health care facility. Payment can however be delayed if there is legal impediment that demands so, the amount involved is so huge that the health insurance involve needs to fall on a giant insurance partner for reinsurance assistance. (Newhouse et al, 1983)

In Ghana, the credit period for paying claims is one month. The period can be exceeded where a district health insurance has exhausted all its funds in the claims account so it relies on the Health Insurance Authority for reinsurance assistance (Act 650, 2003)

According to the Health Insurance Regulation, LI 1809 (2004) the management of a district mutual health insurance scheme has power to reduce or deny the payment of tariff claimed by facility provider where they are satisfied that the claims contain any of the following :

- Over servicing of the patient by the health care facility.
- Unnecessary diagnostic and therapeutic procedures and intervention,

as determines through peer review.

- Irrational medication and prescriptions as determines through peer review.
- Fraud.
- Gross and unjustified deviations from current accepted standards of practice or treatment of protocols.
- Inappropriate referral practices.
- Provision of services other than those for which accreditation has been granted.
- Use of fake, adulterated or substandard pharmaceuticals.
- Use of drugs other than those provided in the National Health Insurance Drug List and traditional medicines approved by the Food and Drug Board.
- False or incorrect information: or
- Failure of health care facility without any justifiable cause to comply with the agreement between the health insurance scheme and the health facility.

Facility providers are to specify only the generic names of drugs they administer to clients but not the brand names on their claims cost statement. Particulars of drugs, medicines and services with their charges issued by the National Health Insurance Authority in consultation with the health ministry to guide the charging, vetting and payment of claims. Therefore, if there is any payment for drug or service which exceeds the tariff amount stated in the Drug List that becomes questionable for auditors (National Health Insurance Drug List, 2008).

2.2.7 Accreditation of the Health Care Facilities

Narayan (2007) writes that the health insurance pools resources together from clients and contracts health facility providers for the provision of quality health care at affordable charges so there are some standards that the Insurance Authority considers before deciding on which facility to deal with. Manuela et al (2004) emphasize in the health insurance study they did in Burkina Faso that facility providers seeking for accreditation should have qualified employees duly licensed to practise, equipment, structures and be operating efficiently for at least one year with good record keeping. Locker et al (1991) add that facility providers should accept the quality standards set by World Health Organization and be prepared to operate within the laws set for the control of the health insurance.

National Health Insurance Regulations (2004) has some of the above conditions as qualifications for accreditation. It adds that accreditation board of the health insurance on the facilities' equipment, personnel, and structures should conduct thorough inspection and if they are satisfied before issuing the accreditation certificate. The accreditation certificate would state the grade of the facility. It gives a warning that it is illegal for health insurance scheme to pay money to unaccredited facility.

The Health Insurance Act 650 (2003) demands specific accreditation requirements for hospitals and community based health planning and services. For the hospitals the requirements are that:

- They must have been approved by Ministry of Health
- They must comply with Ministry of Health's approved guidelines

for ambulatory surgical clinics as well as other administrative

orders of the Ministry in case of ambulatory surgical clinics

- They must comply with the provisions of the Private Hospitals and Maternity Homes Act, 1958 as amended and Regulations made under that Act.
- They must be members in good standing in any national association of licensed hospitals in the country , and
- They must have quality assurance programme.

For the community based health planning and services, the requirements are that:

- They must be organized or managed by members of the community for improving the health status of the community through preventive, promotive and curative health services.
- They must be affiliated to at least one health facility accredited by the Insurance Authority, or have facilities that are necessary to provide health care services that the Authority may determine, and
- They must have a quality assurance programme.

According to the Health Insurance Regulation LI 1809 (2004) every health professional working in a health care facility that seeks accreditation should be duly licensed to practise the relevant profession in Ghana by the appropriate regulatory body of the profession, be a member in good standing of relevant national association of the profession, abide by the code of ethics of the profession and observe the practice guidelines or protocols, peer review and payment mechanisms of the insurance scheme.

The accreditation can be denied where the laid down procedures have not been duly followed by the health care facility (Manuela et al, 2004). In Ghana, the Health Insurance Authority can deny the accreditation or revoke already given accreditation where the health care facility does not operate in conformity with their laid down procedures. However, the facility can seek for review of the denial or the revocation (Act 650, 2003). In a similar work did by Locker et al (1991) in Canada on accreditation of health care facilities, reveals that health care facilities can be denied accreditation on the grounds that there is non compliance with any of the accreditation requirements. They added that where the Insurance Authority suspects of fraud or change in ownership of the health care facility for the purpose of impropriety or violations of conditions previously committed. Manuela et al (2004) emphasize that accreditation should be revoked where the facility fail to comply with any of the accreditation conditions, looses its license to operate or is convicted of fraud.

Accreditation is renewed in Ghana every two years. Application for renewal of accreditation is commenced six months prior to the expiration of the previous accreditation. However, health care facility whose accreditation has been revoked cannot renew its accreditation until the ban on it has been lifted (Health Insurance Regulation, 2004)

2.2.8 Registration and licensing of the District Mutual Health Insurance Schemes in Ghana

According to Act 650 (2003), each district mutual health insurance scheme registers with the Insurance Authority for a license to operate. The documents for the registration are financial statements and a business plan that projects the activities for the two years ahead. The license expires at the end of every two years.

2.2.9 Management of Health Insurance Schemes' Reforms

In many advanced countries, health insurance management has taken a new shape. In Israel, the Netanyahu Commission as reveals by OCED (1987) says that the health ministry no longer deals with the health care services for the individuals. Both the health insurance and accredited health care facilities are managed by autonomous independent corporations giving them the necessary flexibility for profitable management funded by earned income based on economic and business considerations. In the United States of America, many reforms have taken place in the health insurance. Prior the coming of President Clinton to the throne of the United States of America, there were many bottlenecks that made the health care financing costly. This therefore made Clinton to add health care reforms as one of his main campaign issues (New York Times, 1992).

The Nation (1993) reports that while the Health Insurance Association of America (HIAA) regularly sponsors television advertisement as part of its promotional agenda on reforms and networks affiliates in major cities to refuse to run a public–interest group advertisement supporting a Canadian-style single-payer health care system.

New York Times (1996) shows that President Clinton used 'managed competition', which centralized the insurance purchase on behalf of employers, individuals and large regional health insurance companies. These compete to provide the basic benefit package defined by the government, which is now more comprehensive and affordable.

2.2.10 Minimum Benefit Package

There is a minimum benefit package of diseases which every district-wide scheme must cover. The package covers about 95% of diseases in Ghana. Diseases covered include among others are; malaria, diarrhoea, upper respiratory tract infection, skin diseases, hypertension, diabetics, asthma and a lot of other diseases ranging from head to toe. However all the district –wide schemes have the right under the law to organize their schemes to cover as many diseases and services as they desire, provided they get approval from the National Health Insurance Authority (Act 650, 2003)

2.2.11 Exclusive List

Certain diseases are excluded from the benefit package because they are too expensive to treat. Other arrangements are being made by the government to finance their treatment. Currently diseases not covered are; optical aids, orthopedic aids, dentures beautification surgery, supply of AIDS drugs, treatment of chronic renal failure, heart and brain surgery. All these diseases constitute about 5% of the total number of diseases that attack the residents of Ghana (Act 650, 2003)

2.3 Other Alternative source of Funding Health Insurance Scheme

In a developing countries like Ghana the funding of the mutual health insurance scheme could take the h=greater portion of the budget of the nation. This calls for support of the richer nation especially the initial stages of the program. In Ghana the Danish government has been the backbone of the health insurance project from 2003. Pressure on foreign aid expenditures, fueled by the desire to cut government budget deficits, has affected population assistance in many developed countries. Australia, Denmark, Germany, the UK, and the

Netherlands have, however, managed to significantly increase funding for population programs following the International Conference on Population and Development (ICPD).www.popline.org/docs/index1223

2.3.1 The Approach of Donor Funding

The foreign donor support comes with their own terms and style, PharmAccess advocates a wide application of private health insurance schemes by facilitating the participation of financially weak people. Together with the Health Insurance Fund (an initiative of a number of Dutch insurance companies and Dutch multinationals with large operations in Africa) PharmAccess developed an insurance model for low income groups. This initiative is supported by the Dutch Ministry of Development Cooperation with a subsidy of 100 million Euros for 6 years.

