

CHAPTER ONE

1.0 Introduction

According to Xu et al, 2005 there is an estimated 1.3 billion people globally do not have access to effective and affordable health care while 150 million people and 44 million households face financial burden annually as a result of paying for health care. Further, more than 100 million individuals are pushed into poverty by the need to pay for health services. (Xu et al., 2005). In the USA, for the example, a recent study by Harvard University researchers found that, the average out-of-pocket medical debt for those who filed for bankruptcy was \$12,000. In addition, the study found that 50 percent of all bankruptcy filings were partly the result of medical expenses (Himmelstein, D et. al. 2005). Every 30 seconds in the United States someone files for bankruptcy in the aftermath of a serious health problem (The Commonwealth Fund, 2004). The practice of cash and carry system in most developing countries serves as impediment to access to healthcare by many poor people. In order to increase access to healthcare for many people, health insurance was identified as alternative health care financing mechanism (World Health Report, 2000).

Health insurance is defined as a risk sharing mechanism that lowers the out-of-pocket payment for medical services at the time of receiving health services (Barr, 1992). The situation involves premium collection from individuals by the insurer, which are used to compensate insured individuals against financial losses resulting from an insured event. In Ghana, the Health Insurance Act (Act 650, 2003) was passed providing the legal framework for the establishment of a nationwide health insurance scheme with the view to provide financial access to health care for citizenry.

One of the underlying principles of insurance is pooling of risks together whereby both high income people at low risk and low income people at high risk pay an agreed premium which provide financial protection against unforeseen events or illnesses. It is also a mutual system where a low income high risk individuals are supported by high income low risk individuals (Davies & Carrin, 2001).

The importance of health insurance cannot be overlooked and the impact of being uninsured is clear and severe. According to national health survey conducted by the Urban Institute in USA, 2002, children who were uninsured were much less likely to have received a well-child checkup within the past year. Another study also revealed that nearly 50 percent of uninsured children did not receive a checkup in 2003, while 26% of insured children did not. (Urban Institute 2004). Uninsured patients are made to pay up front, full medical bills during or before service delivery. If not they are turned away except in life – threatening circumstances (Henry J, Kaiser, 2006)

It is always important to recognize that membership size is a critical feature, in community based insurance scheme and has to be studied from time to time (Carrien et al, 2005). A study by (Criel & Waelkens 2003) on Maliando Mutual Health Organization in Guinea-Conakry revealed that membership dropped from 8% to 6% of the population covered due to dissatisfaction with the quality of health care provided by health facilities. Guy Carrin et al,(2005) also acknowledged in a study on Community-based health insurance in developing countries that reduction in subscription rate demands better understanding. The same study pointed scheme management factors such as affordability of premium, unit of enrolment, time of collecting premium and trust in integrity and competence of Managers may influence peoples desire to enroll as members given the voluntary nature of community based insurance scheme.

A critical observation from the above suggests that the success of health insurance depends on the ability of the scheme to maintain its clients as well as attracting new ones. This also implies that the viability of the scheme is measured based on the percentage of population enrolled in order to ensure that adequate revenues are collected.

It is therefore important to consider factors that would affect clients' satisfaction in order to ensure sustainability of the health insurance scheme especially when there is continual increase in the non-renewal rate in the study district.

1.1 Problem Statement

Health expenditure is described by WHO as catastrophic if people's expenditure on health care is equal or greater than 40% of their capacity to pay (Kawabata et. al, 2002). One of the promising alternatives of financing healthcare in developing countries is Mutual Health Organization (MHO). (WHO, 2005) MHO is believed to cover healthcare cost for its members to enable them overcome financial constraints associated with medical care and this has been initiated in many developing countries on pilot scale (Carrin et al. 2005).

Implementation of health insurance policy in most of these developing countries is however faced with a lot of challenges such as socio-economic factors, perception, cultural factors, and distance from health facilities. A study in China indicated that only about 10% of the rural and informal sector workforce populations in the developing world enroll onto the community – based health insurance((Tabor, 2005).

According to Atim's West and Central Africa study on 22 community health insurance (CHI) on beneficiaries and target population in 1998, the enrolment rate for CHI in Benin was 24% with target population of 13,000. Two CHI schemes in Ghana and Mali had an enrolment rate of 53% and 25% of the target population of 25,000 and 200,000 respectively. Finally in Senegal only 26% of target population of 13,650 enrolled over a period of 3 years of schemes operation.

It is necessary to pay attention to enrolment in terms of renewals and those joining for the first time. And this is emphasized by Guy Carrin et al, 2005 study acknowledging that reduction in subscription rate in Community-based health insurance demands better understanding in developing countries. The same study noted that determinants such as affordability and time of collection of premium, and trust in competence of scheme management could influence peoples' perception of joining the scheme as members. A study on Maliando Mutual Health Organization in Guinea-Conakry also revealed that membership size dropped from 8% to 6% of the population covered due to dissatisfaction with the quality of health care provided by health facilities (Criel & Waelkens 2003)

In Ghana, further study by Atim et al, 2001 noted that most schemes have relatively small membership and lack adequate financial management.

The Ghana nationwide health insurance act was passed in August 2003 for the establishment of district mutual health insurance scheme by all districts in order to improve on access and quality of health care services in the country.(GHS and PHRplus, 2004).

In the Berekum district there is continuous decline in renewal rate of mutual health insurance scheme membership. The scheme registered about 70% of the district population during its first year of implementation in 2004. However, the scheme has been experiencing continual downward decline in its membership from 5% to 8% for years 2005 and 2006 respectively. The drop out rate increased to 12.5% in 2007 and it was 8% as at mid-year 2008.(Berekum district NHIS Annual report, 2007, Berekum district NHIS Half year report, 2008).

Inability of a scheme to maintain its membership is a threat to the success of the scheme since the financial status of the scheme is dependant on its membership. This correlate with the assertion by Tabor (2005) that high drop-out rate can really affect the reputation of a community based health insurance and this will make it more difficult to manage partnerships with providers as well as threatening the financial sustainability of the scheme.

It is therefore necessary to determine whether insured clients are satisfied with services of healthcare providers and scheme management as well as finding out about their understanding of national health insurance scheme.

1.2 Justification

In the year 2004, 69,000 people in Berekum district registered with the District NHIS representing 70% of the total population. The scheme ever since its inception to 2008 has not been able to maintain its membership leading to a drop out rate of 5% and 8% in 2005 and 2006 respectively. This drop out increased to 12.5% in 2007 and 8% as at June 2008. (Berekum district NHIS Annual report, 2007, Berekum district NHIS Half year report, 2008). This situation among other determinants, could affect the sustainability of the scheme since the financial status of the scheme is dependant on its membership size.

The above observation has necessitated the study into what accounts for non-renewal of membership with Berekum Mutual health insurance scheme.

1.3 Research Questions

In the light of the above discussions the research sort to answer the following questions

1. Does scheme management affect clients' non-renewal to scheme?
2. To what extent does health service provision affect non-renewal at facility level?
3. What is clients' understanding and expectation of the concept of NHIS?
4. What intervention could be put in place to avert the situation of non-renewal in Berekum district?

1.4 General objective

To investigate the determinants of non-renewal with National Health Insurance scheme in Berekum district.

1.5 Specific objectives

1. To determine scheme management related factors that influence non-renewal
2. To identify healthcare service providers factors which influence non-renewal
3. To find out about clients understanding and expectation of NHIS concept.
4. To outline recommendations for sustenance and improvement in membership/enrolment.

1.6 Background of Study Area

Berekum district is one of the nineteen districts in Brong Ahafo region of Ghana which shared boundary with Jaman district to the north, Wenchi and Tain districts to the northeast, Dormaa district to southwest. It is bounded to Sunyani municipality on southeast and to Asunafo on the south. The district capital is Berekum and is about 30 kilometers away from Sunyani, the regional capital. The District has been divided into three sub-districts; Berekum North, Berekum South and Jinijini Sub-districts. . It has a total surface area of 1094.2 sq.km with estimated population of about 110,453 for the year 2007 based on the 2000 census with a growth rate of 2.5% . Majority of inhabitants in the district are Brongs and about 55.3% of them are into farming and petty trading. The district has male to female ratio of 1:1.1. The district has average rainfall of 203cm and is about 800-900 above sea level. (Berekum District Health Annual Report, 2007)

The district has total staff strength of 460 for the health service delivery and a total of 23 health facilities. Tables 1 and 2 below show the breakdown of staff and health facilities in the district.

The district has Doctor/patient ratio of 1: 15,779 and Nurse/patient ratio of 1: 1,105 in 2007. The farthest health centre from the district capital is about 15 kilometres away and the rest are within 10 kilometres range. The road network to any of these health facilities is quite good and vehicles ply the road frequently, though the roads are untarred. (Berekum District Health Annual Report, 2007)

Table 1: Number and Categories of Health Staff in Berekum district, 2007

STAFF CATEGORY	NUMBER OF STAFF
Medical Officer	7
Pharmacist	6
Nurses	83
Midwives	17
Medical Assistants	2
Disease Control Officers	10
Laboratory Technicians	5
Health Extension Worker	65
Health Support Staff	265
TOTAL	460

Source: District annual health report, 2007

Table 2: Number of Health Facilities in Berekum district, 2007

TYPE OF HEALTH FACILITY	NUMBER OF HEALTH FACILITY
District Hospital	1
Private Hospital	1
Health Centre	9
Functional CHPS Zone	5
Maternity Homes	7
TOTAL	23

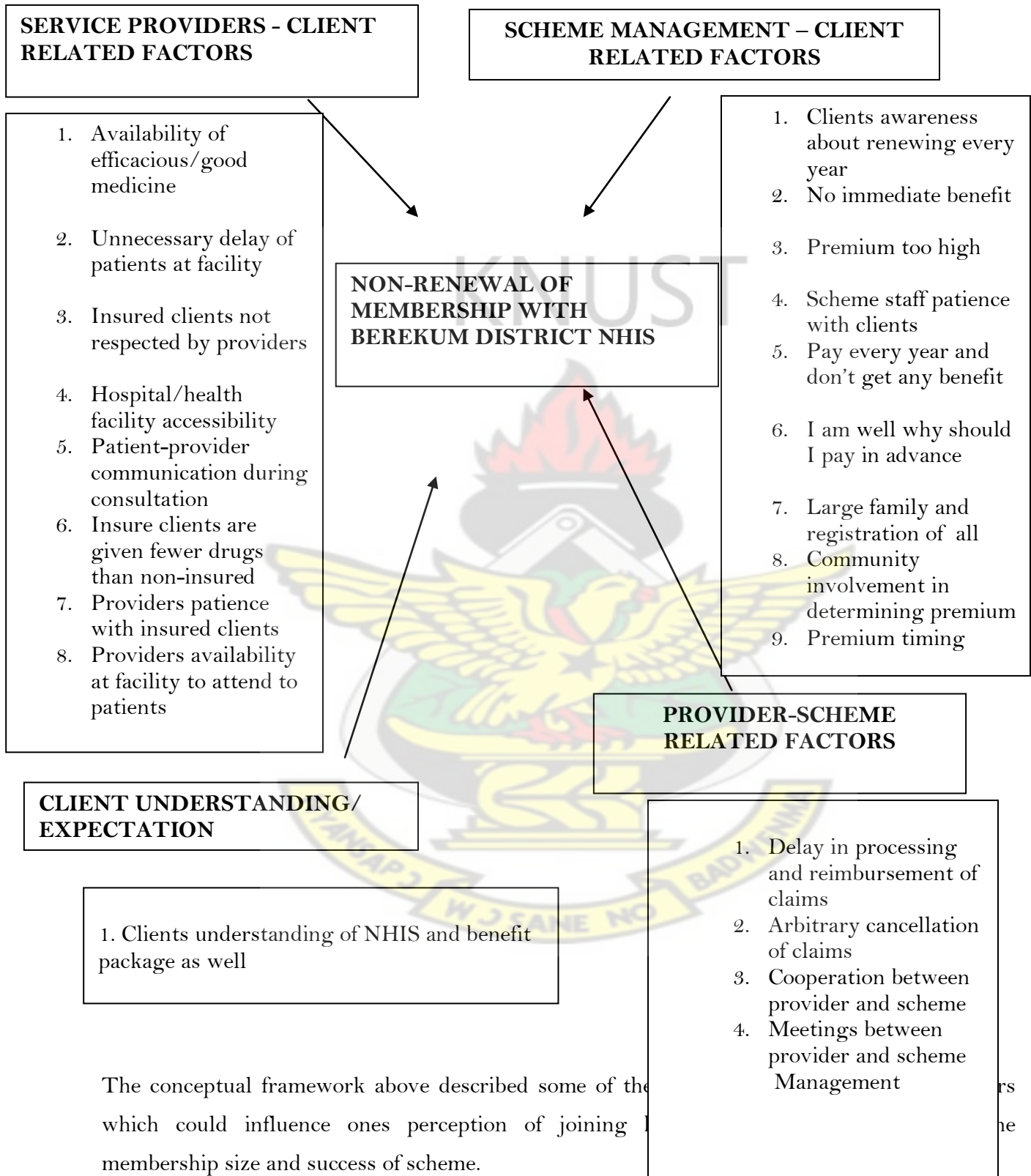
Source: District annual health report, 2007

KNUST



1.7

CONCEPTUAL FRAMEWORK



Factors such as risk aversion, high income level, low insurance premium, high user fees, trust in providers' quality of care and management of scheme could enhance ones demand for health insurance. A study by Criel and Waelkens, 2003 indicated that poor quality of health care services affects the membership of Community based health insurance.

