UNIVERSITY FOR DEVELOPMENT STUDIES, WA

PROSPECTS AND CHALLENGES OF FINANCING HEALTHCARE DELIVERY IN THE EAST GONJA DISTRICT THROUGH THE NATIONAL HEALTH INSURANCE SCHEME

BY

MOHAMMED BASHIRU-BANCHIRIGA

(B.Sc. Accounting with Computing)

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DECLARATION

Student's Declaration

I hereby sincerely declare that except for references to others people's works which has been duly acknowledged. This thesis is my original work and has never been presented for any degree in any other Institution / College / University.

..... 04-10-2017.

Signature Date

Name: Mohammed Bashiru-Banchiriga

Supervisor's Declaration

I hereby declare that the preparation and presentation of the thesis was supervised in accordance with the guidelines on supervision of thesis laid down by the University for Development Studies.

..... 04-10-2017

Signature Date

Name: Allou Leander Achageba

ABSTRACT

The National Health Insurance Scheme (NHIS) in Ghana was established by Act, 2003 (Act 650) replaced with the NHIA Act, 2012 (Act 852) with the view to improving financial access of Ghanaians, especially the poor and the vulnerable, to quality equitable basic health care services and to limit out-of-pocket payments at the point of healthcare delivery. This study is to find out the prospects available and challenges of financing healthcare delivery through the National Health Insurance Scheme in the East Gonja District of Northern Region. An unstructured interview was used to elicit information from the key informants. Questionnaire was used to collect information from 150 individuals of the various communities selected. The results show that 93.3% of all respondents were satisfied with the level of care provided by the health facilities and the average distance travelled to reach a facility. Though respondents appreciated the benefits of the Scheme considering the applicable premiums, poverty still remained the major barrier for not joining the Scheme. The scheme provided good physical accessibility to residents. Thus inaccessibility of scheme structures and quality of services provided by the Scheme were not a challenge to the scheme. The Scheme should adopt the use of social and religious event as publicity channels, enhance enrolment of School children. Policy makers should consider expanding of the exempt categories and also add second cycle institutions to the exempt categories or give rebates to encourage enrolment.

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ACRONYMS

CBHI: Community Based Health Insurance

CUHC: Centre for Universal Health Care

DFID: Department for International Development

DMHIS: District Mutual Health Insurance Scheme

EGD: East Gonja District

EU: European Union

GDHS: Ghana Demographic and Health Survey

GH: Ghana

GIMPA: Ghana Institute for Management and Public Administration

GPRTU: Ghana Private Road and Transport Union

GSS: Ghana Statistical Service

ILO: International Labour Organization

IPD: In-patient Department

LI: Legislative Instrument

MDA: Ministries, Departments and Agencies

MDGs: Millennium Development Goals

MHO: Ministry of Health

MHOs: Mutual Health Organizations

NGO: Non-Governmental Organization

NHIA: National Health Insurance Authority

NHIL: National Health Insurance Levy

NHIR: National Health Insurance Regulation

NHIS:	National Health Insurance Scheme
NIC:	National Insurance Commission
OECD:	Organization for Economic Corporation and Development
OPD:	Out-patient Department
PHC:	Primary Health Care
PMHIS:	Private Mutual Health Insurance Scheme
PRO:	Public Relation Officer
SHU:	Save for Health Uganda
SSNIT:	Social Security and National Insurance Trust
VAT:	Valued Added Tax

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CHAPTER ONE

1.0 BACKGROUND TO THE STUDY

Many low-and middle-income countries rely heavily on patients' out-of-pocket health payments to finance their health care systems (Xu et al. 2007). According to the World Health Organisation (WHO), empirical evidence indicates that out-of-pocket health payment is the least efficient and most inequitable means of financing health care and prevents people from seeking medical care and may exacerbate poverty (WHO, 2000; Xu et al. 2003; Hjortsberg, 2003).There is a growing movement, globally and in the Africa region, to reduce financial barriers to quality health care generally, but with particular emphasis on high priority services and vulnerable groups (Witter and Garshong, 2009).