The Health Insurance Fund concept is based on risk pooling, donor support, co-payments and utilization of public as well as private health care providers. The concept uses donor money to subsidize insurance premiums for previously uninsured people with a low income. This intervention is expected to generate an increasing demand for prepaid health schemes and will thereby improve investment opportunities in local health capacity. The concept furthermore facilitates the enforcement of quality standards, as it focuses on the output side of the health care sector and relates payment of providers to their performance. Consequently, the Health Insurance Fund model enhances and optimizes health care capacity, increases access and improves the quality of provided care. The Health Insurance Fund is an independent, Netherlands based foundation. PharmAccess serves as partner of the

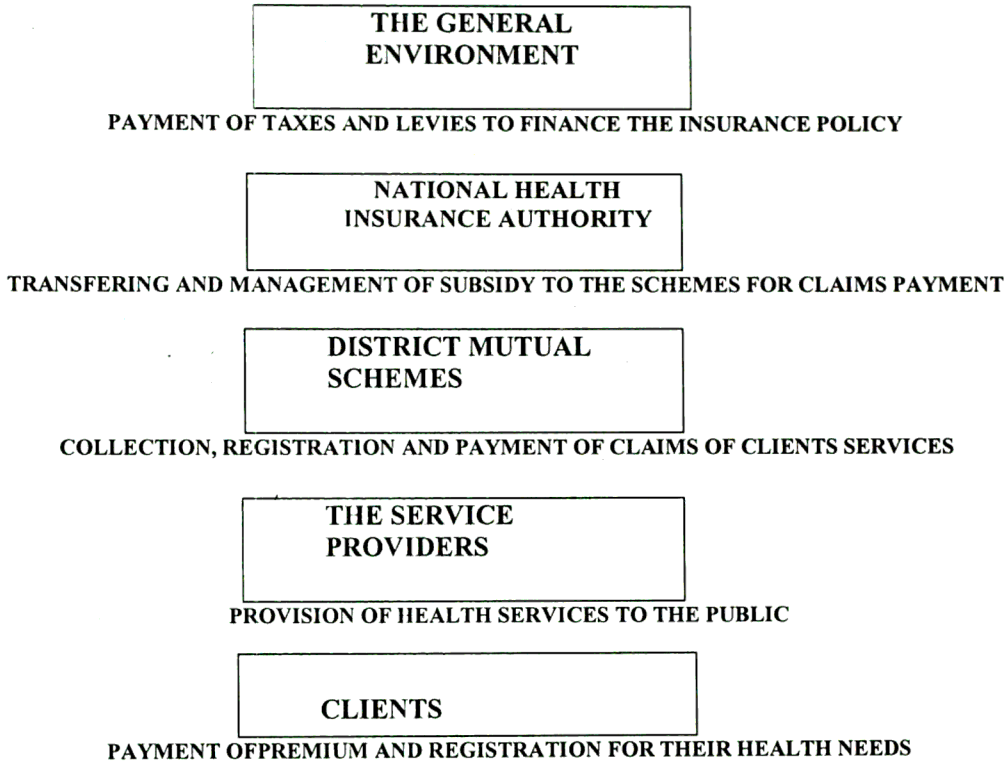
Fund and is responsible for the initiation and development of the insurance schemes, as well as for the implementation thereof by contracted local partners. Walle Nicolas (2001)

2.3.2 Problems associated with donor support

The funding from donor is not sporadic in nature. This inconsistent nature depicts a number of problems to the beneficiaries of the fund especially in the developing economies. McKie Kristin (2007) in his article said, Contrary to the logic of resource mobilization and other social movement theories, international donor funding to grassroots social movements seem to be correlated with movement decline in many East African cases. His paper seeks to establish whether there is a causal link between increased international donor funding and demobilization, a link that, if proven to exist, can help us to better theorize social movement decline in this subset of movements.

Catriona Waddington (2004) identifies these challenges with donor funding as, the multiplicity of earmarked funds confuses the situation for decision-makers, Duplication, Local ownership, distortion of resource allocation etc. She concluded that we should not be assumed that earmarked donor funding automatically increases the allocation of developing country resources towards programmes that yield the greatest health benefits. Sometimes it does, sometimes it does not – how the funding is designed can influence this.

The conceptual framework



CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter covers the steps used in conducting the study. It looks at the population and sampling, research design, research instruments data collection procedures and data analysis.

3.1.1 Population and Sample Size

The population consisted of all the health care facilities that serve the district dwellers, the management of the district scheme and the clients of the Ahafo Ano North District Mutual Health Insurance Scheme. The health care facilities were made up of the ones located in the Ahafo Ano North District, the ones in the nearby districts and the regional specialist hospitals of Ashanti and Brong Ahafo Regions.

About 80 health care facilities are operating in the area. In all, a random stratified sampling of 40 was chosen for the study. The selection procedure was made up of 30 facilities in the district and the rest was chosen from the nearby service providers.

The rationale for the selection procedure was to get an unbiased and a true representation of all the accredited and unaccredited health care facilities.

The clients and non clients of the scheme were also interviewed. 100 people of the community were selected. The core managers of the Ahafo Ano North District scheme were also questioned.

3.1.2 Instruments

The instruments used in the study were asking questions through interviews and questionnaires. Questionnaires were designed to collect data for the study. Some respondents delayed in answering their questionnaires but upon several visits and encouragements, the researcher managed to get them back.

Interviews were conducted. As most of the people interviewed were illiterates, interviews in the form of conversation helped the researcher to ascertain the needed responses.

3.1.3 Data Collection Procedure

Primary data was collected from the questionnaires sent to the facilities and the interviews conducted on the field. The raw data was then processed to give meaning to readers. There were some secondary data for the financial analysis. This was the income and expenditure of the scheme.

3.1.4 Data Analysis

Qualitative and quantitative methods of analyzing statistical data were employed in the data analysis. The results were subsequently computed into percentages. Percentage values, which were not round figures, were approximated to the nearest whole numbers, for ease and simplicity of interpretation. Computer data analysis software such as SPSS and Microsoft Excel were the main tools that were used to analyze the data in order to help the results interpretation. The SPSS was used to analyze the pre-coded questions. The open-ended questions were analyzed by listing all the vital responses given by the respondents. They were then considered based on their relevance to the research. This gave the general ideas about the problem in question.

3.2 Ahafo Ano North District – Profile

The Ahafo Ano North district is located in the North Western part of the Ashanti Region. It shares common borders with Brong Ahafo Region to the North and West, Atwima District to South and Ahafo Ano South district to the East. The district is the third smallest in the Ashanti after Kumasi and Afigya Sekyere district. It has a total land area of 567km2. Ahafo Ano North district is estimated at 85,936(2006). Between 1984 and 2000, the population of the district increased from 44,799 to 71,952 (2000 population and housing census). This gives a relatively, annual growth rate of 2.96%, if this annual growth rate is used to calculate the projected figures for 2009, the population would be estimated approximately as 93,795.

The spatial pattern of development and population is an important stage in the planning process because development policies, programmes and projects manifest. Therefore, the distribution of settlement in terms of population size and service provision is examined. The district has more male population than females.