Reasons such as low user fee, individuals risk seeking behavior if illness is uncertain and importance for current consumption because they are too poor to insure against eventual experience and disappointment and unaffordable premium levels were found for non-insurance hence affecting membership in the same study.

It essential for scheme managers to provide important information such as scheme finances and be accountable to the community as well (Creese and Bennett 1997). This is because abuse of schemes funds can easily take away the confidence of the community in the scheme

Trust is very important in the health insurance implementation. (Arrow 1963; Mechanic and Rosenthal 1999; Jowett 2003). And it has been defined in three dimensions in the context of insurance by Mechanic, 1998 as follows;

Firstly, patients trust in service provider which is patient experience in terms of provider ability to diagnose and treat illnesses.

Secondly patients trust in scheme management that is scheme management ability to improve on access to health care as well as quality of care for clients

Thirdly trust as a result of legal backing or commitment for the insurance scheme

A study by Tabor (2005) also indicated factors such as poor service, changes in price and/or services, lack of effective marketing, and conceptual misunderstanding of insurance as reasons for high attrition rates.

Involvement of community in running of the scheme is also very helpful as members seem to own the scheme and avoid unnecessary use of healthcare services thus moral hazard. Further community involvement helps them to have common interest of adopting healthy lifestyles to reduce cost of health care (Garba and Cyr 1998).

KNUST



CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Health Insurance and the Concept of Risk Sharing

Social insurance is a policy being implemented in some countries as source of funding for health services for protecting the poor against risk of major illnesses.

Thailand and Vietnam have implemented this policy for a long period and are still striving to achieve universal coverage while many countries in Africa and Asia are also trying to follow suit in adopting the policy.(Saveroff, 2004).

There is still a debate on social insurance as some countries see it as bad idea because it raises costs and inequalities in poorly governed countries. For instance in Latin America, the social insurance has operated for more than 50 years but still failing to achieve universal and equitable access.(Saveroff, 2004)

According to Saveroff's opinion piece on social insurance in 2004, social insurance means different things for different people. Some people define it as any insurance that is not for profit, while for some it refers to a social security system as in the case of Germany.

Social health insurance however is mostly described as national programmes which aim to finance basic package of health services through dedicated payroll tax or payment of some premium. This requires an independent agency to manage the health insurance fund.

Barr (1992) also described health insurance as a risk sharing mechanism that lowers the out-of-pocket payment for medical services at the time of receiving health services.

According to Townsend, household with access to insurance have the potential to increase their income level and diversify their financial risk (Townsend 1995).

Davies and Carrin, (2001) described health insurance as pooling risk together whereby both the high income earners at low risk and low income earners at high risk pay an agreed premium which provides financial protection against unforeseen events or illnesses. This risk sharing/pooling is very beneficial as it allows financial resources to be shared among healthy and sick individuals. However, risk pooling becomes limited particularly when community health insurance membership size is small and as such increasing scheme coverage becomes a challenge. (G. Carrin et al., 2005)

Again, Savedoff was of the opinion that, political problems of governing the health system will not be changed by implementing social insurance in developing countries and the following reasons were given:

In most social insurance, payroll taxes are the main the source of funds as it is easier to collect than voluntary premiums and general tax and this gives workers stake in the health insurance system. In most developing countries, the formal sector workers form a very small portion of the total employment and this poses a risk of making the system a ticket to access health services.

Secondly, countries implement social insurance with the idea of sharing burden of health care cost among households but in most developing countries the social insurance are found to cover health services such as reproductive health care, vaccinations, treatment of gastrointestinal and respiratory illnesses which are supposed to be promoted by national health policies. These services do not form insurable risks given the situation that theses service are common and frequent and expected and as such premiums that cover such services should be high relative to benefits. In this case, the concept of using the efficiencies of risk pooling to subsidize care for the poor becomes a mirage.

Finally the paper mentioned that social health insurance is does not solve fundamental health problems in some developing countries particularly, in the low-income countries since their fundamental problem is not ineffective financing. The problem with these low-income countries is under-financing of health care services or inefficient spending of public funds by political governments. In situations like this, even the best-designed social health insurance will fail.(Savedoff, 2004)

2.2 Insurance in Ghana

National health services was introduced immediately after the independence in 1957 to provide free health care services to the population and financing of services was from government revenue (World Bank 2004). The country was then hit by global financial crises as a result of

sudden increased in oil prices on the international market between 1970s and 1980s. The World Bank and International Monetary Fund proposed changes in their support to developing countries which resulted in decreased in health budget, putting health sector into serious economic crises. In 1985, user-fee system was introduced in Ghana to save the situation which is the basis for implementation of Hospital Fee Act (Cofie et al, 2004).

The introduction of policy of out of pocket payment of health care services by the government also known as 'cash and carry' system resulted in decreased utilization of health services by many people particularly the very poor creating financial barrier to access health care by the people (Dovlo and Nyongator 1999, Arhin- Tinkorang,2000, Hutton 2002, Nyongator,2000). Those having access to health care were also facing the problem of quality of care the received from public owned facilities (Danida,2003). Accessing health care services for the exempted groups such as poor and vulnerable groups such as children under five years, pregnant women and aged was also very difficult.(MOH,2002).

As a result of low access to health care services by the people in the country, the government requested for alternative ways of financing health services in order to remove financial barrier to health care for the poor. The Ministry of Health proposed health insurance as alternative way of financing health care services in Ghana.

Ministry of Health in 1994 initiated feasibility study for establishment of the scheme to enable government to formulate policies that will be suitable for all Ghanaians irrespective of your financial status. (Cofie et al, 2004)

Findings from the feasibility study indicated the possibility for establishment of the scheme but concerns such as raising standard of quality of care in public health facilities, availability of technical administrative personnel to manage the scheme, other socio-economic issues with regards to premium, coverage and payment were also raised.

Several health insurance schemes such Nkoranza, Dodowa, Okwahu etc were tested ever since. Existing schemes were reviewed in 2002 and report was presented to the Government (Akor, 2002). The promising findings in the report led to adoption and passing of Health Act 650 in the country on August 2003. This led to establishment of National Health Insurance and subsequently operationalization of health insurance throughout the country.

One of the oldest health insurance schemes in Ghana is Nkoranza District Health insurance scheme. This scheme was established in 1988 by St. Theresa's Hospital in order to make health care services financially accessible to residents in the district. The scheme was also instituted to curb the problem of financial losses to the hospital as a result of unpaid bills by poor residents and people who abscond after receiving health services due to their inability to pay for the service fee. (GHS and PHRplus, 2004).

The benefit package for the scheme was previously for admissions and only emergency services over 24hours. In course of implementation the benefit package was increased to cover some selected OPD services, snakes and dog bites. Premium was 25,000 cedis per head per annum. The scheme is currently operating towards the standards enshrined in the National Health Insurance Act.

Mutual Health Organization (MHO) is one of the best alternatives of financing healthcare in developing countries (Commission on Macroeconomics and Health 2001; World Health Organization 2005). MHO covers healthcare cost for its members to enable them overcome financial constraints associated with unexpected medical care and this has been initiated in many developing countries on pilot scale (Carrin et al. 2005).

In Ghana, the government in an attempt to implement the poverty reduction strategy has introduced national health insurance to be implemented nationwide in an effort to provide accessible, affordable, good quality healthcare to all Ghanaians. (Poverty Reduction Strategy (2003), The National Health Insurance Act (NHIA 2004) was passed in 2003 (National Health Insurance Act 650, 2003) followed by the National Health Insurance Regulations late 2004 (National Health Insurance Regulations 2004).

According to the NHIA every district in Ghana should establish MHO with sources of fund such as sales tax, formal sector worker contributions, and voluntary payments by informal sector workers. In order to ensure standardization in the operation of MHO in the country, the government has defined minimum package healthcare services and premium levels for the schemes. In addition issues such as, family registration, probation periods, and tariffs have been determined by the government (NHI Regulations 2004).

Political willingness to establish scheme, purchasing power of community as well as perceived quality of care are some of the factors that contribute to the success of MHO. (Criel et. al. 2004). Community involvement and local ownership as well as local autonomy in determining premiums, benefit packages and decision making provide sense of responsibility to the scheme by members and prevent increased financial burden on the MHO due to over utilization by members. This could lead to increased subscription and success of the scheme (Atim 1999; Arhinful 2003).

It has also been established by a study that most schemes in Ghana have relatively small membership and lack adequate financial management (Atim 1999; Atim et al.2001; Aikins 2003). A nationwide survey report gave an overview of the organizational structure and financial management of 45 operational MHO in Ghana, indicating inadequate financial management and regulation of the schemes by Ghanaian authority. The report recommended that, the National Health Insurance Council should fully enforce the law which demands that, all districts MHO should submit audited report to the Council as provided under the 2003 Insurance Act and be given enough autonomy to help community to participate in decision making (Baltussen R et al. may 2006)

2.3 Scheme Design

The design of the health insurance scheme involves three stakeholders as follows:

1. Scheme administration
2. Clients of the Scheme
3. Health Care Providers

An Insurance Scheme will function very well if there is good relationship and understanding between the 3 stakeholders. The Act 650, 2003 also mandated establishment of National Health Insurance Council to coordinate the relationship between the 3 stakeholders and oversee the activities of the scheme administration.

2.4 Types of Schemes

The Act 650, (2003) paves way for establishment of 3 types of scheme namely,

1. District wide National Insurance Scheme

2. Private National Health Insurance Scheme
3. Private Commercial insurance Scheme

In Ghana the District wide National Health Insurance Scheme is supported by the central Government by establishing the scheme and providing start up fund, bail out fund when scheme is on distress and also pay premium for indigents, under 18 years of age, pensioners covered by SSNIT scheme, pregnant women, SSNIT contributors and aged 70 years and above using national health insurance fund. The private ones established as mentioned above do not enjoy any financial support from the government. (National health insurance Act, 2003)

The local government through District Assemblies is given the mandate to establish the district wide insurance scheme according to the Act. The Part III section 29(2) of the Act states that

‘Every district assembly shall identify promoters to initiate action for the registration of the scheme as a company limited by guarantee under the companies code 1963(Act 179) for the relevant district within sixty days of the coming into force of this Act or within such further period as the council may direct’.

The district Assemblies supposed to determine the personnel with technical competence for the establishment of the scheme as well as carrying out social mobilization activities. (National health insurance Act 650, 2003)

2.5 The Establishment of District Wide National Health Insurance

According to the act 650, 2003, local government through District Assemblies are to ensure establishment of district wide scheme, identify persons with technical know-how to support establishment, coordinate all activities and undertake social mobilization. Every district wide mutual health insurance scheme is to be managed by a governing body and Scheme Manager (Adjei et al, 2004)

The governing Body - The membership of the body is between 7 and 15 persons and is elected by a general assembly. The general assembly is made up of registered and fully paid up

members of the scheme. The main function of the body is policy direction and appointment of employees of the Scheme as well as arbitrating in any local dispute that may arise between scheme manager, provider and clients. (S. Adjei et al, 2004)

The Scheme Management - This is a body or a committee and it ensures day to day administration of the Scheme. The basic staff composition of the management is as follows,

1. Health Insurance Scheme Administrator
2. Publicity and Marketing Manager
3. Claims Manager
4. Accountant
5. Data Control Manager
6. Data Entry Clerk

2.6 Sources of Funds for Scheme

About 80% of contribution to the insurance funds is through taxation by central Government, and this includes

- 2.5% out of 17.5% of each formal sector worker's SSNIT contribution is deducted and pay into insurance fund as premium for each worker in formal sector.
- 2.5% national health insurance levy on the sale of goods collected through the Value Added Tax system.
- Grants, donations, gifts and any other voluntary contribution made to the Fund
- Money accrue to the Fund from investments made by the Council

All these funds must be approved by Parliament of Ghana.