Health insurance schemes are increasingly recognized as a tool to finance health care provision in developing countries and has the potential to increase utilization and better protect people against (catastrophic) health expenses and address issues of equity (WHO, 2000). Health financing systems through general taxation or through the development of social health insurance are generally recognized to be powerful methods to achieve universal coverage with adequate financial protection for all against healthcare costs (Weber et al. 2000 cited in Doetinchem et al. 2006; Carrin et al. 2005).

Many African countries including Ghana, Rwanda, Tanzania, Kenya and Nigeria are experimenting with a variety of comprehensive social health insurance schemes that combine both private and public-funding arrangements (Carrin et al. 2008; Witter and Garshong, 2009; Mensah et al. 2010).

Ghana has prioritized universal coverage, defined as 'access to adequate healthcare for all at affordable price' (WHO, 2005), of health care and has therefore put in place policies and programs to meet this goal (Osei-Akoto, 2003). A number of health financing reforms have been implemented aimed at increasing overall resources to the health sector and ensuring equitable allocation (Atim et al. 2001), the recent of which is the National Health Insurance Scheme to enhance social health protection. Prior to the establishment of the NHIS in 2003, Ghana had implemented most of the known healthcare financing mechanisms including general tax and donor funding, out-of-pocket payments, community based health insurance schemes.

However, these approaches were not successful in improving access to quality healthcare and reducing out-of-pocket expenditures. For instance, the implementation of the user fee policy (Cash and Carry) in the public sector in 1985 resulted in inequities in financial access and utilization of basic and essential health services between different socio-economic groups and between poor rural and richer urban dwellers (Waddington and Enyimayew 1990; Asenso-Okyere et al. 1998; Nyonator and Kutzin 1999; Agyepong, 1999). Many low-income households regularly postponed medical treatment, resorted to self-treatment, or used alternatives provided by unregulated healers, spiritualist, and itinerant drug vendors, often with disastrous results (Oppong, 2001 cited in Mensah et al. 2010 and Gobah et al. 2011). To cushion the burden of out-of-pocket payment for health care, the government introduced an exemptions policy targeted at children under the age of 5, prenatal care for pregnant women, the indigent and paupers,

the elderly, and for some disease-specific services (Government of Ghana/SAPRI 2001; Sulzbach et al. 2005 cited in Singleton, 2006). Despite having a relatively comprehensive policy, there was considerable evidence that the exemption policy was poorly funded and implemented as many of those who should have been exempted did not receive them (Nyonator and Kutzin, 1999 as in Nyonator et al. 1997).

The poor implementation of the exemption policy, increased financial barrier to health care access to the poor. Utilization of health care as assessed by average OPD attendants decreased from 1.6 – 1.9 in the 70s to 0.3 – 0.4 in the 90s. Thus the exemption policy that was introduced to mitigate the effect of 'cash and carry' on the poor became ineffective, because the poor implementation which among other things was the results of the fact that no system for identifying the poor was put in place and also managers became obsessed with fees collection.

The people, therefore, had reduced access to hospital services and, consequently had a negative impact on the financial performance of health facilities (Atim and Sock, 2000). These difficulties in affording cost of health care and loss of revenue for most health facilities prompted some, mainly mission hospitals, to introduce insurance schemes managed jointly by the facility and the community as a strategy to avoid the problems associated with paying for services at the point of care. By 2003, there were 168 smaller Mutual Health Organizations covering only about 1% of the population leaving many Ghanaians vulnerable in the event of a catastrophic illness (Atim et al. 2001; Sulzbach et al. 2005) also cited in (Kasimu, 2011).

It was in this context that the National Health Insurance Scheme Act 2003 (Act 650) which was replaced by Act 2013 (Act 852) was introduced as an alternative to the cash and carry system of health financing.

"Before the introduction of the National health Insurance scheme tax revenue, donor funds and Internally Generated Funds (IGF) constitute 80% and 20% respectively of health care financing" (MOH 2012). The replacement of the cash and carry system means the health insurance will cover the Internally Generated Funds.