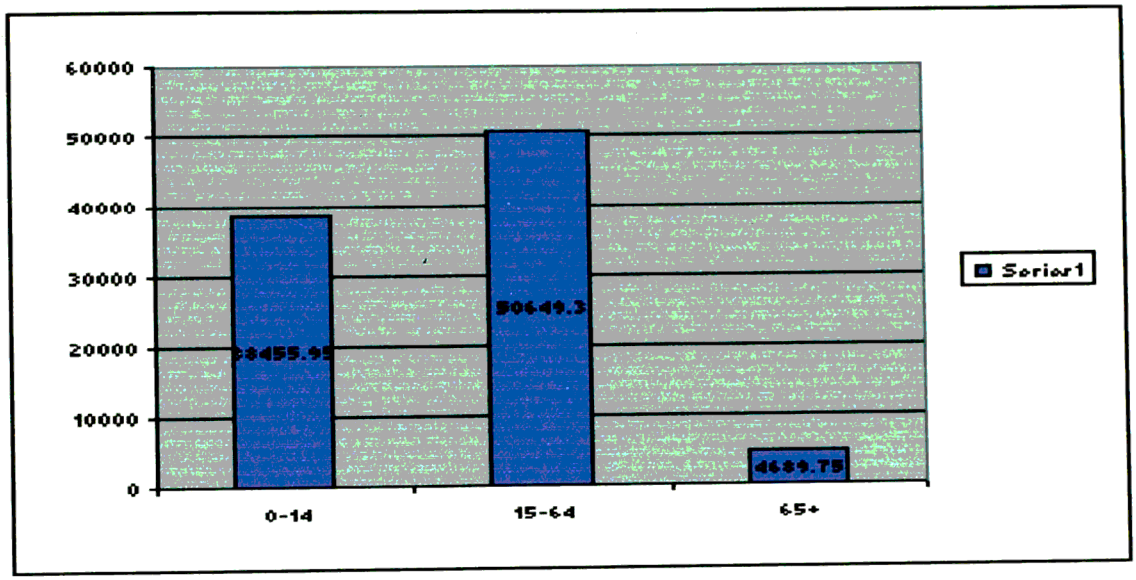
Ahafo Ano North district is the smallest or least populated district in the Ashanti region with just 2.0% of the total share of the regions population. There are about 1887 localities in the district. Tepa is the only settlement with over 5000 population, with Asuhyiae, Anyinasuso, Akwasiase, Mabang, Abonsuaso, Manfo, and Betiako,

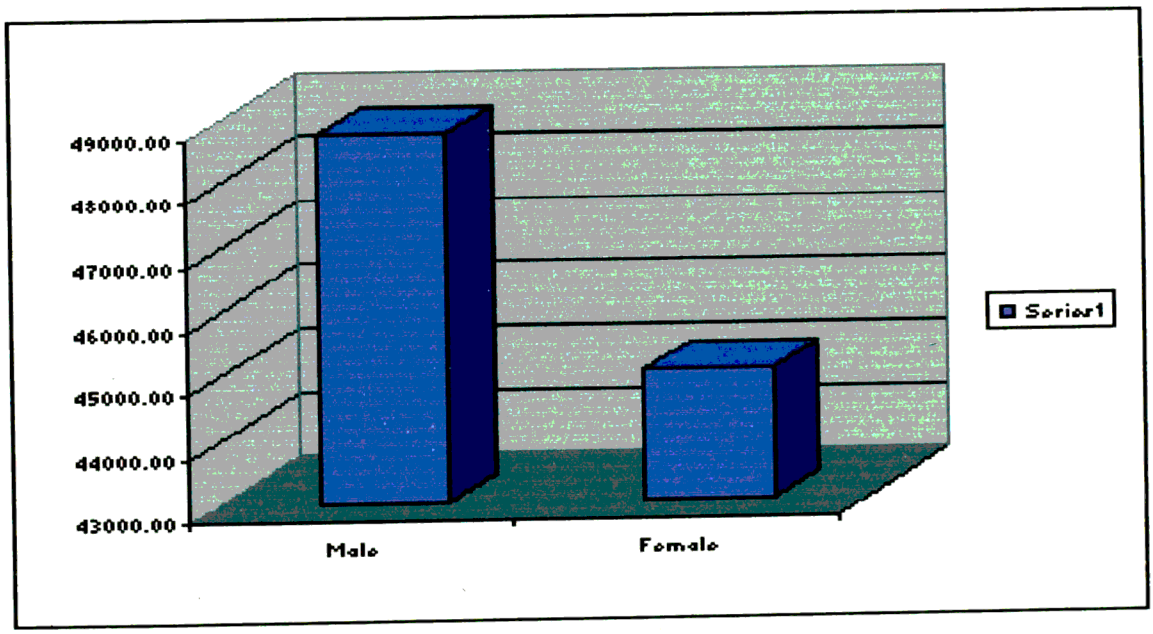
which have population falling within 2000 to 5000, the rest of the settlements have a population below 2000. Given the estimated district population of 93,795 a further analysis of age group has also been made below:

Figure 1: The population distribution and diagram

Age	Male	%	Female	%	Total	%
0-14	19696.95	21.0	18759.00	20.0	38455.95	41.0
15-64	26262.60	28.0	24386.70	26.0	50649.30	54.0
65+	2813.85	3.0	1875.90	2.0	4689.75	5.0
Total	**48773.40**	**52.0**	**45021.60**	**48.0**	**93795.00**	**100.0**

Source: 2000 population and housing census.





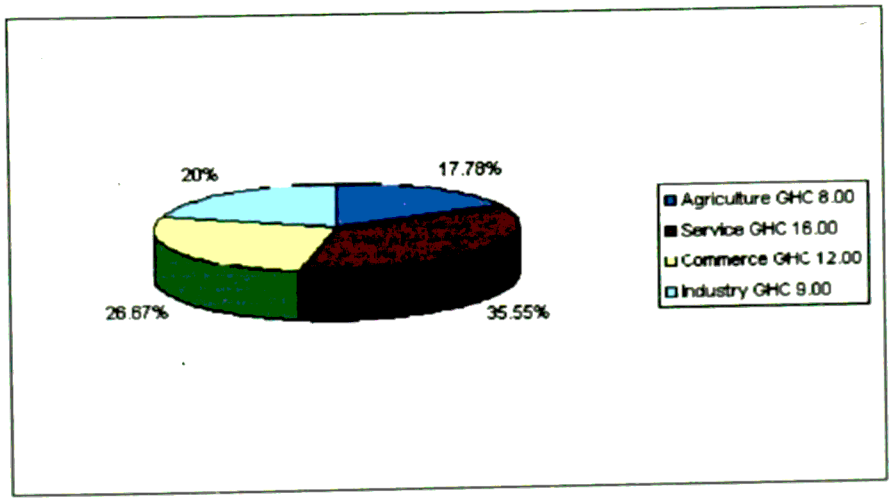
This structure or composition indicates that not withstanding the relatively low population growth rate and the population size, majority age group, 41.0% of the district population is children below 15years as shown in the table above.

The main occupation of the people in the Ahafo Ano North district is farming. It employs about 83% of the total labour force, both direct and indirect. Commerce and industry (mainly small scale) also employs 13% and 4% respectively. Analysis of household income and expenditure show that average monthly income for the population is about GhC 9.00 and most of the people who earn this income are engaged in agriculture which account for about 83% of the total labour force as a result of the subsistence nature of farming in the district. The table infra shows the sources of household income in the district from the 2002 socio-economic survey.