Majority of this national health insurance fund are used to subsidize or cover the exempted groups such as indigents, under 18 years of age, pensioners covered by SSNIT scheme, pregnant women, SSNIT contributors and aged 70 years and above. (National health insurance Act, 2003)

For the informal sector, community health insurance Committee are to group residents into social classes as core poor, poor ,middle income and the rich. The core poor will not pay anything whiles the rest in the paying classes will pay not less than GH 7.20 Ghana cedis as premium for a year. (Adjei, et al, 2004).

2.7 Accreditation of Service Providing Facilities

All facilities being public, private and Quasi in the country rendering health services and wish to operate under NHIS is to be accredited to provide services to insured clients. However, all public health facilities were accepted into the scheme. The National Health Insurance Council is mandated to accredit health facilities who wish to provide services to NHIS clients according to the Act 650, 2003. The purpose of the accreditation is to ensure that, health providers on board will provide highest standards and quality services to all clients.

The accreditation process involve the use of national checklist to assess clinical services laboratory, pharmaceutical and support and management services. Some of the service areas assessed during accreditation are as follows:

1. Organization and management structure which includes staff strength, policies, financial procedures, medical statistics and information management.
2. Quality assurance practices such staff and patient safety, infection prevention and control and safety structures
3. General infrastructure such as the availability of consulting room, waiting area, screening area, equipment for service delivery, ward management and communication facilities
4. Possibility of patients having rights of privacy, confidentiality and informal consent.

However, for a facility to be accredited, it should have operated for 6 months and have high quality assurance programme, use protocols/guidelines approved by the NHIS Council, should be in compliance with NHIS drug list and should have health professionals who have registered to their recognised regulatory bodies.

Each accredited facility will be given license which is renewable every two years after the initial five years of accreditation.

The NHIC has the authority to revoke license of facility that defies regulations of health insurance operations. (Adjei, et al, 2004).

2.8 Minimum Benefit Package for Insured Clients

The NHI Act 650, 2003 has outlined benefits package (or health care services) for a member of the health Insurance scheme (See Appendix 1). The purposes of this minimum benefit package are:

- (1) To ensure that all clients have access to an equal level of health care that provides adequate protection when one is sick.
- (2) To ease financial burden on the scheme as a result of excess cost due to extra expensive care and leading to sustainability of Scheme.

However, the district can include other health care services in the benefit package to meet the special health needs of the people in its catchment area if only it has the capacity to absorb additional cost and this must be approved by the Council. (Adjei, et al 2004)

2.9 Termination of Membership

The Scheme may terminate membership of an individual base on the following reasons.

- Failure to pay contribution within an agreed period in accordance with the constitution of the scheme
- Submission of fraudulent claims
- Refusal to provide material information required by the scheme.(National health insurance Act, 2003)

2.10 Making Patient's Bill

Currently, itemized billing system which covers services and all items used on the patient is paid fully by the scheme. The services and items used in the patients are recorded in the costing sheet found in the patients' folder, followed by the use of daily summary sheets to generate patients' bill. This itemized billing system is backed by Regulation 62 of the National Health Insurance Regulations, 2004 (L.1.1809) to form basis of generating patients bills for payment by schemes. This billing system is to continue until new directives in generating patients' bills are provided. All medical claims/ bills should be prepared and delivered by service providing facilities to patients' insurance organization. All health services providing

facilities are to identify focal persons in accounts department to prepare the bill with the exception of health centres where the In-charges will be responsible for that. The District Health Administrations have the obligation to make claims on behalf of health facilities that lack the capacity to handle claims.

2.11 Out patient services bill

This involves registration of patients at any service providing unit within the facility in separate registers which contains the different groups of patients as paying patients, exempted patients, patients of health insurance scheme and patients of corporate scheme.

At each Unit, the service providers will give requested services to the patient and enter the cost in the costing sheet in patients folder which will finally be endorsed by Head/ deputy of the service providing unit. Costing sheet will remain in the patient folder until all services requested for the patient are provided. The patient folder should be at pharmacy/dispensary as the last point of service provision. The patient folder will then be sent to accounts unit for bill preparation. Subsequently the patient folder with duplicate copy of the cost sheet is sent to Records Unit for storage. (PPME, GHS, 2004)

2.12 In patient services bill

In patient services bill covers all services provided to the patient on every day. The patient is registered in inpatient register and patient folder containing costing sheet and daily summary sheet. Services requested by the prescriber are provided to the patient and cost is entered on costing sheet which is finally signed by the Head of that Unit. The total cost of services provided to the patient is recorded on daily summary sheet for each day until the patient is discharged. The bill of the patient is calculated by the ward in-charge using the daily summaries and sent to the accounts Unit for bill preparation.

The patient folder containing copy of costing sheet and daily summary sheet is sent to Records unit for storage. (PPME, GHS, 2004)

2.13 Compilation of bills for schemes

Bills should be made on individual clients/patients and submitted to the scheme according to the regulation 62 of the National Health Insurance Regulation using NHIS form 8. The bills for each month should be submitted to the scheme within the first week of the ensuing month.

With regard to outpatient bill, a summary of costing sheets of patients enrolled in scheme who attended the health facility for the month and services provided is submitted to the scheme.

For inpatient services, number of patients discharged for that month with summary of individual bills as well as services provided is submitted. Summary of the bills could be attached with copies of individual costing sheet. A copy of all bills submitted to the district insurance scheme should be given to district health management team (DHMT). The district insurance scheme should make payment directly to the health facility and notify the DHMT. (PPME, GHS, 2004)

2.14 Financial Report on Insurance System

The DHMT is required to submit quarterly financial report on the insurance system to the Regional Director of Health Services for onward submission to Director General, National Health Insurance Secretariat and the Director of Policy Monitoring and Evaluation. The financial report should cover total number of outpatients, total number of admissions and discharges for the reporting quarter. It should also indicate total charges for various units of services such as drugs, laboratory etc. provided to patients.

Furthermore, it should indicate cumulative bill to date of reporting, total amount of monies reimbursed to health facilities in the district and outstanding balance (PPME, GHS, 2004)

2.21 Scheme Management and Factors Affecting Membership

Currently, it has been established that out-of-pocket spending on medical care is increasing and as a result, many poor people avoid going for medical care since they lack the resources to pay. Community health insurance has therefore become a means of improving access to health care among the poor and protecting the poor from indebtedness and impoverishment resulting from medical expenditures (World Health Report 2000).

Community health insurance CHI has been defined as “any not-for-profit insurance scheme that is aimed primarily at the informal sector and formed on the basis of a collective pooling of health risks, and in which the members participate in its management (Atim C 1998). Other terms which have been used in reference to Community health insurance CHI include ‘micro

health insurance' (Dror et al 1999), 'local health insurance' (Criel, 2000) and 'mutuelles' (Atim C 2001).

All the above mentioned terms describe CHI as prepayment and pooling of resources to cover the cost of health-related events. The CHI is often initiated by a hospital targeting residents in the catchment area which could either be community or district and membership is voluntary rather than mandatory as in the case of social health insurance which covers all people in the formal sector.

Clients trust in schemes management and the health system could also affect willingness of clients to subscribe to the scheme. Though there is limited evidence to this, studies of community-based health insurance (CBHI) outlined some strategies to increase levels of trust such as;

- ▣ Improving on levels of politeness and behaviour of medical staff to patients, (Criel and Waelkens, 2003).
- ▣ Improving quality of care (Schneider, 2005).
- ▣ Transparency and accountability in management of the scheme (Schneider, 2005).
- ▣ Disciplinary measures to punish fraud (Schneider, 2004, Meessen et al, 2002).
- ▣ Subsidies for the poor (Schneider, 2005).
- ▣ Increased community involvement in scheme management (Schneider et al, 2001, Hsiao, 2001, Atim, 1999).

All these help to increase willingness to pay hence increase membership.

To increase efficiency of the scheme, activities such as creating awareness among the community; collecting premium; monitoring for fraud; submitting claims; and channeling the reimbursements should be ensured. Ensuring these activities also create a sense of ownership among the community and increases accountability. (Devadasan et. al. 2004)

One of the weaknesses of the CHIs is the inadequate inbuilt mechanism to prevent adverse selection (possibility that more people at the high risk of falling sick enroll in the scheme than those of low risk) and moral hazard (people's behavior whereby the insured seeks health care more intensively than when he/she is not insured.).The problem of adverse selection could

however be minimized by measures like, a larger enrolment unit, a mandatory enrolment, a definite collection and waiting period and limited acceptance of people with chronic illnesses are measures to prevent this. Most CHIs use co-payment as a main measure to minimize patient induced moral hazard (Baltussen et al, 2006).

In India, a study showed that the average subscription rate of Yeshasvini programme ranges from 10 to 50 percent of the target population. The study pointed out the following as reasons for people not paying anymore:

(1) No immediate benefit; (2) premium too high; (3) “we are well, why we should pay in advance? When we fall sick, we shall pay”; (4) large families – this is specially since most of the CBHI’s unit of membership is the individual; (5) “(Insurance scheme) Hospitals are far away and so we have to pay a lot to access hospitalisation. Better use the premium money to go to a nearby doctor”; and (6) “we pay every year, but do not get any benefit out of it. So we have decided not to pay anymore” (Devadasan et. al. 2004)

Scheme management as well as quality of services received from health care provider can influence one to join the insurance scheme or renew membership. Clients renew their membership if they are satisfied with services they received from health care provider.

A study in Senegal confirmed that delivery of high quality services is very essential for mobilizing demand in the medium and long term (D+C cooperation 2001). It is important for the scheme management to make people aware of the package of services they have for them so that they will join the scheme. A study in Guinea-Conakry showed that Maliando Mutual Health Organization subscription rate dropped from 8% to 6% of the target population as a result poor quality services delivered at the health center level (Criel & Waelkens 2003).

It is important for scheme management to put in place premium collection mechanism which will favour both poor and the rich. In rural areas, premium collection could be done at the time of harvest of cash crops will result in positive response for schemes (Bennett et al, 1998)

2.22 Community Socio-Economic Status and Factors affecting NHIS Sustainability

The fundamental principle of insurance is to share cost of health care services among people where payment of agreed premium is done in advance by both high income and low income

earners for protection against unexpected illness or events. A study revealed that severe poverty is impediment to success of insurances scheme and reference was made to South Borgou, Benin where two mutual health organizations have instituted solidarity funds to pay premiums for the handicapped, elderly and destitute persons (Tabor, 2005)

This gives an indication that success of the scheme largely depends on ability of the people to pay the premium which is also a dependant on occupation of the people in that particular area. According to a theory by Maslow, in communities where there are no job avenues, the people find it very difficult in meeting their needs let alone higher level needs (Humble, 1967). A study conducted in Minnesota, USA found that communities with more job avenues are more likely to subscribe to health insurance scheme than those with no job avenues (Health Economics program; issue paper April 2000).

Sustainability of health insurance scheme depends on certain factors such as quality of health care, premium, benefit package as well as socioeconomic and cultural or religious characteristics of households and communities. Abject poverty among members can be an impediment to the success of the insurance scheme (D+C Development and Cooperation, November/December 2001)

As indicated earlier, the financial status of the households and communities coupled with ability to pay premium is one factor which indeed influence the sustenance of insurance scheme. The premium should be affordable to people in the community so that more people will get enrolled onto the scheme.

It is important to ensure that community insurance cover different population groups and a WHO study by Bennett et al, (1998) noted that central government subsidies could help the vulnerable population groups to join the scheme. This is also supported by a Thies's study which also indicated income as major factor for non-enrolment as the poor always have lower probability of enrolling onto the scheme than rich ones (Ju" tting,2001,Jakab et al. 2001). This study also placed emphasis on the issue of having exemption policies for the poor households so that they can register their membership with the scheme.

Health insurance should not favour only the high income earners but should cover all the vulnerable groups. A good indicator of equality of access to health services is to enroll all people of various income levels including the poor ones (G. Carrin et al. 2005). In most developing countries, households with large family and low income find it difficult to enroll onto CHI due to their inability to pay premium. A research conducted revealed that there is increased utilization of health care services among the poorest insurance clients due to mandatory prepayment. As a result some schemes prevent the very poor from joining the scheme by setting premium unaffordable to the poor (Yip and Berman, 2001)

The pooling strength is reduced by inability of the people to pay premium and this makes the sustainability of the scheme difficult (Bennett et al., 1998). In implementing a health policy, communities need to be taken into consideration since excluding them may influence access to health care. This is because community characteristics such large family size, low education levels, lack of viable economic activity in the community could affect their demand for health services (Wagstaff et al. 2001)

The main reason for non-enrolment is poverty according to a research by Schneider and Diop (2001). It has also been established that reasons such as low user fee level, individual uncertain risk-seeking behaviour, unknown risk aversion, necessity for current consumption because of poverty and mistrust in the insurance mechanism are for non-subscription into insurance scheme (Schneider, 2004),

A study by Meesen et al (2002) demonstrated that trust and solidarity among members is an important factor for making associations viable. It was also established that information is important in enhancing peoples trust in management of Community Health Insurance Schemes as was found in the Maliando Scheme in Guinea-Conakry, which also depends on a high degree of social homogeneity (Criel & Waelkens, 2003).