The policy goal was to institute a national health insurance scheme to assure equitable universal access for all residents in Ghana of an acceptable quality package of health services. The policy objective was that within the next 5 years from the NHIR, 2004 (L.I. 1809) every resident in Ghana will belong to an Insurance Scheme.

The strategy for the scheme implementation was a multi-scheme approach as Social type health Insurance and Private Commercial health insurance. The former type may be either District-wide mutual health Insurance (DMHIS) or the Private Mutual health insurance Scheme (PMHIS) with the government supporting only the former which will be the main Insurance.

The membership of NHIS is opened to all persons resident in Ghana by subscription. However, the Act 650 exempts some sections of the population from paying premiums to access the benefits provided by the scheme. They include:

- Children under 18years
- Residents aged 70 years and above

- The indigent (poor)
- In 2008, a free maternal care policy was instituted to provide free ante-natal and post-natal care to all pregnant women.

However, the NHIA succeeded in getting the National Health Insurance Act, 2003 (Act 650) replaced with the National Health Insurance Act, 2012 (Act 852). One key feature of Act 852 is the integration of the hitherto semi-autonomous District-wide Mutual Health Insurance Schemes into a Single-Payer System, and thereby transforming same into district offices of the NHIA. This transformation is expected to inject some efficiency into the operations and management of the NHIS. The scheme is currently operational in one hundred and fifty-five (155) district offices across the country. It has a total active membership of 8.8 million representing 35% of the population. A total of 3,575 health care facilities have been accredited to provide services to the insured (NHIA, 2012).

Funding for healthcare financing under the NHIS as established by the Act comes from a Fund created by the Act, with income from two main sources: the National Health Insurance Levy (NHIL) which is a 2.5% top-up of the Value Added Tax (VAT), and a 2.5% transfer from the existing Social Security and National Insurance Trust (SSNIT) worker contribution per month. In addition however, the Act levies working persons who do not contribute to SSNIT a yearly premium ranging from GH¢7.20 to GH¢48.00 depending on one's level of wealth. The Act further provides for a certain category of persons to join the Scheme and benefit thereof without having to pay any premiums. These exempt categories include

aged persons who are 70 years and above, children below 18 years whose parents have registered with the scheme, SSNIT pensioners and the indigent (NHIA, 2012).

There exist a National Health Insurance Fund (NHIF), financed from the NHIL, SSNIT deduction from the formal sector employees, funds allocated to the scheme by Parliament, returns on investments made by the National Health Insurance Council (NHIC) and others including grants, donations, gifts made to the fund. The NHIF provides funds for reinsurance to the DMHIS, subsidy or outright pre-payment for the core poor and vulnerable who do not have the ability to pay and to support programs that improve access to health services. The NHIL accounted for about 61.5% and 61.0% of total income of the NHIS in 2008 and 2009 respectively. Formal sector contributions made up 16.9% and 15.6% while the informal sector premium constituted only 5.0% and 3.8 % respectively (NHIA, 2010).

1.1 Statement of the Problem

Financing healthcare poses a great challenge to most nations globally (NHIA, 2012). The ability of national governments to provide funding for healthcare and to sustain the funding is a huge responsibility and Ghana is not an exception. Globally, new and innovative ways are being developed by governments to ensure that quality basic health care is available to all at affordable price and is equitable (NHIA, 2012).

In relation to the above, the study is to find out the prospects available and challenges of financing healthcare delivery in the East Gonja District through the National Health Insurance Scheme which since its introduction in 2004 has rapidly increase healthcare utilization by residence and has recently been bedevilled with serious challenge of low enrolment by residence and lack of interest by existing subscribers to renew their membership when it expire.

1.2 Objectives of the Study

The goal of the study is to determine the prospects and challenges of financing healthcare in the East Gonja District. The specific objectives of the study are to:

- Determine the prospects of financing healthcare delivery in the East Gonja district through the National Health Insurance Scheme.
- Determine the level of confidence in health delivery through NHIS by residence in the district.
- Determine the challenges of financing healthcare delivery through the NHIS in the East Gonja District.
- Determine the quality of services provided by Health Facilities under the NHIS in the District.