Figure 2: Economic Activities and diagram

No.	Sample Number	Category	Average income Per House a Month	No. of people
1	20	Agriculture	GHC 8.00	40
2	15	Service	GHC 16.00	30
3	10	Commerce	GHC 12.00	20
4	5	Industry	GHC 9.00	10
Total	**50**		**GHC 45.00**	**100**

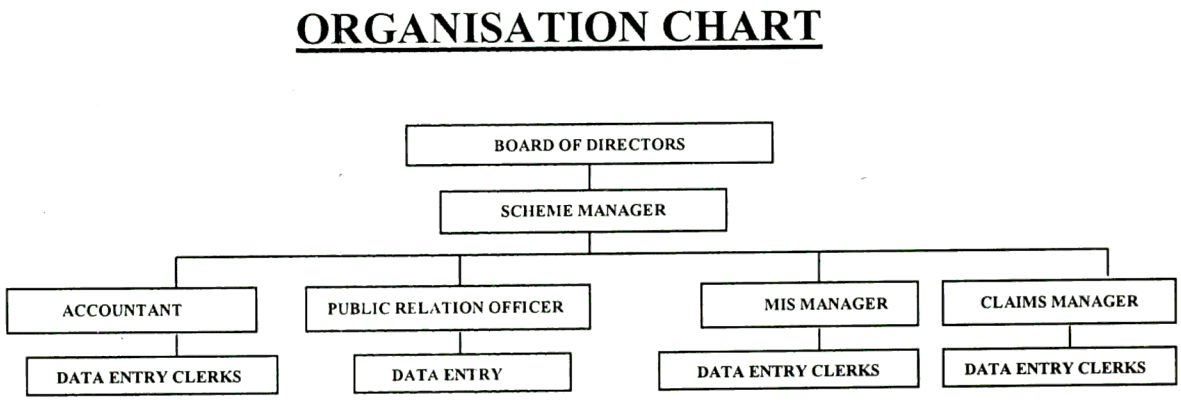
Source: socio- Economic Survey 2002



3.3 Brief History of the scheme

The scheme came into existence as a result of the legislative instrument (1890) in 2004 after the National Health Insurance Act (Act 650) in 2003, which allows the establishment of a district mutual health insurance scheme. During the year 2004-2005 there was a sensitization program for the take off of the scheme. Registration and partial implementation actually took place in 2006. The scheme is managed by a board of 15 members who in consultation with the district administration appoints managers to head various departments of the scheme. The management of the scheme consists of the scheme manager, the accountant, the management information system manager, the claims manager and the public relations manager. The scheme has been able to cover about 50% of the population in the district when it comes to registration.

3.4 The Organizational Chart of the scheme



CHAPTER FOUR

DATA ANALYSIS AND DISCUSSIONS

4.0 Introduction

This chapter starts with the overview of the statistical procedures, presentation of the results, discussion of findings and ends with evaluation of the results.

4.1 Overview of the Statistical Procedures

For the purpose of the analysis the survey was conducted in a three identified group which comprises the service providers, the management of the scheme and the client or non client of the community. They were interviewed to find out their general opinion about the operations of the scheme and the feasibility of the one time premium payment. Spurious correlation was the statistical technique used in analyzing the data collected from the field because there was no direct causal relationship between them.

4.2.0 Presentation of the results

Presentation starts with the results of the Health Insurance scheme managers at the district followed by the facility providers and the people in the community.

4.2.1 Social Security and National Insurance Trust Registration

All the National Health Insurance Scheme's accredited facility providers have registered their permanent workers under the Social Security and National Insurance Trust (SSNIT). It is only the casual employees who have not been registered.

With the unaccredited facilities, only few of their core staff has been registered with SSNIT. In some facilities, all the staff is non-SSNIT contributors.

Concerning the accredited facilities, 70% of them have more than half of their staff registered with Social Security and National Insurance Trust whilst 40% have less than half of their employees with the SSNIT.

4.2.2 Ownership of the Facilities

Out of the 20 accredited facilities sampled for the study, 60% belong to the government; 25% are private health facilities and 15% are mission facilities.

4.2.3 Premium

On the premium payment, there was 3 alternative answers above GHC10, below GHC10 and above GHC20 out of 10 staff members all of them responded that is was below GHC10 that represents 100% saying the premium is affordable especially to those who are classified by the policy not to pay premium but also said the premiums appeared to be expensive and not within the reach of many Ghanaians.

4.2.4 Registration Percentage to the Population of the District

Figure 1: The Registration in figures

Registered members of the District to the District population (Figures)			
	2007	2008	2009
District population	88,479	91,098	93,795
Number Registered	28,463	31,773	49,711
Male	13,415	14,895	22,106
Female	15,048	16,881	27,838
Active Members	9,154	11,086	26,347
SSNIT Contributors	1,289	1,497	2,108
Pensioners	43	54	119
Under 18	16,503	18,168	25,850
70+	1,907	1,964	3,331
Indigents	345	328	525
Card Bearers	27,774	31,017	49,214
Pregnant Women	11,163	12,474	3,480

Source: Annual Report of AADMHIS 2009

Figure 2: The Registration in Percentage

Registered members of the District to the District population (%)			
Number	32.17%	34.88%	53%
Male	47.13%	46.88%	44.47%
Female	52.87%	53.13%	56%
Active Members	32.16%	34.89%	53%
SSNIT Contributors	4.53%	4.71%	4.24%
Pensioners	0.15%	0.17%	0.24%
Under 18	57.98%	57.18%	52%
70+	6.70%	6.18%	6.70%
Indigents	0.39%	0.36%	0.56%
Card Bearers	97.58%	97.62%	99%
Pregnant Women	42.47%	39.26%	7%

Source: Annual Report of AADMHIS 2009

The number of registered members to the population of the district was said to be a little above 53%. This indicates that there are a substantial number of the people in the district who have not yet join the scheme. It is estimated to be half the population of the community.

4.2.5 Proportion of Income that goes to Administration

Figure 3: The Structure of Income of the Scheme

Financial information			
	2007	2008	June 2009
Premium Collected	48,594	43,523.55	29,038
Registration Fee	24,904	42,652.66	31,175
Subsidy Received	183,237	288,686.50	186,198.21
Admin Support Received	18,000	20,000	

Source: Annual Report of AADMHIS 2009

On the issue of income that goes to the administration of the scheme it was estimated to be about 20%. The 80% percent of the monies collected are used to pay for claims.

4.2.6 The Challenges Hindering the Progress of the Scheme

The challenges of the scheme were uncountable but these were the frequent ones which the respondent could not hide. Among them are inadequate staff and staff training, politicization of the scheme, fraudulent service providers, and clients not able to renew their cards on time, no clear cut procedure of operation of the scheme, high illiteracy in the community, low income level of the people, some drugs and diseases are excluded by the health insurance law. From the survey it shows that the schemes need to be looked at critically on some of the problems they face to bring sanity in the operation and provision of service.

4.2.7 Suggested Interventions by the Government

Almost all the people interviewed on the possible government intervention talked about one of the measures that may help to improve the scheme.

- Payment of subsidy should be hastened
- Provision of good condition of service to the staff of the scheme
- Staff training on new methods to improve the operation of the scheme
- The provision of equipment and logistics to facilitate the operation of the scheme at various districts
- A clear cut operational system for the scheme's operation
- If possible the schemes should be free from politics by having a neutral and independent body to manage the national health insurance authority as it is been done elsewhere.
- Increase the subsidy from GHC 14 to GHC 18 per client
- Control and monitoring should be intensify and regular to curb the misuse of funds
- Increment of the levy to accumulate more fund
- Additional sources of funding should be created by the government

4.2.8 Payment of Claims

Claims were said not been be paid in full to the service providers. The National Health Insurance Scheme accredited facilities do not charge the health insurance clients directly but indirectly transfer their charges to the District Mutual Health Insurance Scheme where they

have registered and paid their premium. The District Mutual Insurance Scheme then vets the claims before payments are effected. Claims are queued based on the time they are brought to the insurance office. Claims are vetted based on the sequence of when they are received. Payment can be delayed when there are backlogs of bills yet to be vetted. The credit period can extend beyond three month. Reasons that were assigned to the inability to pay claims are as follows: delay in the release of the government subsidy, the system of operation of the scheme where the providers are to submit their claims after60 days of the utilization and scheme also has 30 days to make payment, the process of re-insurance takes a lot of time and very cumbersome and the delay on the part of the service providers because of the vetting process.