2.23 Awareness, Perception and NHIS Sustainability

Insurance scheme sustainability depends on schemes ability to maintain its membership and attracting new ones and this also depends on awareness and perception of the people about the insurance scheme. In most countries it is easier enrolling people in the formal sector onto the

insurance since they have a reliable income. This is in conformity with assertion by Savedoff (2004) that payroll taxes are the main source of funds in most social insurance, as it is easier to collect than voluntary premiums and general tax and this eventually gives formal workers a stake in the health insurance system. However this poses a risk of making the insurance system a ticket to access health services, since formal sector workers form small portion of the total employment in most developing countries.

A study by Tabor (2005) indicated that awareness about concept of insurance is low among most low income clients as they found it difficult in differentiating credit from insurance. It was also acknowledged by the same study that drop-out rates could be very high if clients feels that benefits they are deriving from being members of the insurance scheme does not correspond with contribution they have made. This could be attributed to general lack of understanding of the insurance.

Again, McCord (2001) pointed out that for clients to renew their membership, they should really understand what they are buying before they pay premium because if they do not understand, they normally hold the perception that the services they are receiving is not worth the premium paid to the scheme. In other words they are not getting value for money paid. This places emphasis on the fact that, there is need for effective communication and education for clients on insurance.

A study conducted in Ghana by Cofie et al about Providers perspective on health insurance in 2004 revealed that majority of health professionals have positive perception about the insurance with the reasons that, it will reduce mortality as people can access to health care as early as possible to avoid reporting to hospital late with complicated cases.

It was also mentioned that insurance initiative will minimize financial losses to the hospital/facilities as a result of dealing with absconders and clients incapable of paying their hospital charges/fees and eventually increase revenue for the service providing facility. The study pointed out that, most health professionals have knowledge on patients' rights to quality health care, confidentially, adequate information in their sickness as well as legal issues in connection with it but know little about providers' rights.

According to the study, perception on providers' own attitude is good but needs improvement. There is lack of staff-patient communication in many hospitals especially with Doctors resulting in frustrations; helplessness on the part of the patients and this affects quality of health care delivery. (Cofie et al, 2004).

The same study also indicated poor functioning of information and education system as well as weak mechanism for public education at local and national levels on insurance and as a result little is known about National Health insurance. Knowledge about the NHI Act was also identified to be limited as few of the respondents claimed to have heard of it on radio, in newspaper and from colleagues.

A study by Cofie et al on Okwahuman health insurance scheme in Nkwakwa Holy Family, an accredited hospital pointed out that insurers have very high expectation, thus they expect to get all kinds of drugs at the hospital pharmacy and feel very disappointed when asked to buy the drug from outside. The study also indicated that insured patients were insisting on their drug of choice and some were indicating their preferences for certain brand of drugs instead of generic. (Cofie et al, 2004).

2.24 Clients' Satisfaction and Service Provision

Clients' satisfaction occurs when their perceptions of the service they have received meet their expectations and there is dissatisfaction when the service falls short of expectations. (Donovan et al, 2001). Peoples expectations are shaped/ formed by a number of factors such as

- Personal needs. This is when the needs of the user of the service are expected to be met and it varies from service to service and from customer to customer.
- Previous experience. That is when ones experience causes him to set a standard so far as that service is concerned. For example, if someone has received excellent care from one healthcare provider they may have high expectations of another healthcare provider.
- Word of mouth and media communication. The opinions of media men and the experience of friends and family also help in shaping expectations about the service.
- Explicit service communications. Printed materials about the service and statements from staff can have a direct impact on expectations.

- Implicit service communications. The physical appearance of buildings can be taken as a guide to the quality of services inside.
- Personal beliefs and values. Expectations may also be shaped by user's values. For example, strong supporters of public services may be more forgiving of poor service.
- Nature of client group. The social class of people tends to strongly influence their expectations. For example, the poor are consistently more satisfied with the health service, while richer people are less satisfied (Ken Judge and Michael Soloman 1993.).

Quality services from providers are also important in increasing the membership of a scheme. It is important to note that people's perception of good quality might be more than a mere clinical-medical notion.

In a study in former Zaire on what people perceive as quality services from providers, the top quality attribute mentioned the health worker's interpersonal qualities such as respect, patience, courtesy, attentiveness, friendliness and straight-forwardness (Haddad, 1998). Also users are very sensitive to interpersonal relations with professionals and user satisfaction is associated with improved compliance.

Technical qualities such as good diagnosis, good treatment, good work and punctuality were second to interpersonal skills. The availability of drugs in health facilities and recovery from the illness were also seen as a measure of quality services (Haddad, 1995).

Satisfaction of customers and citizens is one of the main policy objectives in many service improvements. There are three possible uses of satisfaction data:

1. Identifying priorities for improvement – The data can be used in determining customers' priorities for improvement. □
2. Benchmarking – satisfaction data can be used to benchmark the performance of one organization against another. It is a management tool for improvement as well as customer's information tool to differentiate service providers.
3. Targets – satisfaction data are used in setting targets which become a symbol of management commitment. The satisfaction information focuses the minds of managers

on the consumers/users of the services they provide. As such if users expectation rises, service providers also emphasize on continual improvement (Donovan N, et. al. 2001).

KNUST

CHAPTER THREE

3.0 METHODS

3.1 Study Area and Study Design

A cross sectional descriptive study was undertaken in the Berekum District in the Brong Ahafo Region.

3.2 Study Population

Adults aged 18 years and above in Berekum district, who were members of the Berekum District Health Insurance Scheme in 2007 and did not renew their membership in 2008 were studied.

3.3 Sample Size and Sampling Procedure

Given the confidence interval of 95% and prevalence of 50% of non-renewal of membership in the Berekum district, a sample size of 400 was calculated including 5% for non-response using Epi- Info Version 3.3.2, 2005. A total of 251 sample size was used for data collection due to resource constraints. The study subjects were selected using simple electronic randomization.

3.4 Data Collection Methods

An interview guide (*appendix 11*) was used for data collection. A record about clients who registered with the scheme in 2007 and did not renew in 2008 was retrieved from the insurance enrollment database. Five Research Assistants who were neither health workers nor staff of the insurance scheme were trained for data collection. The records about clients retrieved from the insurance enrolment database were used, to trace the study subjects to their residence where the interview guides were administered onto them.

3.5 Pre –testing

Preceding the data collection, the data collection tools were pre-tested among selected sample of target population to ensure that tools were functioning properly.

3.6. Data Management and Analysis

All interview guides administered were checked for accuracy and completeness before data was coded and entered. The data was analyzed using Epi- Info Version 3.3.2, 2005. And a descriptive analysis was done for the various study variables.

3.7 Limitations of the Study

As a result of resource constraints, a total of 251 sample size was used for data collection instead of the calculated 400 sample size.

3.8 Study Variables

The study variables includes age, sex, educational level, ethnicity, religion, occupation, marital status, reasons for non – renewal, scheme management and health service providing related factors as well as client related factors.

3.8.1 Operational definitions of study variables

Age: number of completed years of the respondent at the time of the study

Sex:	gender of the respondent.
Occupation:	the work or job of the respondent at the time of study
Marital status:	whether the respondent is married or not, or divorced
Religion:	the religious category of the respondent.
Educational level:	the highest educational level the respondent has attained at the time of the study
Ethnicity:	the ethnic group of the respondent.
Reasons for non-renewal:	what made the client not to renew his /her membership
Health service providing factors:	reasons for non-renewal that are attributed to the health care provider
Scheme related factors:	reasons for non-renewal that are attributed to the Scheme
Client related factors:	reasons for non-renewal that are attributed to the client
Client expectation	what clients hope to get from being member of scheme.

3.9 Study Assumption

An assumption made is that, clients who have not renewed their membership with scheme are representatives of those who have not registered with the scheme before.

3.10 Ethical consideration

Consent of the eligible study subjects was obtained before interview guides were administered onto them. The study subjects were also assured of records confidentiality and codes were used to avoid identification. Permission was sought from Management of both district health insurance scheme and district health directorate.

Age Group (N=251)	Frequency	Percentage
18 – 27	125	49.8
28 – 37	56	22.3

KNUST



CHAPTER FOUR

4.0 RESULT

4.1 DEMOGRAPHIC VARIABLES

Table 3: Age group of respondents who did not renew their membership with NHIS, Berekum in 2008

38 – 47	35	13.9
48 – 57	18	7.2
58 – 67	10	4.0
68 – 77	4	1.6
78 – 87	1	0.4
88+	2	0.8

From the table 3 above, about 50% of the respondents were youth aged 18 years to 27 years. Almost all 97.2% the respondents were within the premium paying age of 18 to 67 years. Again majority 72.1% were youth and in their economically productive age of 18 to 37 years. This data profile only emphasis the belief young people have, that they are less likely to fall sick and therefore do not see the need to make provision for the future health need.

Table 4: Sex distribution of respondents who did not renew their membership with NHIS, Berekum in 2008

Sex (N=251)	Frequency	Percentage
Female	154	61.4
Male	97	38.6

As depicted in table 4 above, female respondents who did not renew their membership with scheme represented over 60% of all respondents. This also places emphasis on the fact most women in our societies are of low income level and largely depends on their husbands for

money for anything they do. Hence, the failure of their husbands to register them could lead to their drop out of the scheme.

Table 5: Educational attainment of respondents who did not renew their membership with NHIS, Berekum in 2008

Education Level (N=251)	Frequency	Percentage
None	46	18.3
Primary	9	3.6
Junior High School	78	31.1
Senior High School	70	27.9
Tertiary	48	19.1

As shown in table 5 above, 81.7% of the respondents had formal education. The level of educational attainment of the respondents who had formal education was relatively fairly distributed from Junior high school through to Tertiary level. A minority of 18.3 % of the respondents had no formal education.

Table 6: Ethnic distribution of respondents who did not renew their membership with NHIS, Berekum in 2008

Ethnic background (N=251)	Frequency	Percentage
Brong	168	66.9
Northerners	34	13.5
Akan	32	12.7
Ewes	8	3.2
Fantes	7	2.8
Gas	2	0.8

The respondents were predominantly Brongs (66.9%), with Gas representing the least ethnic group (0.8%). This is the reflection of the ethnic profile of the population of the inhabitants of the study area.

Table 7: Occupational distribution of respondents who did not renew their membership with NHIS, Berekum in 2008

Occupation (N=251)	Frequency	Percentage
Farmer	61	24.3
Trader	58	23.1
Student	34	13.5
Artisan	29	11.6
Unemployed	23	9.2
Teacher	20	8.0
Apprentice	13	5.2
Others	13	5.2

Majority (77.3%) were engaged in some form of income earning activities. The rest were either unemployed (9.2%) or in school (13.5%). Most of them were engaged in Farming and petty trading (47.4%). Interestingly, a significant number of teachers (8%) form part of the study population who did not renew their membership with the scheme. Though these teachers' premium is paid under the formal sector financing of the scheme (SSNIT contribution), they are still required to pay administrative charge of 3.00 Ghana cedis to register their membership with scheme.

Table 8: Distribution by marital status of respondents who did not renew their membership with NHIS, Berekum in 2008

Marital Status (N=251)	Frequency	Percentage
Married	108	43.0
Single	107	42.6
Living with a partner	19	7.6
Divorced	9	3.6
Widowed	8	3.2

Forty three percent of the respondents were married while 3.2% were widowed. Significant number of the respondents was single (42.6%). Most of these single respondents might be depending on the parents for survival and may not be able to afford premium if their parent fail to pay for them.

Table 9: Religious affiliation of respondents who did not renew their membership with NHIS, Berekum in 2008

Religious Affiliation (N=251)	Frequency	Percentage
Christian	210	83.7
Moslem	36	14.3
Traditionalist	5	2.0

The respondents were largely Christians by religion (83.7) however, 2% of the respondents were practitioners of African traditional religion. This is the reflection of the religious profile of the population of the inhabitants of the study area.