1.3 Research Questions

Considering the objectives above the following questions would be relevant to guide the study.

- What are the prospects of financing healthcare through the NHIS in East Gonja District?
- What is the level of confidence of residence in healthcare delivery through the NHIS in the District?
- What are the challenges of financing healthcare delivery through the NHIS in the District
- What are the qualities of services provided by health facilities under the NHIS?

1.4 Significance of the study

The health of a people to a very large extent determines their productivity and wealth. The 2010 Population and Housing Census indicates that a significant proportion of the people of East Gonja District (over 75%) are living below the poverty line of GH¢120.00 per annum (approximately US $120 per annum). It then implies that approximately the same proportion or even above might not be able to access health care under the 'cash and carry' system. Inability to access health care will lead to poor health status of the residents and thus lower their productivity. Eventually the poverty of these residents will worsen and thus increase the number of those below the poverty line. It was for these reasons that National Health Insurance Scheme was introduced by Government as a social intervention program intended to provide financial risk protection against out of pocket catastrophic healthcare expenditure for all residents in the Country and East Gonja in particular.

This study is therefore seen to be very important as it sought to identify the prospects and possible challenges of financing healthcare through the NHIS in the District. By this, stakeholder and other interested parties would find it easy to access and develop programs to improve the sector of healthcare financing in the district.

1.5 Delimitation

The boundaries of the study is limited to the East Gonja district and the operations of NHIS in the district. There are 20 districts in the northern region with district offices of the NHIS and about 160 nationwide. It's further restricted to 30 communities out of 362 settlement of which 150 individuals were selected as respondents.

1.6 Limitation

In every research there would be setbacks. The problems that hindered the progress of this study were inadequate time and resources to conduct the research. Also the researcher found it difficult to obtain ethical clearance from Healthcare providers.

1.7 Organization of the Study

The study would be divided into five main chapters. Chapter one is the introduction which give an overview of the study

Chapter two would be literature review that would deals with already existing information and theories concerning the topic.

Chapter three however, would deal with methodology and process that would be used in gathering data for analysis.

Chapter four would talk about the analysis and interpretation of data and Chapter five would also include the summary, findings, recommendations and conclusion of the study.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

Financing health care has been a very difficult task all the world over and various countries continue to explore several avenues to lessen the burden of financing health care on government and to further improve access to quality health care by all residents. Among the several alternatives considered by the Ghana government is the introduction of the National Health Insurance Scheme (NHIS) (Atim et al, 2001). The NHIS was established in 2003 with actual implementation starting in 2005 with the expectation that every resident in Ghana shall register and join a health insurance scheme.

The NHIA over the years has been experiencing increasing claims and other costs over the years. While this may be attributed to the increasing number of active members, moral hazards that are associated with Insurance Schemes may not be ruled out. Out-patient utilization of healthcare services increased from 0.6 million in 2005 to 25.5 million in 2011. However, in 2012, outpatient utilization decreased to 23.9 million and In-patient utilization increased from 28,906 in 2005 to 1,451,596 in 2011. In 2012, inpatient admissions decreased to 1,428,192 and associated Claims payment has been the major cost driver of the Scheme. Claims payment has increased from GH¢7.60 million in 2005 to GH¢616.47 million in 2012 (NHIA, 2012).

To conduct a detailed analysis of these factors would only be possible when we take a review of literature on health care financing and their alternatives,

challenges faced by implementing schemes and other related issues. This chapter therefore covers identifiable systems of health care financing, health insurance as a health financing method, and problems on smooth implementation of the National Health Insurance Scheme in Ghana.