4.2.9 Increase in Patients Attendance

It was clear from the respondents that attendance over the years has increase due to these reasons inadequate sensitization preventable diseases, the concept of "it is free", and no limitation on the number of attendance after you have registered with a mutual scheme.

4.2.10 Feasibility of One Time Premium

There was a varying opinion on the issue of one time premium payment. About 20% of the respondents went for the affirmative, another 70% went against the idea but the 10% said they cannot tell if it is feasible or not.

4.2.11 Drugs Served by the Facilities

All the facilities interviewed served both locally manufactured and imported drugs. The unaccredited facilities serve more of the imported drugs than the local ones. The accredited facilities serve more locally manufactured drugs than the foreign ones. The accredited facilities either serve the drugs from their own dispensaries or issue drug prescription forms to patients to accredited pharmacy or drug shop.

4.2.12 Prescription of Drugs

90% of the accredited facilities prescribe only the drugs on the National Health Insurance Scheme's tariff structure. About 10% of them seldom prescribe drugs outside the drug list to patients and tell them to buy on their own.

The facilities operating under 'Cash and Carry' can prescribe any drug they think can help the patients. There are fewer restrictions on them as to which drug on what drug list or tariff structure to prescribe.

4.2.13 Charges for Drugs and Non Drugs

The accredited facilities charge National Health Insurance clients according to the tariff structure of the insurance scheme on drugs prices and services fees. The non health insurance clients who attend the accredited facilities are charged as 'Cash and Carry' patients. The unaccredited facilities charge their patients based on their profit margin.

It must be clarified that currently there is no health facility in Ghana that operates fully under the National Health Insurance scheme without still operating under the 'cash and

carry' system because it is not every resident who has registered with the National Health Insurance. This therefore buttresses the fact that whether the facility is accredited or not, the patients who visit there come with either health insurance policy or cash to pay for the medical care.

4.2.14 Payments for Services and Drugs

The unaccredited facilities, payment is made for drugs and non-drugs immediately after receiving the treatment by the patient. At times, initial deposit is demanded before treatment begins and the balance is paid immediately after treatment. All payments are made before patients are discharged.

The National Health Insurance Scheme accredited facilities do not charge the health insurance clients directly but indirectly transfer their charges to the District Mutual Health Insurance Scheme where they have registered and paid their premium. The District Mutual Insurance Scheme then vets the claims before payments are effected.

Claims are queued based on the time they are brought to the insurance office. Claims are vetted based on the sequence of when they are received. Payment can be delayed when there are backlogs of bills yet to be vetted. The credit period can extend beyond one month.

4.3 Discussions of the findings

4.3.1 Social Security and National Insurance Trust Registration

In Ghana, Social Security and National Insurance Trust was one of the organizations that President Kufour's administration negotiated for loan to finance the formation of the National Health Insurance Scheme (Health Insurance and the SSNIT Contributor, 2004).

The government in a way to repay the loan made it a policy to subsidize the premium of any SSNIT contributor who registers with NHIS. Currently, the government pays fourteen (GHC14) Ghana cedis per year for each SSNIT contributor. In Ghana, it is compulsory for every employer whether Non Governmental Organization (NGO), profit oriented, public or private organization who employs someone to deduct 5% of the employee's remuneration, 0add 12.5% of the employer's own income and pay on behalf of the employee to SSNIT.

In the study, most of the NHIS accredited health facilities pay the SSNIT contributions of their staff. Majority of the unaccredited health facilities pay for only few of their core staff. 70% of the accredited facilities pay for more than half of their entire working force. 40% of the unaccredited facilities pay SSNIT contributions for less than half of their entire staff. Where an employee sees that his/her premium would be subsidized, he/she would not hesitate in registering with NHIS. This buttresses the reason why more SSNIT contributors register than non-SSNIT contributors do. The unaccredited facilities, since many of them do not pay SSNIT contributions for their workers, many of their workers do not join NHIS. This is because the premium is quiet expensive to them. There is a positive correlation between SSNIT contributors and registration of the NHIS and a negative correlation between non-SSNIT payers and NHIS registration. The more people get premium subsidies from SSNIT, the more they are willing to register with NHIS. Many hesitate to join the NHIS because they do not get any reduction in the payment of their premiums.

It is evidenced that despite many announcements on the communication media about National Health Insurance yet for some reasons, there are many people who have refused to join. In the study where all the elements of the population are literates and in addition, have

some knowledge about health, there are some facilities administrators who have refused to join the National Health Insurance Scheme. 60% of the unaccredited facilities administrators who have not registered with the scheme. For the entire sample, 20% have not registered with the scheme. According to President Kufour's last Independence Day Speech (2008), he reiterated that the National Health Insurance Scheme has covered 50% of the entire population. This therefore implies that many residents have not registered with the scheme.

The views from the non-health insurance registered clients reveal that the concept of the National Health Insurance is based on affordability so inferior drugs and services are rendered to commensurate with the premiums the clients are paying. For them, quality can never be compromised so they see no need of joining the National Health Insurance Scheme (NHIS) because the quality health care they need cannot be provided by the NHIS.

4.3.2 Ownership of the Facilities

With the accredited facilities, 70% belong to the government, 30% are private facilities there were no mission facilities. It can be seen that the government is doing exactly what he is encouraging other stakeholders to do in the health care service. Almost all the government facilities Ahafo Ano North District have been accredited by the National Health Insurance Authority in contrast to the private or the mission facilities.

Out of the 10 unaccredited facilities sampled for the study, none is a government facility provider, but they are private and mission facilities. The private unaccredited facilities are numerous than the mission and the government unaccredited facilities. This implies that most of the private facilities prefer the 'Cash and Carry' system of health financing than the health insurance. According to them, under the 'Cash and Carry' system, there is no 'credit

sales' in health financing where they have to wait for some time before they receive money from patients. They always have money to meet their operational costs. They are able to get money on time to pay all their creditors on time. The accredited facilities indicated that they are always under pressure to pay their creditors and attributed this to the fact that they operate with the dictates of the scheme's operations.

There is a positive correlation between the government health care facilities and the accredited facilities of National Health Insurance Scheme. The more the government establishes more health care facilities, the more they would be working with the NHIS. On the other hand, when the private facilities are more only few would be working with the NHIS, so there is a negative correlation.

4.3.3 Number of Attendance and claims

Figure 4: Attendance and claims Payment in GHC

Total Claims and Attendance			
	2007	2008	June 2009
Total Claims Submitted	279,981.11	763,672.57	417,598.27
Attendance	32,376	54,616	19,902
Payment	246,311	695,555.33	315,213.17

Source: Annual Report of AADMHIS 2009

For the accredited facilities, the clients' number keeps increasing because people now understand the concept of the National Health Insurance Scheme. The diseases that people previously endured because they had no money to cure them are now outdated. The NHIS has increased the attendance for these accredited facilities. In view of this, when one visits any of the accredited facilities and does not go there very early in the morning or dawn, one would meet a long queue and would have to spend a longer time there. The survey

conducted indicated that there has been a significant increase in attendance of patients to the hospital which is about 41% from 2007-2008. The attendance keeps increasing because patients from sister schemes can visit these facilities on transfer. The Tepa district hospital has many departments to provide various services to patients so many people from around the area come there for health services.