4.2 NATIONAL HEALTH INSURANCE MEMBERSHIP VARIABLES

Table 10: Distribution of respondents who did not renew their membership with NHIS, Berekum in 2008 by membership indicators

Variables	Yes		No	
	Freq	%	Freq	%
Registered 1st and 2nd batch in 2007 (N=251)	248	98.8	3	1.2
Benefited during 2007 benefit year (N=248)	127	51.2	121	48.8
Household members registered 2008 (N=251)	191	76.1	60	23.9

Almost all the respondents (98.8%) were active members of the insurance scheme in 2007 period under consideration. The remaining 1.2% might have been active members during 2006 period but did not renewed the membership in 2007 and hence form the part of the database for inactive members About 51.2% of the respondents who were active members during 2007 benefit period enjoy health care services. Majority of the respondents (76.1%) have other members of their household currently insured with the health insurance scheme.

Table 11: Distribution of respondents who did not renew their membership with NHIS, Berekum in 2008 by type of health service enjoyed

Type of Benefit (<i>N</i> =127)	Frequency	Percentage
OPD	99	78.0
Admission medical	15	11.8
Admission Surgical	10	7.9
Others	3	2.4

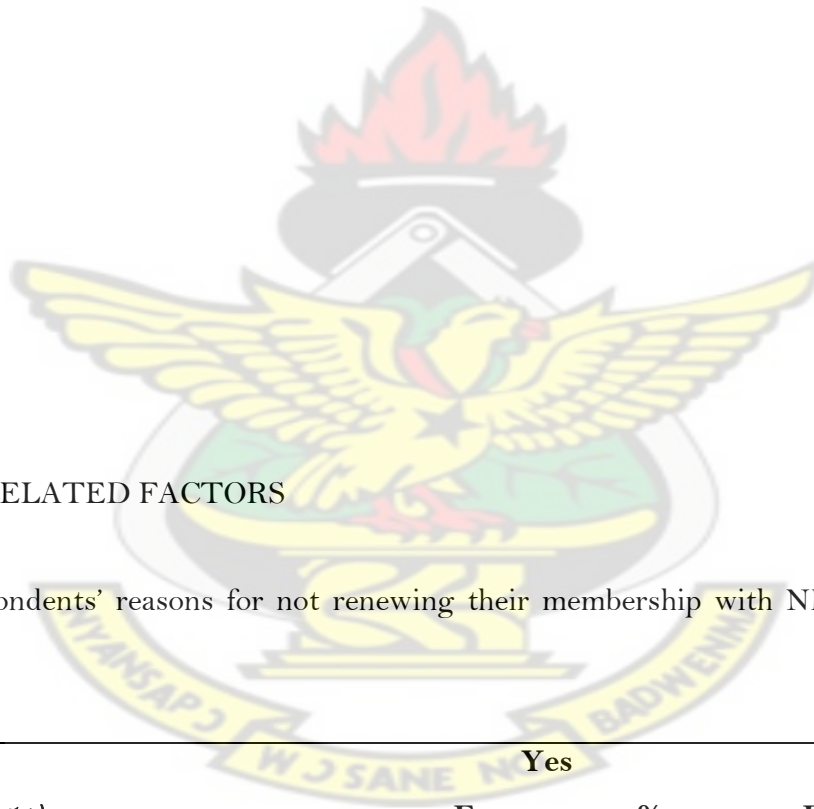
Most of the respondents (78%) benefited from outpatient services. Others like anti-natal and delivery services constitute 2.4%.

Table 12: Distribution of respondents who did not renew their membership with NHIS, Berekum in 2008 by household members who are current active members of the health insurance scheme

Category of household members registered (<i>N</i> =191)	Frequency	Percentage
18 years and above	122	63.9
Less than 18 years	69	36.1

About 64% of respondents' household members aged 18 years and above are current active members of the scheme. This could also mean that vulnerable members of respondents are registered with the scheme

KNUST



4.3 SCHEME RELATED FACTORS

Table 13: Respondents' reasons for not renewing their membership with NHIS, Berekum in 2008

Reasons (<i>N</i> =251)	Yes		No	
	Freq	%	Freq	%
Can not afford premium and registration	86	34.3	165	65.7
Premium timing unfavourable	38	15.1	213	84.9
I have a large family and can not enroll all	33	13.1	218	86.9
ID cards take too long to process	25	10.0	226	90.0
No immediate benefit	20	8.0	231	92.0
I enroll every year but I do not fall sick	16	6.4	235	93.6

Scheme staff are not patient	13	5.2	238	94.8
Our complaints are not settle	11	4.4	240	95.6
I am well and no need to pay	9	3.6	242	96.4
Did not know I have to renew every year	7	2.8	244	97.2
No Community Involvement in fixing premium	2	0.8	249	99.2
Do not know where to renew	1	0.4	250	99.6

Scheme related reasons why respondents did not renewed their membership were high premium(34.3%), unfavourable premium collection time (15.1%), a large family size and can not enroll all” (13.1%) and “ID cards take too long to process” (10%). Other reasons cited were “no immediate benefit upon registration (8%), no community involvement in determining premium (0.8%) and low individual risk perception (6.4%)

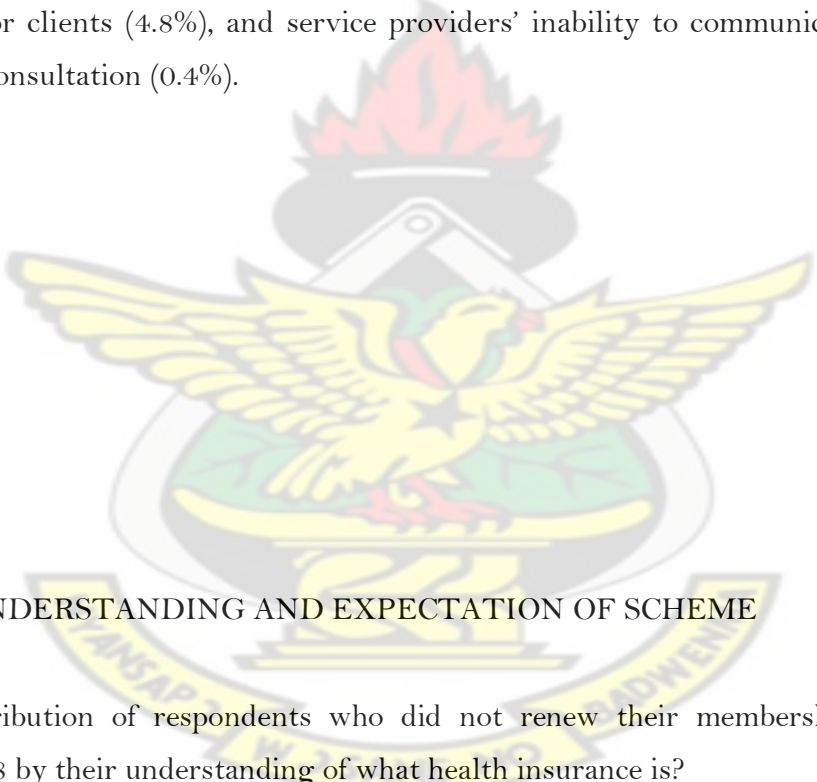
4.4 SERVICE PROVIDER RELATED FACTORS

Table 14: Respondents’ reasons for not renewing their membership with NHIS, Berekum in 2008

Reasons (<i>N=251</i>)	Yes		No	
	Freq	%	Freq	%
Insured clients are delayed at the health facility	61	24.3	190	75.7
Insured clients are not given good medicine	21	8.4	230	91.6
Drugs are not available for insured clients at the health facility	14	5.6	237	94.4
Insured clients are given fewer drugs	12	4.8	239	95.2

Health workers are impatient with insured clients	11	4.4	240	95.6
Insured clients are not treated with respect	9	3.6	242	96.4
Health facility is far away and I have to pay more to access	6	2.4	245	97.6
Health workers are always not available	2	0.8	249	99.2
Service providers do not communicate with insured clients during consultation	1	0.4	250	99.6

The main reason which is related to quality of care received from health service providers cited for non – renewal was insured clients are delayed at the health facility (24.1%). Other reasons were perception that insured clients are given inferior drugs (8.4%), non availability of drugs at health facility for clients (4.8%), and service providers’ inability to communicate with clients during clinical consultation (0.4%).



4.5 CLIENT UNDERSTANDING AND EXPECTATION OF SCHEME

Table 15: Distribution of respondents who did not renew their membership with NHIS, Berekum in 2008 by their understanding of what health insurance is?

Do you understand the NHIS? (<i>N</i> =251)	Frequency	Percentage
Yes	208	82.9
No	43	17.1

Most of the respondents (82.9) indicated that they understand what health insurance is. Their definition and or explanation are categorized in the table below.

Table 16: Categorization of respondents who did not renew their membership with NHIS, Berekum in 2008 by their definitions and or explanation of health insurance

What is NHIS? (N=208)	Frequency	Percentage
Incorrect	121	79.3
Correct	43	20.7

The concept or definition of health insurance is pooling resources together to provide financial protection against unforeseen events or illnesses.

Based on the above criteria, about 80% of the respondents do not understand the insurance concept as claimed in table 15. Most of them see it as “passport to access free health care” or as “a policy of the government to finance their health needs”.

Table 17: Distribution of respondents who did not renew their membership with NHIS, Berekum in 2008 by their expectations from the health insurance scheme

What is your expectation from scheme? (N=251)	Frequency	Percentage
Ensure that providers improve services to insured clients	112	44.6
*Scheme should consider the premium and benefits	67	26.7
Allow for late registration	23	9.2
Scheme staff should settle our complaints	16	6.4
Scheme staff should respect insured clients	15	6.0
ID cards should process on time	13	5.2
**Make NHIS universally accessible	5	2.0

**Here, respondents expect the following from the insurance scheme:*

1. *“If I do not benefit this year, my membership should be carry forward to next year”*
2. *“There should be free medical examination for those of us who do not benefit with the benefit period”*
3. *“If the parents pay for their premium and the registration, their under age children should be registered free”*

*** The respondents expect that the benefits should be accessible from one district to another without necessarily transferring their membership.*

About 45% of the respondents expect the health insurance scheme to put measures in place to ensure that health service providers provide improve services to insured clients. Other expectations of the respondents are directly related to the insurance scheme such as making the scheme universally accessible (2%) and Scheme should consider the premium and benefits (26.7%)

The logo of the Kenya National University of Science and Technology (KNUST) is centered in the background. It features a yellow bird with its wings spread, perched on a green base. Above the bird is a white shield with a red and black design. The entire emblem is set against a white background with the word 'KNUST' in large, grey, semi-transparent letters at the top.

CHAPTER FIVE

5.0 DISCUSSION

This chapter focuses on discussion of field data in chapter 4 in relation to scheme management and service provision factors as well as client understanding/expectation which could influence subscription or non renewal to scheme, hence the success of health insurance scheme.

5.1 Scheme Management

Inability to pay premium was the major reason for the non-renewal of membership. Indeed as high as 34% of those interviewed did not renew their membership because they could not afford the premium. The study also revealed that majority of the respondents were youth forming about 72% and are in their economic productive age 18 to 37 years and considering that, in our

economy most of these youth are not gainfully employed and therefore could explain this phenomenon of unaffordability of premium.

Further, about 61% of respondents who did not renew their membership with the scheme were females. Generally most women in our societies are low income earners and largely depends on their husbands for money for their upkeep which includes health care. Hence, the failure of their husbands to register them could lead to their inability in paying premium. This implies that the purchasing power of an individual is a factor which contributes to membership which is supported by an assertion that inability of the people to pay premium makes the sustainability of the scheme difficult (Bennett et al., 1998).

Another significant reason for non renewal of membership was unfavourable timing of premium collection which constitutes 15%. According to the demography of the respondents about 47% are farmers and those engaged in petty trading. The occupation of an individual can really affect his/her ability to pay premium. The income level of most farmers is at its peak when they harvest their farm produce. This places emphasis on the fact that premium collection at the time of harvest of cash crops will result in positive response for schemes in rural areas. (Bennett et al, 1998).

However, the research also revealed that a significant number of teachers (8%) who have reliable occupation and income form part of the respondents who did not renew their membership with the scheme. Low risk behavior and perception of an individual could account for this and indeed the study indicated about 6% of respondents who did renew their membership was due to this factor. A study by Criel and Waelkens, 2003 also indicated that individuals risk seeking behavior if illness is uncertain account for non-insurance hence affecting membership.

Sometimes, this situation of the formal sector workers (teachers) not renewing their membership beg for better understanding of the health insurance system, considering the fact that Teachers have reliable income and their premiums are deducted at source (SSNIT contribution), but still fail to pay an administrative fee of 3 Ghana cedis to renew their membership with the scheme.