Under the 'Cash and Carry' system of health financing, the management of the unaccredited facilities train their staff to adopt friendly care environment that attracts many patients to attend. Many patients visit these unaccredited facilities not only because of the attractive environment but also because of the respect and treatment that they get from the health professionals working there. Many Ghanaians have the perception that private health facilities deliver more quality services and drugs than the state owned health facilities. In view of this, the patients are prepared to pay any amount of money that they would be charged because they presume the services and treatment they receive commensurate with the money they pay.

Now because of the increasing number of registration of the scheme the unaccredited facilities are been left for those who are perceived to be well to do. Interestingly, the attendance of patients to the unaccredited facilities is also rising despite the operation of the health insurance scheme. These unaccredited adopt marketing strategies such as positioning to place themselves in the minds of patients that they provide quality health care so patients after quality health care rely on them.

4.3.4 Premium Payment

SSNIT contributors pay smaller amounts as premium because they get subsidies from the government. Non-SSNIT contributors pay the full premiums. They do not receive subsidies from the government when paying their premium. Many of them complain that the premiums are expensive. For such clients registration is difficult for them.

There is a positive correlation between the SSNIT contributors and registration of NHIS. The more the people contribute part of their income to SSNIT towards future pension the more they are willing to register with the NHIS because they will be enjoying some subsidies. On the other hand, there is a negative correlation between non-SSNIT contributors and NHIS registration. Since they do not enjoy any subsidies in the payment of premiums, they think that the premiums are expensive so registration becomes a problem.

The government transfers money to support the administration and claims payment from the central coffers. There is 2.5% of tax on all proceeds from VAT so when VAT service collects tax, 2.5% is sent to National Health Insurance Authority for onward disbursement to the District Mutual Health Insurance Schemes (DMHIS). The amount disbursed is based on the number of registered clients that a DMHIS has. A DMHIS that has more clients can receive more than a DMHIS with small number of clients.

4.3.5 Drugs Served and Charged By the Facilities

Although all facilities serve both locally manufactured and imported drugs, the quantities they serve differ from one facility to another and also differences exist from accredited to unaccredited facilities.

The accredited facilities use the tariff structure of the NHIS to guide them in charging the drugs to the clients. The tariff structure contains the drug list and the charges for all the services. The accredited facilities are expected to operate within the drug list when they are serving the drugs. This drug list uses the generic names and not the brand names. If any of the accredited facilities serve a client a drug, which is outside the drug list of the District Mutual Health Insurance Scheme that facility stands to loose. Most of the drugs the accredited facilities prescribe are limited to the ones on the drug list. However, on few occasions they prescribe drugs that are not on the drug list to clients to buy.

The unaccredited facilities do not have that problem in prescription of drugs. Since they are operating under 'Cash and Carry' system of health financing, all drugs whether imported or locally manufactured, once patients pay for them immediately they are served. The mindset of the patients that attend these unaccredited facilities is that they are paying for quality drugs so no matter how high the clients are charged for the drugs, they understand that they are paying for quality services. The unaccredited facilities serve more imported drugs with renowned brand names. This strategy serves as the bedrock of the quality service.

There is a positive correlation between serving of more locally manufactured drugs and the drug list of the National Health Insurance Scheme. The drug list is there to minimize cost so if there is a locally manufactured drug that can perform the same function as the imported one it will go for the locally manufactured one. The imported drugs are costly so the NHIS drug list prescribes the foreign drug where there are fewer locally manufactured ones.

4.3.6 Payment of claims for Services and Drugs

The accredited facilities compile the list of the all National Health Insurance Scheme clients and submit them to the District Mutual Health Insurance Scheme (DMHIS) office for payment. Normally, the credit period of the DMHIS to repay the claims is one month.

The submitted claims are queued based of the sequence of when they are received at the DMHIS office. These days the number of clients' attendance to the facilities is increasing because people now understand the concept of health care. Vetting of claims can exceed one month. Vetting goes with background investigations and enquiries before approving or rejection some of the charges on the claims return forms. The payment can only be effected when the claims department is certain that all the vetted claims are correct before recommendation for payment is made. The vetting process can delay the payment beyond one month if the submitted claims contain many 'forged bills'. In addition, a DMHIS can exhaust its funds in the claims account so it has to do reinsurance by sending all the documents of the outstanding claims to the National Health Insurance Authority (NHIA) for them to bring money for payment. NHIA would also send auditors to investigate and do background investigations before payment is done. All these processes go with time so payment can be delayed. This buttresses the fact that the creditors of the accredited facilities put more pressure on them when the facilities do not pay them on time. Delay in paying the accredited facilities can also delay the payment of their salaries especially if the accredited facility is a private and is not paid by the Accountant and Controller General's office.

The unaccredited facilities operate under the 'cash and carry' system so there is no problem for the payment for drugs and services. Once patients attend the facilities, there is assurance

that payment for drugs and services rendered would be made. There is the assumption that when the patients do not have money they would not try even to go there. No credit period given to the patients. Everything transaction is based on cash.

The unaccredited facilities are most of the time able to meet the needs of their creditors on time. Most of them are able to pay their employees on time. The balance on their accounts receivable is kept at the barest minimum.

4.3.7 Challenges and Government interventions for improvement of the scheme

The survey has revealed a number of challenges that are bedeviling the scheme's operations. From the various responses it suggests that there are a lot of things to be done to a proper system of health insurance in the country. There should be a serious consultation with actuaries to strengthen the operation of the district mutual health insurance schemes. There is a saying that "a healthy people build a healthy nation". The life of every individual counts, and every individual has something to offer towards the building of a better nation Ghana. The interventions made by the respondents manifest the commitment of the people to build a strong health insurance system in the country. The government is expected to put measures that bring the scheme to the level that will be comparable to schemes around us. The people are now enlightened and wouldn't want to see that their right is been trample upon.

4.3.8 Feasibility of One Time Premium Payment

The policy will require a member of the scheme to pay for his or her health for once in his life time. The issue of how much that will be the rate has not been ascertained. Insurance concept says that it is a pool of resource that is not used by all contributors at the same time

but to the one in need. Do we defile the concept of insurance if we pay for once in our life time? Most of the interviewee answered in the negative to the question of one time feasibility. Many of the respondents believe that the scheme is fragile which have many challenges that need to be fixed. So the issue of funding it with one time premium is not the best and might collapse the scheme. But the management of the scheme has different opinion this is due to the consultation and explanations with them and the government on the policy as they responded affirmative. Their response may be influence politically. There is also some argument that over 70% of the beneficiaries do not pay any premium. Among them are the pensioners, under 18 years, indigents. aged 70+, pregnant women and SSNIT contributors.

4.4 Evaluation of the Findings

It is seen that SSNIT contributors enjoy some subsidies in paying their premiums and this is one of the motivating factors that influences them to register with the scheme. If a SSNIT contributor does not register with NHIS, he/she feels cheated, his /her money was used to finance the formation of the NHIS. If SSNIT contributors form the majority of the population, then NHIS clients' registration would not be a problem.

On the contrary, the bulk of the population are in the informal sector who are non-SSNIT members with little or no formal education at all so convincing them to join the scheme is difficult. This buttresses the reason why after four (5) years of operation about 50% of the population is still yet to join the NHIS. Even in the class of health professionals, some

people oppose the operation of the National Health Insurance Scheme because they have many problems with it than the 'Cash and Carry' system of health financing.

With regards to the Ghana's health insurance, there are four (4) stakeholders in the health care provision and delivery. They are the government, the mission or the churches, the private and the patients. The National Health Insurance Authority (NHIA) does not discriminate against giving accreditation to any group of the health facility providers. The NHIA has set standards so any facility seeking for accreditation must meet the standard so that it can be accredited. In Ahafo Ano North District of Ashanti Region, almost every government Community-based Health Planning and Services (CHPS) zones have been accredited by the NHIA. But there is no pressure that enforces all the health care providers to join the NHIS, the 'cash and carry' system of health financing will continue to operate alongside the NHIS. Because of the increasing interest of Ghanaian in the health insurance concept, every health facility provider does not want to be left out.

The time spent at the facilities is something that patients really consider. When more patients visit a facility there is the tendency that more time would be spent for any late comer. In view of this, some people who have valid NHIS policies at times visit the unaccredited facilities to do away with time wasting. These days more and more patients are attending the health care facilities so if there is no expansion on the existing facilities, there would be a time that the available facilities would be overstressed and break down especially of the accredited facilities. The long queuing at the accredited facilities opens the door for those who can afford to visit the unaccredited facilities even though they might have registered with the NHIS.

In addition, both the accredited and the unaccredited facilities serve their patients with both locally manufactured and imported drugs, the accredited facilities serve more of the locally manufacture ones than the imported ones. This is because the accredited ones have operational manual on drug prescription from the NHIA. The drug list of the NHIA normally goes for the generic names so the brand with the lowest cost is taken as the price for that drug at which any facility that serves that drug should charge. If a brand name with higher cost is served the District Mutual Health Insurance Scheme (DMHIS) would only pay the charge in the drug list so the excess charge would be a cost to the facility.

The payment for drugs and services, the accredited facilities receive bulk income whiles the unaccredited ones receive money in bits (piece meal). The unaccredited ones normally do not extend any credit facility to any patient but the accredited facilities prepare their claims bill for payment for a period minimum of two weeks before sending them to a DMHIS for payment. If an accredited facility does not have enough working capital, its operations can be halted because payment for claims submitted can be delayed.

The mutual insurance concept was introduced to help Ghanaians pay for their health needs as and when they fall sick. They are there to prepare for unforeseen diseases that may befall them at the time they are not prepared financially. As the number of attendance increases there is no doubt that pressure mount on the already insufficient pool of money that has been contributed. The one time premium will allow more and more members to join the scheme which is good anyway but on the same premium paid for years. The law of mutual health insurance in Ghana does not allow the scheme to invest any of the income at their disposal to any business venture. The monies are supposed to be used solely for the payment of

claims at the district level. On the contrary there are always outstanding bills that the districts owe to the service providers which hinder the quality of health delivery to patients in Ghana.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

The study was to investigate the feasibility of one time premium payment and other related issues to health financing of the National Health Insurance Scheme (NHIS) in the Ahafo Ano North District of the Ashanti Region.

The statistical tools used were stratified sampling and correlation technique. The study looked at three groups to find answers to the research questions set they are the management of the scheme, the health service providers and the clients and non client in the Ahafo Ano North community.

5.1 Summary

The study shows, a little above 50% of the entire population of the district have taken the National Health Insurance policy to cover their families and about 47% of the respondents have not taken the National Health Insurance policy to cover their families.

Social Security and National Insurance Trust (SSNIT) contributors enjoy subsidies in paying their SSNIT their premiums but non-SSNIT contributors do not receive any subsidies in paying their premiums. There is a positive correlation between SSNIT contributors and National Health Insurance Scheme (NHIS) registration. The more people register with SSNIT, the more they register with NHIS. Majority of the population of Ghanaian workforce are non-SSNIT contributors. This majority group often hesitates to register with

NHIS because they do not enjoy any subsidies in their premium payments. This accounts for the reason why 50% of the population has not yet registered with the NHIS.

According to the SSNIT contributors, the premiums are affordable. The rest who do not enjoy any subsidies complain that the premiums are expensive. There is a negative correlation between NHIS registration and those who do not enjoy the subsidies in the payment of premiums.

Patients who visit the accredited facilities spend more time at the facilities waiting to be served because of the large number of patients who attend the said facilities. On the other hand, patients who visit the unaccredited facilities spend less time there and get enough time to attend to other things. As more time is wasted at the accredited facilities, some of the NHIS clients who can afford to pay for their medical bills attend the unaccredited facilities to avoid time wasting.

The existing equipment and gadgets at the accredited health facilities are being over stretched because of the increase in the number of patients' attendance. They can easily be broken and run down if practical measures of expansion are not embark on immediately.

Both the accredited and the unaccredited facilities serve locally manufactured and imported drugs. The unaccredited facilities serve more of the imported drugs than the accredited facilities. The imported drugs with their renowned brand names are costly so the National Health Insurance Authority does not allow the accredited facilities to serve the clients more with such drugs because their costs alone can collapse the schemes. The unaccredited facilities are not restricted in prescribing drugs to their patients. As they give more of the

imported drugs to patients people form the perception that they give quality drugs to their patients.

The accredited facilities charge their procedures in working and drugs according to the tariff structure of National Health Insurance Scheme. They do not use their own arbitrary powers to charge at any price they want. The unaccredited facilities are not restricted in charging their procedures and drugs to the patients. They can serve the patients any drug and transfer the cost to the patients at ease.

The number of attendance is increasing for both the accredited and unaccredited facilities. The NHIS clients' number is increasing almost everyday so many clients these days attend the hospitals and clinics.

The unaccredited facilities have put in place friendly patients' care high quality standards and welcoming environment that attract many patients to their facilities.

The payment for services and drugs, the accredited facilities compile the medical bills and transfer them to the District Mutual Health Insurance Scheme (DMHIS) for the payment. The unaccredited facilities demand money immediately the treatment and the drugs are given to the patients. At times initial deposit is demanded before treatment begins. There is no credit facility given to the patients. Everything is by cash.

There are a number of challenges that need to be looked at in other to sustain the operation of the schemes. The government subsidy is woefully inadequate and delayed in coming to the district schemes for payment to the health providers. This is putting much pressure on

the health facilities because they can not pay their creditors on time. There is also the issue of fraudulent activities at the schemes. The challenges have the potential to collapse the schemes.

One time premium payment cannot be said to be feasible in the eyes of the respondents as most of the think it is a political talk and that there a lot of problem with the scheme that needs to be fixed to strengthen its operations than to add more to it in the area of funding.

5.2 Conclusion

On the surface, the one time premium was not feasible but the population of the beneficiaries of the scheme who are been taken care by the government subsidy suggest that is feasible. The other factors and challenges of the scheme did not give any hope for the one time payment of premium.

All the respondents working in the accredited facilities have taken the National Health Insurance Scheme policies and some of the respondents of unaccredited facilities have taken the NHIS policies. Majority of the respondents of the unaccredited facilities have not taken the NHIS policies.

There was a category of people in the community who are by virtue of the law of insurance and government policy are not allow to pay premium, those who fall in that group are Social Security and National Insurance Trust (SSNIT) contributors, the indigents, aged 70+ years, under 18years, pregnant women, and pensioners so they enjoy subsidies in paying their premium and pay a little for their annual premiums. The other group of the public who are not in these category pay the full premium and they form the minority of the population. They are much reluctant to register because of the full premium they pay.

It is evident that long queues are normally seen at the various accredited facilities because of large attendance at the hospital. This makes patients who visit the accredited facilities spend more time in queuing before they are served. This situation sometimes makes some of the NHIS clients visit the unaccredited facilities to avoid time wasting.

The increase in the number of attendance has made existing equipment and tools at the accredited facilities overstretched and can breakdown soon.

The accredited facilities serve their patients more of the locally manufactured drugs and less of the imported drugs. The unaccredited facilities serve their patients more of the imported drugs and less of the locally manufactured drugs.

The NHIS tariff structure procedures is used by the accredited facilities in charging their and drugs that they serve in contrast to the private unaccredited facilities.

The patients' attendance to the health care facilities is generally increasing for both the accredited and the unaccredited facilities.

The system of payment by the health insurance delayed the accredited facilities as they are supposed to submit their claim after 60 days to the utilization and the scheme also has 30 days to make payment, but the unaccredited facilities transact their business with their clients on cash basis alone and do not give credit.