The study also revealed that large family size is also a contributory factor for non-renewal of membership. The large family size could be explained by large number of children by married couples who form 43% of respondents. In most insurance schemes, beneficiaries are considered as individuals and therefore must register as such and this requires large financial resources or commitment particularly for large households to enroll its members. Even though children under 18 years do not pay premium, they are charged administrative fee of three (3) New Ghana cedis. This implies that families with large number of wards either below 18 or above “especially the unemployed” still need enough financial resources to register its members with the scheme. Indeed, large family sizes also played important roles in non-renewal of membership. This finding is consistent with those of a study in India which also found low subscription rate because of high premium and large family sizes (Devadasan et al, 2004).

Also important factors such as delay in processing of identification cards and no immediate benefits were reasons for non-renewal. These issues might have arisen because of lack of understanding of principles of insurance which emphasis the pooling of risk and an initial period of investment of premium before contributors begin to benefit. Clients of the scheme should be educated on these issues. These findings also conform to those of a study in India by Devadasan N et al, 2004 which found, no immediate benefit and people paying every year without getting any benefit as some reasons for people not paying anymore.

Some clients did not know where to go to renew their membership while others did not know that they have to renew their membership yearly. Clients should be kept well informed.

Also of concern is the attitude of scheme staff. For some clients, the disrespectful attitude of staff was the reason why they refused to renew their membership. This issue must be investigated and resolved since it has the potential of discouraging membership and renewal of membership

Lack of community involvement in fixing premium was also identified as a reason for non-renewal of membership. Some of the clients were of the view that Scheme Management do not involve them in fixing the premium and see it as imposition. This concern of the people is an important factor since involving them in determining premium and how payment should be made would help the community/ clients feel that, they are part of the decision making process

hence become more responsible to the management of the scheme. This finding is similar to that of a study which found that community involvement and local ownership as well as local authority in determining premium, benefit package and making decision provides sense of responsibility to scheme by members can increase subscription and success of scheme.(Atim, 1999, Arhinful, 2003). This opinion is emphasized that involvement of community in running of the scheme is very helpful as members seem to own the scheme. (Garba and Cyr 1998).

5.2 Service Provider factors

About 24% of those interviewed were of the view that insured clients delay in the receiving health services. The delay could be explained by the increased number of persons attending hospital following the introduction of the Health Insurance Scheme. Many people now have financial access to health services than before resulting in increased numbers of persons attending health facilities. This coupled with the fact that there was no corresponding increase in the numbers of health staff may explain the longer period of time spent by client in health facilities. The district at the time of the study has Doctor/patient ratio of 1:15,779 and Nurse/patient ratio of 1:1,105 and this indicates woefully inadequate Doctors and Nurses to provide medical services to clients at facility level which could affect quality of services.

It was also revealed by the study about 8% of the respondent were with the perception that insured clients are given fewer and low quality drugs. The perception of low quality drugs for insured clients is a recipe for non-membership and non-renewal. These findings are in conformity with another study in which perception of low quality services were responsible low subscription (Schneider et al, 2005).

Again non-availability of drugs at health facilities for insured clients was a reason why some people did not renew their membership. This could be due to the fact that, some health facilities at times do not have some of the drugs on the National health insurance drug list at the time of serving clients and as such need to ask the insured clients to go and search for the drugs in any pharmacy shop accredited by the scheme. This invariably causes inconveniences to the sick insured client and some of them may no longer search for the drugs after their inability to locate accredited shop within their vicinity. This issue has to be addressed by ensuring that accredited health facilities have most of the drugs on National health insurance drug list at all

times and this is in conformity with findings of a study where availability of drugs in health facilities and recovery from illness are seen as measures of quality services from provider which can really influence membership/subscription with scheme (Haddad, 1995). The non-availability of drugs in health facilities could also be attributed to the fact that most schemes are unable to pay the bills submitted by the health service providers on time and this further affects drugs procurement by the service providers to serve clients.

The disrespectful and impatient attitude of staff of health facilities was also found to be a factor responsible for non-renewal of membership. This perhaps could be attributed to the fact that there is increased OPD attendance rate in all health facilities since the operation of National Health Insurance Scheme without corresponding increase in health staff numbers resulting in high workload for staff coupled with tiredness. This could account for awful behavior of some health staff to clients. The poor attitude of service providers need to be corrected since it could discourage clients from renewing their membership. These findings are in support of the observation that service provider interpersonal qualities such as patience, courtesy, attentiveness and friendliness. (Haddad, 1998) and improving on levels of politeness and behavior of medical staff to patients (Criel and Waelkens, 2003) as well as improving quality of care (Schneider, 2005) can have influence on clients' decision on joining scheme or renewing their membership with scheme.

Besides the above, one issue which really affects quality of health care delivery is lack of staff-patient communication in hospital particularly with Doctors resulting in frustration and helplessness for patients (Cofie P et al, 2004). Lack of staff-patient communication was also a factor contributing to non-renewal of membership and this could be due to increased or high workload for medical staff since the introduction of the Health Insurance. This makes it difficult for some medical staff to interact patiently with clients during consultation. This issue has to be looked into and resolved as it could deter people from subscribing to the scheme.

Another important factor which was identified to be a reason why people did not renew their membership was difficulty in accessing health services by clients. This observation could be explained as; insured clients were of the perception that that they have to pay a lot of lorry fares or walk long distances before they can reach an accredited health facility for health

services. They feel that, they could use their monies to access health care services from a nearby health facility instead of registering with the scheme and attend hospital which is situated far away from them. And this finding is in conformity with observation by Devadasan N et al, 2004, in a study in India, which found that people decided not to pay anymore since hospital is far away and have to pay a lot to access hospitalization. There is need for Scheme Management to give accreditation to all facilities particularly those closer to clients.

5.3 Client Understanding and Expectation

Clients satisfaction occurs when their perception of a service they have received meet their expectation (Donovan N et al, 2001). This expectation is also believed to be formed by a lot of factors including previous experience, personal needs, word of mouth and media communication (Ken Judge and Micheal Solomon, 1993). The study also showed that about 80% of the respondents do not understand the concept of health insurance but understand health insurance as “ passport to access free health care or as policy of government to finance their health needs. This understanding of the people is far from the underlying principle of insurance which is pooling risks together whereby both high income people at low risk and low income people at high risk pay an agreed premium to provide financial protection against unforeseen events or illnesses (Davies and Carrin, 2001).

This poor understanding of the people on insurance concept could be attributed to inadequate public education or awareness creation on insurance scheme and this can really influence clients' expectation and satisfaction as well. This correlates with the fact that, activities such as awareness creation among community on the scheme can increase efficiency of the scheme and its success (Devadasan N et al, 2004). Again, Tabor (2005) and McCord (2001) also noted that, general lack of understanding of health insurance concept (risk – sharing) is a factor influencing non-renewal of membership by clients. Hence, the need for effective communication and education for clients or citizenry.

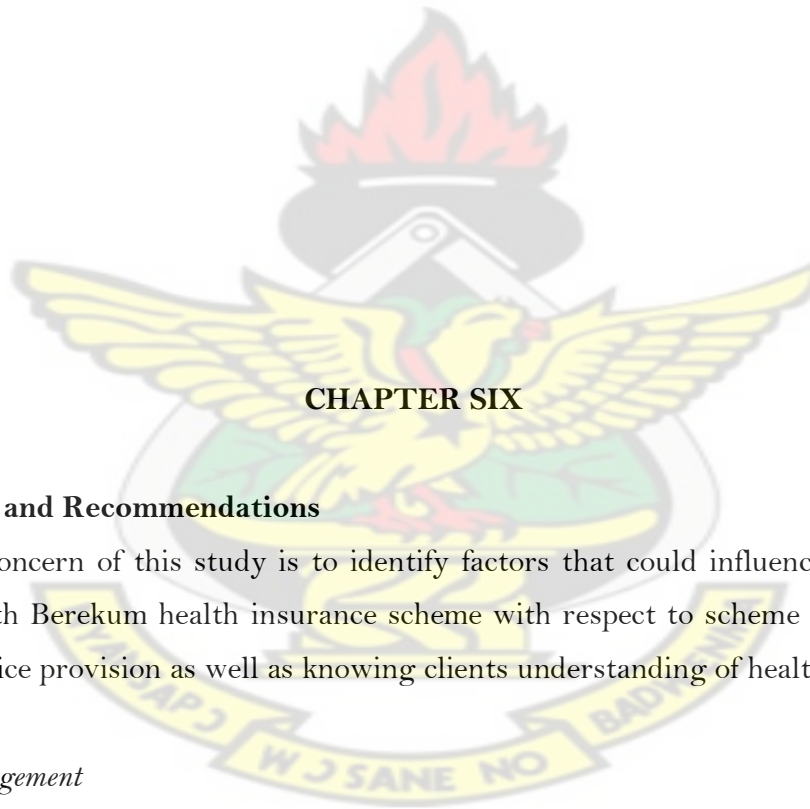
The study revealed that about 27% of the respondents (non- renewed clients) have the following expectations;

- a) If they do not benefit this year, their membership should be carried forward to the following year

- b) There should be free medical examination for those who do not benefit during the benefit period

All these expectations could be attributed to poor understanding of insurance and inadequate awareness creation among community

KNUST



CHAPTER SIX

6.0 Conclusion and Recommendations

The principal concern of this study is to identify factors that could influence non-renewal of membership with Berekum health insurance scheme with respect to scheme management and health care service provision as well as knowing clients understanding of health insurance.

6.1 Scheme management

A high premium charge was identified to a major reason for people not renewing their membership with scheme. As revealed by the study that majority of the respondents are females and women in most cases have low purchasing power and depend largely on their husbands for income for daily activities especially health care needs.

Unfavourable timing for premium collection was also a major factor contributing to non renewal of membership with the scheme. The occupation of majority of the people in the area is

farming and petty trading and income level of these people is optimum during harvesting period and as such premium collection time outside this harvesting season becomes an impediment for most of them to join the scheme.

In addition to factors contributing to non renewal in the district is large family size and registration of all members. This is very common with households of large members and has to enroll all onto the scheme. This really increases the financial burden of the household couple with fact that most of them are not gainfully employed or are into farming activities with irregular income.

Finally, individual's low risk perception and behavior and no immediate benefit after initial payment of premium were reasons for some individuals not renewing their membership. This implies the scheme management must really educate the people on concept of risk sharing/pooling of insurance so that the entire community will understand that, health insurance is not for only the vulnerable ones (high risk individuals)

6.2 Service provision

Poor quality of service issues such as delay of clients at health facility during service delivery was identified as recipe for non renewal. This could due to increased utilization of services by insured clients since the implementation of the health insurance policy without corresponding increase in numerical strength of health professional at service delivery point.

Non availability of drugs at facility level for clients during service provision was identified to cause non renewal as sick insured clients find it very frustrating going round to search for accredited pharmacy shops for their medicines.

Again difficulty in accessing health services by clients was a reason for non renewal of membership. As some insured clients were of the perception that that they have to pay a lot of lorry fares or walk long distances before they can reach an accredited health facility for health services.

Furthermore, staff attitude such as impatience, disrespectfulness and lack of staff-patient interaction during service provision were also responsible for non renewal of membership with scheme.

6.3 Client Understanding and Expectation

Considering the fact Clients satisfaction is influenced by their perception and expectations of the services they receive which in this case the insurance scheme. The study revealed that far more than two-thirds of the respondents do not understand the concept of health insurance but see health insurance as “ *passport to access free health care or as policy of government to finance their health needs*”. This notion of the people is far from the underlying principle of insurance which is pooling risks together whereby both high income people at low risk and low income people at high risk pay an agreed premium to provide financial protection against unforeseen events or illnesses.

In addition some clients were found to have expectations such as membership to be carried forward to the subsequent year in case they do not fall sick or attend hospital in the active year of their registration while others expect to enjoy some benefits such as free medical examinations if they do not benefit from scheme during the benefit period. Inadequate community awareness or education about the concept of health insurance scheme and other related issues could account for this.

6.4 Recommendations

Based on the key findings of the study contributing to non-renewal of membership, the following recommendations were made;

6.41 Scheme management

1. There should be intensified public awareness creation/ education to the communities about concept of health insurance as well as benefit package as the study revealed that individual risk behavior and no immediate benefit influencing membership

2. Scheme management should ensure community involvement in determining premium as well as how and when it should be collected. This will provide sense of ownership and enhance community demand for insurance. This implies that scheme management need to strengthen General Assemblies every year to address the concerns of members and fixing of premium as well.
3. The scheme management should also put in place mechanism that would accommodate payment of premium by installment
4. Management should ensure that most facilities in the area are accredited to render health care services to clients especially facilities which could be easily accessed by the people.
5. The scheme management should collaborate with other institutions such as Ministry of Finance, Agriculture and Local Government to diversify the local economy by putting in programmes aim at providing the local people with reliable income to enable them enroll onto the scheme.

6.42 Service provision

1. Management of health insurance accredited facilities should ensure that drugs on national health insurance drugs list are always available at facilities for clients.
2. Service providers should be trained on interpersonal skills which could enhance ones' demand for their services, hence increase ones' willingness to join the scheme.
3. With respect to service provision, Government should increase the staff strength of most health facilities to cope with the increasing workload so that quality of services could be assured.

6.43 Client Understanding and Expectation

1. There should be extensive community awareness and education to enable the people understands the principles, importance and the benefits of health insurance by Scheme Management at all levels.
2. There should be strong collaboration between Scheme Management and Community Based Organizations as well as other stakeholders in the schemes' operating areas to sensitize community members on health insurance.

KNUST



REFERENCES

Adjei S, Agyepong-Amarteyfio I, Seddoh T (2004), National health insurance, a handbook for service providers, Ghana Health Service.

Aikins M (2003) Emerging Community Health Insurance Schemes/Mutual Health Organisations in Ghana. Achievements and Challenges. Danida, Accra.

Akor, S.A (2002) Establishing health insurance in Ghana. The district-wide mutual health organization approach. Accra, Ghana, Ministry of Health

Arhinful DK (2003) The Solidarity of Self-interest: Social and Cultural Feasibility of Rural Health Insurance in Ghana, African Studies Centre publishers, Leiden. ISBN: 90.5448.055.6.

Arhin-Tinkorang, D.C. (2000), Mobilising resources for health. The case for user fees revisited. Report submitted to working group 3 of the Commission of Microeconomics and health. Geneva, WHO.

Arrow KJ. 1963. Uncertainty and the welfare economics of medical care. *The American Economic Review* **80**: 941–73.

Atim C (1999) Social movement and health insurance: a critical evaluation of voluntary, non-profit insurance schemes with case studies from Ghana and Cameroon. *Social Science and Medicine* **48**, 881–896.

Atim, C (1998): 'Contribution of Mutual Health Organisations to Financing, Delivery, and Access to Health care: Synthesis of Research in Nine West and Central African Countries', Bethesda, Maryland, Abt Associates Inc: p 82.– (2001): *Contribution of Mutual Health Organisations to Financing, Delivery, and Access to Health care: Nigeria Case Study*, ILO, Geneva.

Baltussen, E. Bruce G. Rhodes, S. A. Narh-Bana and Agyepong I (2006). Management of mutual health organizations in Ghana, *Tropical Medicine and International Health* volume 11 no 5 pp 654–659 may 2006

Barr N. (1992) Economic theory and the welfare state: a survey and interpretation. *Journal of Economic Literature*. Vol.30 (2). ISBN 0022-0515

Bennett S, Creese A, Roland M (1998) Health Insurance Schemes for People outside Formal Sector Employment, Division of Analysis, Research and Assessment, Paper no. 16 World Health Organization, Geneva.

Carrin G, Waelkens MP & Criel B (2005) Community-based health insurance in developing countries: a study of its contribution to the performance of health financing systems. *Tropical Medicine and International Health* **10**, 799–811.

Commission on Macroeconomics and Health (2001) *Macroeconomics and Health: Investing in Health for Economic Development*. Report of the Commission on Macroeconomics and Health. World Health Organization, Geneva

Cofie P, Essegbey T, Seddoh T and Adjei S (2004), *What are staff saying? Providers Perspective of the National Health Insurance in Ghana*, pp 10-22

Creese, A.; Bennett, S. (1997), *Rural Risk-Sharing Strategies*. In: Schieber, G.(ed.), *Innovations in Health Care Financing*. Proceedings of a World Bank Conference, March 10-11, 1997, Washington, D.C.

Criel B, Atim C, Basaza R, Blaise P & Pia M (2004) *Community health insurance (CHI) in sub-Saharan Africa: researching the context*. *Tropical Medicine & International Health* 9, 1041.

Criel, B. and Waelkens, M. P. (2003) 'Declining subscriptions to the Maliando Mutual Health Organisation in Guinea-Conakry (West Africa): what is going wrong?' *Soc Sc Med* 57 1250-19

Criel, Bart (2000): *Local Health Insurance Systems in Developing Countries: A Policy Research Paper*, ITM, Antwerp.

D+C Cooperation (2001) *Journal of economics and health* No. 6, November/December edition, page. 4 – 5, Geneva.

Danida (2003). *The proposed National Health Insurance Programme*. Report of the Annual Health Sector Review 2002

Davies P & Carrin G (2001) *Risk-pooling: necessary but not sufficient*. *Bulletin of the World Health Organization* 79, 587.

Davies P. & Carrin G. (2001) *Risk-pooling: necessary but not sufficient*. *Journal: Bulletin of the World Health Organization*. Vol. 79, issue 7 pages no. 587-857. Geneva.

Devadasan N, Kent Ranson, Wim Van Damme, Criel B, (2004). Community Health Insurance in India, An Overview, *Economic and Political Weekly* July 10, 2004, pages 3179-3183

Diop, Francois, Pia Schneider, Damascene B. (2000) Summary of Results: Prepayment Schemes in the Rwandan Districts of Byumba, Kabgayi, and Kabutare. Technical Report No. 59. Bethesda, MD: Partnerships for Health Reform

District (2007) Annual health report, Berekum district. Ghana

Donovan N, Brown J and Bellulo L, (2001). Satisfaction with Public Services: A Discussion Paper November 2001

Dovlo ,D. and Nyonator, F. (1999) Migration of graduates of Ghana Medical School, A preliminary rapid appraisal. *Human Resources for health Dev J* 1999;3

Dror, D and C Jacquier (1999): 'Micro-Insurance: Extending Health Insurance to the Excluded', *International Social Security Review*, 52 p 71

Garba, M.; Cyr, V. (1998), Présentation de mutuelles du Sud Borgou et Zou Nord au Bénin. Paper presented at the Seminaire-Atelier de CIDEF - Les Mutuelles de Santé en Afrique: Concept Importé ou Réalité Émergente? Experiences et Perspectives, Paris, May 1998.

Ghana – Poverty Reduction Strategy Paper (2003). World Bank, Washington.

Ghana Health Service, (2004) Guidelines for Design and Implementation of Mutual Health Insurance Schemes in Ghana, July, 2004.

GHS (2002) Ghana Health Service Annual report. Accra , Ghana, Ministry of Health

Ghana Health Service and PHRplus (2004), A District- based approach to monitoring and evaluating the process and early effects of the implementation (The HI Act in Ghana), July 2004, pp 25.

Guy C., Maria-Pia W., Bart C. (2005) Community-based health insurance in developing countries: a study of its contribution to the performance of health financing system, *Tropical Medicine and International Health*, page: 799-811, Blackwell Publishing Ltd

Haddad S., Fournier P., et al. (1998). What does quality mean to lay people? Community perceptions of primary health care services in Guinea. *Social Science and Medicine*, Vol. 47, No. 3, pp. 381-394.

Haddad S, Fournier P. Quality, (1995). costs and utilization of health services in developing countries. A longitudinal study in Zaire. *Soc Sci Med*; 40: 743-753.

Health Economics Program (2000) Access to employer-based health insurance in Minnesota. Issue paper April 2000. MDH

Henry J. Kaiser Family Foundation.(2006). The Uninsured: A Primer, Key Facts about Americans without Health Insurance January 2006

Himmelstein, D, E. Warren, D. Thorne, and S. Woolhandler,(2005)."Illness and Injury as Contributors to Bankruptcy, *Health Affairs Web Exclusive* W5-63, 02 February, 2005.

Humble J.W (1967) *Improving Business results*, Maidenhead, UK. McGraw-Hill

Hutton, G (2002) User fees and other determinants of health services utilization in Africa; A review of informal health sectors.(Final draft reports) Swiss Tropical Institute, Basel

Jakab M, Preker A, Krishnan C et al. (2001) Social inclusion and financial protection through community financing: Initial Results from Five Household Surveys. *World Health Organisation, Commission on Macroeconomics and Health*, Geneva.

Jowett M. 2003. Do informal risk sharing networks crowd out publicvoluntary health insurance? Evidence from Vietnam. *Applied Economics* 35: 1135-61.

Judge K and Soloman M, (1993). Public Opinion and the National Health Service: Patterns and Perspectives in Consumer Satisfaction, *Journal of Social Policy* 22, 3, pp299-327.

Ju" tting J (2001) The Impact of Health Insurance on the Access to Health Care and Financial Protection in Rural Developing Countries. The Example of Senegal. HNP Discussion Article. World Bank, Washington, DC

Kawabata K, Xu K & Carrin G (2002) Preventing impoverishment through protection against catastrophic health expenditure. *Bulletin of the World Health Organization* 80, 612.

McCord, Michael. 2001. Microinsurance: A Case Study Example of the Provider Model: GRET Cambodia. Micro-Save Africa, Nairobi.

McCord, Michael 2001. Health Care Micro-insurance – case studies from Uganda, Tanzania, India and Cambodia, *Small Enterprise Development*, Vol. 12, No. 1.

Mechanic D. 1998. The functions and limitations of trust in the provision of medical care. *Journal of Health Politics, Policy and Law* 23: 661–86.

Mechanic D, Rosenthal M. 1999. Responses of HMO medical directors to trust building in managed care. *Milbank Quarterly* 77:1–14.

Meessen, B., Criel, B., Kegels, G. (2002) 'Formal pooling of health risks in sub-Saharan Africa: Reflections on the obstacles encountered', *International Social Security Review*, 55.

National health insurance (2007) Annual report, Berekum district scheme, Berekum district, Ghana

National health insurance (2008) half year report, Berekum district scheme, Berekum district, Ghana

Nyonator, F and Kutzin F. (2000) Health for some? The effects of user fees in the Volta Region of Ghana. Paper presented in Health systems financing in low-income Africa and Asian countries, Clermont Ferrand, 30th Nov.- 1st Dec.2000 ([.id21.org](http://id21.org))

Policy Planning Monitoring and Evaluation Division, Ghana Health Service,(2004) Guidelines For Managing Patient Records and Billing Systems in Health Facilities, December 2004.

Schneider, P. (2005) 'Trust in micro-health insurance: an exploratory study in Rwanda', Soc Sci Med, 61, 1430-8.

Schneider, P. (2004) 'Why should the poor insure? Theories of decision-making in the context of health insurance', Health Policy Plan, 19, 349-55.

Schneider, P. D., FG., Maceira, D., Butera, D. (2001) Utilization, cost and financing of district health services in Rwanda., Technical Report No. 61. Partnerships for Health Reform Project, Abt Associates Inc., Bethesda, MD.

Tabor R. (2005) Community-Based Health Insurance and Social Protection Policy, Washington DC: World Bank.

The Commonwealth Fund.(2004) Wages, Health Benefits, and Workers' Health. Issue Brief, October 2004

The Urban Institute. (2004). Key Findings from the 2002 National Health Interview Survey.9 August 2004.

The Six Hundred and Fiftieth Act Of The Parliament of The Republic of Ghana (2003) entitled the National Health Insurance Act 650

Townsend RM. (1995) Consumption insurance: an evaluation of risk bearing systems in low-income economies. *Journal of Economic Perspectives*. Vol. 9, no. 3 page 83-102

Wagstaff A., Paci P., Joshi H (2001) Causes of inequality in health: Who you are? Where you live? Or who your parents are? The World Bank. Working Paper 2713, Washington, DC:

William D Savedoff, (2004), Opinion piece, Is there a case for social insurance? *World Health Organization, Health Policy and Planning* 19(3): 183-184 © Oxford University Press.

World Bank (2004). Public policy. Growth and poverty; A country economic memorandum. Washington , World Bank.

World Health Organization (2005) 58th World Health Assembly, 2005. Social Health Insurance: Sustainable Health Financing, A58/20. World Health Organization, Geneva

World Health Organisation (2000): *The World Health Report 2000: Health Systems: Improving Performance*, WHO, Geneva.

Xu K, Evans D, Carrin G, Aguilar-Rivera AM.(2005). *Designing Health Financing Systems to Reduce Catastrophic Health Expenditure*. Technical Briefs for Policy-Makers. WHO/EIP/HSF/PB/05.02. Geneva: WHO.

Yip, W and P Berman (2001): 'Targeted Health Insurance in a Low Income Country and Its Impact on Access and Equity in Access: Egypt's School Health Insurance, *Health Economics*. Vol. 10, Issue 3 pages 207-220

KNUST

APPENDIX 1

The Minimum Benefit Package

The minimum benefit package is as indicated below (*Adjei S., et al 2004, pp23-24*)

Outpatient Services

- Consultations including reviews. These include both general and specialist consultation.
- Requested investigations for general and specialist outpatient services (laboratory investigations, x-rays, ultrasound scanning etc.)
- Medication – prescription drugs on the National Insurance Scheme Drug List, traditional medicines approved by the Food and Drugs Board and prescribed accredited practitioners.
- Out-patient/Day Surgical operations (hernia repair, incision and drainage, haemorrhoidectomy).
- Outpatient physiotherapy.