There was clear evidence that the insurance operation is characterized by heavy political influence in the recruitment of employee as well as policies to be implements to strengthen the operation of the scheme.

5.3 Recommendations

The tax base should be expanded to provide enough funding for the schemes. Additional sources of funding (foreign donors partners) should be arranged by the government to see the sustenance of the health insurance program. The issue of re-insurance should be revisited to facilitate easy transfer of fund to pay claims of the health providers eg. networking of the system. This will also call for training and hiring of highly qualified staffs to manage the challenges.

As much as possible the scheme's operation should be free from political interference especially the policies that are used to run the health insurance scheme. The staffs that are been sent away because of their perceived political affiliation has already acquired some training and those coming in will need additional fund for training this is strongly in regards to the upmost decision makers of the scheme.

The tariff structure should be revised as soon as there is a change in the general prices of drugs and medical practice to reflect the actual rates that should be charged by the service providers. This will ensure quality health care delivery to the clients.

The subsidy per client should also be increase from the current GHC14 to GHC18 to help the providers. The current subsidy is woefully inadequate and that can for many private facilities not join the scheme. The government should encourage all the health care facilities to get on board to get accreditation from the NHIA so that there would be less competition

among the facilities. At least 50% of the submitted claims should be paid at once to enable these facilities to have some money to some of the pressing needs of their creditors

The accredited facilities especially the government ones should embark on good patients care training skills for their staff so that patients can be welcomed very well there.

If possible the law of the insurance that do not allow the schemes to invest with extra income in any activities should be changed for the for idle income to generate more income for the scheme.

5.4 Suggestions for future Research

Future research on this topic involves more schemes and client to bring the conclusions reflective enough.

The next research should be in the urban areas of the country. This will ensure that we have more literate respondents rather than the few that were interviewed.

If a similar work in the urban centres and the cities the results could also be compared to ascertain the similarities and the differences.

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APPENDIX

TO THE MEMBERS AND NON MEMBERS OF THE SCHEME

As part of the requirement of an MBA programme I am pursuing at KNUST school of Business, Kwame Nkrumah University of Science & Technology, Kumasi, I am conducting a research on the topic "Health Insurance Financing". Your view in this regards are highly needed. Please answer the items below as frankly as possible .The answers you will give will be treated in strict confidentiality and will be used solely for the research. I count on you maximum cooperation

1. How many dependents below 18 years do you sponsor?

   a. [1] b. [between 2 and 5]

   c. [Between 6 and 10] d. [11 or more] e. [0]

2. Have you taken health insurance policy? a. [Yes] b. [No]

3. If the answer is 'no' to question 2, give reasons_____

4. How much do you pay as health insurance premium?

   a. [Below GH C 10.00] b. [Below GH C 20.00]

   c. [Below GH C 30.00] d. [Below GH C40.00]

   e. [GH C 50.00 or above]

5. Is the premium? a. [Affordable] b. [Costly]

6. what is your opinion about the operation of the health insurance in your district

   a. good b. average c. very good d. excellent

7. What are some of the problems you think hinders the operation of the scheme?

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8. Do you think the one time premium is possible? a Yes b. No

9. If the answer in question 8 is No/Yes why?

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10. What do you think the government should do to improve the operation of the scheme?

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TO THE SERVICE PROVIDERS

As part of the requirement of an MBA programme I am pursuing at KNUST school of Business, Kwame Nkrumah University of Science & Technology, Kumasi, I am conducting a research on the topic "Health Insurance Financing". Your view in this regards are highly needed. Please answer the items below as frankly as possible .The answers you will give will be treated in strict confidentiality and will be used solely for the research. I count on you maximum cooperation

1. Do you provide service or facility? a. [Private clinic/hospital]

   a. [Chemist/Pharmacy] b. [Government community health planning service/ clinic/health centre/hospital]

   c. [Mission clinic/hospital] d. [Private maternity home]

   e. [Mission maternity home]

2. Which type of drugs do you often give to your patients?

   a. [Locally manufactured drugs] b. [Imported drugs] c. [Both]

3. What attract many people to your health care facility?

   a. [The quality of the service you render]

   b. [The friendly customer care service you offer]

   c. [Health insurance]

4. Where do people who visit your facility come from?

   a. [Your community] b. [Places other than your community]

   c. [Referrals]

5. Which type of drug do you often serve? a. [The drugs on health insurance drug list] b. [Any drug that can help the patient]

   c. [Only the drugs that you have in store]

6. How do you charge the patients for the drugs and/or the services you render? a. [According to health insurance tariff structure]

   b. [According to your own standard and discretion]

7. Has the National Health Insurance Authority accredited your facility?

   a. [Yes] b. [No]

8. If the answer to number 15 is 'no', do you intend to apply for accreditation for your facility?

a. [Yes] b. [No] c. [Not decided]

9. Please write the name of your facility_____

10. Considering your current stand on the National Health Insurance Scheme, is your attendance number rising?

a. [Yes] b. [No]

11. How long do you wait before you are paid for the services and/or the drugs that you give to patients?

a. [Immediately after rendering the service and/or the drug]

b. [Till National Health Insurance pay the bill]

c. [Demand initial deposit and spread the balance over some days]

12. Where there are delays in collecting money for work done, do your creditors put pressure on you? a. [Yes] b. [No]

13. If your facility has been accredited, state the longest delay you have experienced in receiving your bill from the District Mutual Health Insurance Scheme_____

14. Do you grant credit facilities to non-NHIS patients?

a. [Yes] b. [No]

15. If the answer is 'yes' to question number 21, please state the length of the credit

_____

16. Do you have any problem with the claims you made to the scheme? A.Yes b. No

17. How long does it take to receive claims from the scheme

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18. What account for the delay if any? .....

19. What do you have to say on the one time premium that has been proposed by the government?.....

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20. What do you think the government should do to improve the operation of the scheme?

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TO THE SCHEME MANAGEMENT

As part of the requirement of an MBA programme I am pursuing at KNUST school of Business, Kwame Nkrumah University of Science & Technology, Kumasi, I am conducting a research on the topic "Health Insurance Financing". Your view in this regards are highly needed. Please answer the items below as frankly as possible .The answers you will give will be treated in strict confidentiality and will be used solely for the research. I count on you maximum cooperation

1. What is the rate of premium for the scheme?

   a. above GHC 10 b. below GHC 10 c. above GHC 20

2. Is the rate enough for the operation of the scheme?

   a. Yes b. No

3. What is the percentage of registration to the population of the district?

   a. 50% b. 40% c. above 60%

4. What is the percentage of the total amount of monies collected by the scheme goes to the administration of the scheme?

   a. 15% b. 20% c. 30%

5. What are some of the problems that hinder the operation of the scheme?

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6. Give the interventions the government is doing to improve the operation of the scheme.

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1. Are you able to pay all claims on time? A. Yes b. No
2. If the answer in question 7 is yes state the reasons.....

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3. If the answer in question 8 is no state the reasons .....

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4. What in you opinion account for the increase in patients attendance to hospital

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5. From the operation of the scheme so far, do you think the one time premium payment is feasible? A. Yes b. No
6. If the answer in question 11 is yes state the reasons .....

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7. If the answer in question 11 is no state the reasons .....

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8. What do you think should be out in place to implement the policy of one time premium

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9. Who are the categories of people that are taken care by the subsidy given by the NHIA?

Pensioners	Yes	No
People above 70years	Yes	No
Under 18 years	Yes	No
Indigents	Yes	No
18-69 years	Yes	No
SSNIT contributors	Yes	No
Pregnant women	Yes	No

16. In your estimation what will be the percentage of the population who do not pay premium to the scheme but enjoy the benefits? .....