In-patient Services

- General and specialist in-patient care
- Requested investigations for in-patient care (laboratory, x-rays, ultrasound)
- Medication – prescription drugs on the NHI drug list, blood and blood products.
- Surgical operations
- In-patient physiotherapy
- Accommodation on the general ward
- feeding (where available)

Specific services

Oral Health

- Pain relief (tooth extraction, temporary relief. Incision and drainage)
- Dental restoration (simple amalgam fillings, temporary dressing)

Eye Care Services

- ◆ Refraction
- ◆ Visual fields
- ◆ A-scan
- ◆ Keratometry
- ◆ Cataract surgery

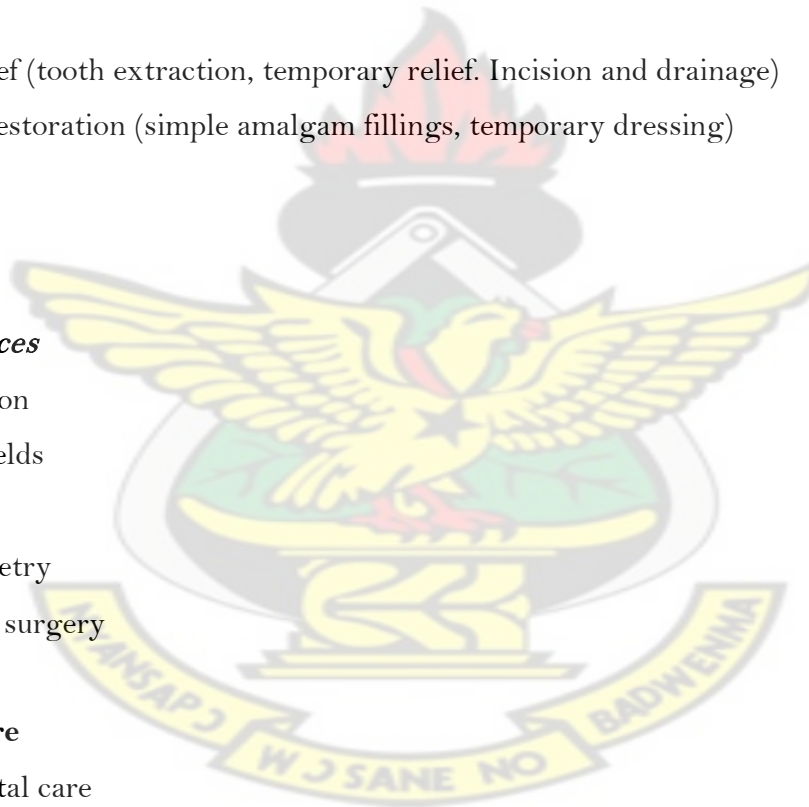
Maternity Care

- ◆ Antenatal care
- ◆ Deliveries
- ◆ Caesarean section
- ◆ Postnatal care

Emergencies

- ◆ Medical emergencies

KNUST



- ◆ Surgical emergencies
- ◆ Paediatric emergencies
- ◆ Obstetric and gynaecological emergencies
- ◆ Road traffic accidents

2.2.7 Health Care Services Not Covered

Some health care services are not covered by NHI Scheme and the reasons for exclusions are

1. Cost of the service is too expensive and can collapse the Scheme since the premium is low.
2. The diseases form only about 5% of morbidity in Ghana.
3. To address equity issues since services are not available at all levels.

Public health Services financed from GOG and DPF are also marked for exemptions as listed below.

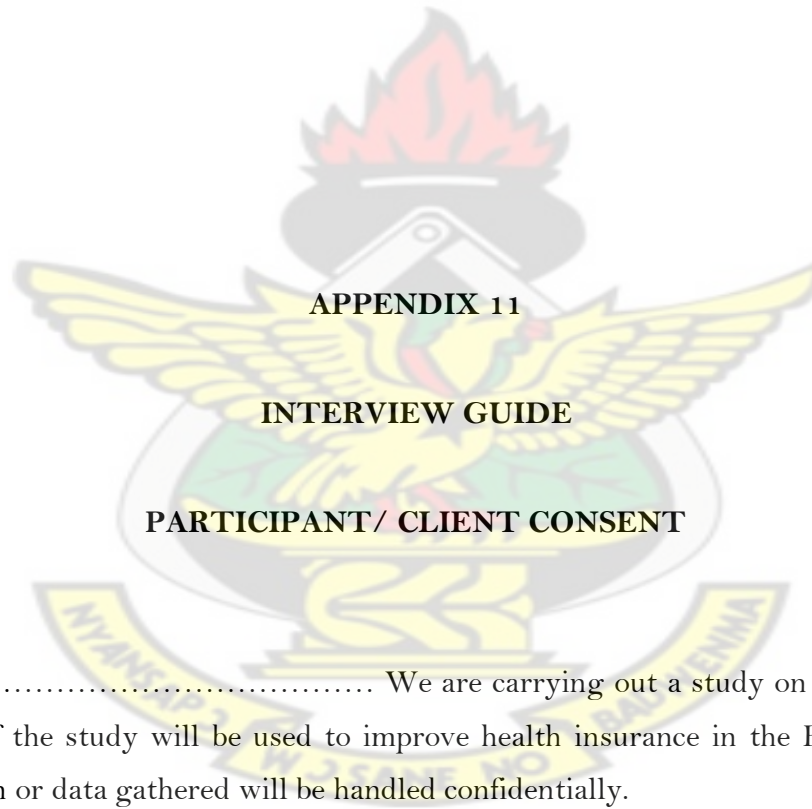
1. Immunization
2. Family Planning
3. Treatment of mental illness
4. Treatment of TB, Onchocerciasis, Buruli Ulcers, Trachoma
5. Confirmed HIV test on AIDS patients

The exclusion lists of services are as follows: (*Adjei S., et al 2004, pp 25*)

- ◆ Rehabilitation other than physiotherapy
- ◆ Cash benefits in the form of reimbursement to individuals appliances and prostheses (optical, hearing, orthopaedic aids, dentures etc)
- ◆ Cosmetic and aesthetic treatments
- ◆ HIV retroviral drugs(symptomatic treatment of opportunistic infections and other AIDS related disease will be covered)
- ◆ Assisted reproduction and gynaecological hormone replacement therapy
- ◆ Echocardiography
- ◆ Optical photography
- ◆ Angiography
- ◆ Orthoptics

- ◆ Dialysis for chronic renal failure(acute renal failure will be covered)
- ◆ Organ transplantation
- ◆ All drugs that are not listed on the NHIS drug list
- ◆ Heart and brain surgery(other than those resulting from accidents) and cancer treatment (other than breast and cervical cancers)
- ◆ Diagnosis and treatment abroad
- ◆ Medical examinations for purposes other than treatment in accredited facilities
- ◆ VIP accommodation

KNUST



APPENDIX 11

INTERVIEW GUIDE

PARTICIPANT/ CLIENT CONSENT

My name is We are carrying out a study on health insurance. The findings of the study will be used to improve health insurance in the Berekum District. The information or data gathered will be handled confidentially. This is a study in collaboration with the District Health Insurance Scheme and District health directorate

The aim of the study

This study will enable us to identify factors that influence non-renewal of membership among health insurance clients in the Berekum District so that management can improve on coverage and enhance the sustainability of the scheme.

Benefit

If you agree to participate, you would be contributing to knowledge that will inform Management decision to help sustain the scheme in Berekum District.

Again, you will be asked questions in relation to reasons why you could not renew you membership.

KNUST

SEMI-STRUCTURED INTERVIEW WITH STUDY PARTICIPANTS

Questionnaire No..... Date.....

RESPONDENT'S NAME

RESPONDENT ID.....

INTERVIEWER'S NAME

(A) SOCIO-DEMOGRAPHIC DATA

1. Age (in years) []

2. Sex? Male [] Female []

3. Educational Level None [] Primary [] JSS [] SSS [] Tertiary []

4. Ethnicity Akan [] Brong [] Ewes []
Northernners [] Fantes [] others (specify);

5. Religious affiliation a) Christian b) Moslem c) Traditionalist
d) Others (specify);

6. Occupation a) Farmer b) Teacher c) Apprentice
d) Trader e) Hairdresser f) Seamstress g) Artisan
h) Others (specify)

7. Marital status a) Single b) Married
c) Divorced d) Living with a Partner e) widowed

8. Did you register with the scheme last year (2007 1st and 2nd batch)? Yes No

9. Did you benefit from insurance by being a member of the scheme last year? Yes No

If yes specify the type of benefits: a. OPD b. admission medical c. admission surgical
others specify.....

10. Has any of your household members registered? Yes No

If yes specify: Children under 18 Wife/husband others, specify.....

11. Have you registered with the scheme this year (2008 1st and 2nd batch)? Yes No

If yes why?

If **No** why have you not renewed your membership?

TICK

Service Providers' related factors

- a) Insured clients are not given good medicine at the health facility []
- b) Insured clients delay when they visit a health facility []
- c) Insured clients are not treated with respect at the health facility []
- d) Health workers are not patient with insured clients []
- e) Drugs are not available at the health facilities for clients []
- f) Insured clients are given fewer drugs than non-insured drugs []
- g) Health workers are not always available to attend to us when we are sick []
- h) Hospital is far away and I have to pay more to access []
- i) There is no provider-patient communication for insured clients during consultation []

Other specify

.....

.....

Scheme Management related factors

- i) Did not know I have to renew my registration every year []
- j) Don't know where to go and renew membership []
- k) Insurance ID takes so long to be processed []
- l) Cannot afford the premium and registration []
- m) I am well and why should I pay in advance []
- n) Scheme staff are not patient with us []
- o) Our complaints are not settled satisfactorily []
- p) No immediate benefit []
- q) I pay every year and I do not benefit out of it []
- r) I have large family and I cannot afford to register all []
- s) No community involvement in determining premium []
- t) Premium timing unfavourable []

Other, specify:

.....

.....

Client Understanding and Expectation of scheme

12. Do you understand National Health Insurance (NHIS)? Yes [] No. []

If Yes, what is it?

.....
.....

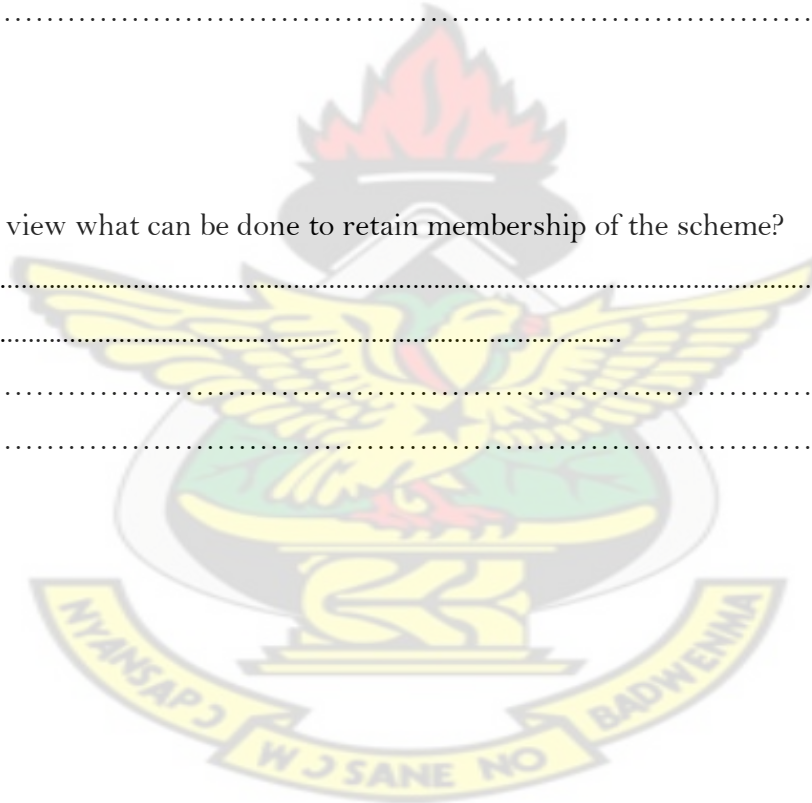
What do you expect to benefit from NHIS as a client/ beneficiary?

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

KNUST

13. In your own view what can be done to retain membership of the scheme?

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



KNUST