2.2 Importance of Health

The health of the people of every nation is normally considered to be the pivot of growth and development of that nation. The international conference on health (Alma-Ata Declaration, 1978) declared that the wealth of the world varies directly with the health of the world's population. The declaration further called for action on all WHO member governments to increase resources for the health sector to ensure that people attain the level of health that will permit them to lead socially and economically productive lives. This declaration therefore determined the level of health care to be the provision of Primary Health Care (PHC) and defined this as the essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

It forms an integral part both of the country's health system, of which it is the central function, and of the overall social and economic development of the community. Good health however does not bring about economic growth alone but it is a vital factor which provides the fertile grounds without which man

cannot carry out other developmental initiatives. Good health does not only minimise disease and infirmities but also enhances the social, economic, psychological and mental wellbeing of the individual (WHO, 1995 as cited in Kasimu, 2009).

From the foregoing attributes, health can be described as a catalyst which accelerates the growth process and serves as a booster to all other factors necessary for human endeavour and progress. Health in fact, commands the energies and vitalities necessary for sustainable economic growth for better quality of life. Akorsa (2005) indicated that the ultimate goal of the health system in Ghana is to provide all persons living in Ghana with quality health services as to maximise their health lives.

Kibashihi (2005) stated that the health of the populace is a very important ingredient for development and it is only when Ghanaians are given quality health services that we can hope for a prosperous Ghana tomorrow. At a World Tobacco Day held in Tamale, Amin (2005) said that no nation can create wealth if the populace is not healthy. All these statements point to the fact that health is an essential factor in growth and development and without it, the pace will be slow.

Due to the importance of health, Ghana has adopted the concept of health-for-all policy for the 21st century (World Health Declaration, 1998) which guarantees health to all people irrespective of race, religion, political affiliation and gender, which among others states:

> "(i) We, the member states of the World Health Organisation (WHO), reaffirm our commitment to the principle enunciated in its constitution that

> the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being; in doing so we affirm the dignity and worth of every person, and the equal duties and shared responsibilities of all for health… (iii) We recommit ourselves to strengthening, adopting and reforming, as appropriate, our health systems, including essential public health functions and services, in order to ensure universal access to health services that are based on scientific evidence, of good quality and within affordable limits, and that are sustainable for the future. We intend to ensure the availability of the essentials of primary health care as defined in the Declaration of Alma-Ata and developed in the new policy. We will continue to develop health systems to respond to the current and anticipated health conditions, socio-economic circumstances and needs of the people, communities and countries concerned, through appropriately managed public and private actions and investments for health."

This has thus over-burdened the country as the health sector alone takes an average of 10% of the total annual budget of the nation (Health Sector 5-Year Programme of Work, 2002).

2.3 Concept and Development of Insurance

The Merriam-Webster Dictionary (2014) describes insurance as, "coverage by contract whereby one party undertakes to indemnify or guarantee another against

loss by a specified contingency or peril". So the basis of insurance is "guarantee against loss".

According to Mehr (1985) and Vaughn (1986), the roots of insurance can be traced back to Babylonia, where traders were encouraged to assume the risks of the caravan trade through loans that were repaid (with interest) only after the goods had arrived safely, and given legal force in the code of Hammurabi (2100 B.C.). Of course, caravans faced the same kind of threats our transportation industry faces today – like robbery, bad weather and breakdowns. The Phoenicians and the Greeks applied a similar system to their seaborne commerce. The Romans used burial clubs as a form of life insurance, providing funeral expenses for members and later payments to the survivors.

With the growth of towns and trade in Europe, the medieval guilds undertook to protect their members from loss by fire and shipwreck, to ransom them from captivity by pirates, and to provide decent burial and support in sickness and poverty. By the middle of the 14th century, as evidenced by the earliest known insurance contract (signed in Genoa, Italy, 1347), marine insurance was practically universal among the maritime nations of Europe. In London, Lloyd's Coffee House (1688) was a place where merchants, ship-owners, and underwriters met to transact business. By the end of the 18th century Lloyd's had progressed into one of the first modern insurance companies. In 1693, the astronomer Edmund Halley created a basis for underwriting life insurance by constructing the first mortality table, based on the statistical laws of mortality and compound interest. The table, corrected (1756) by Joseph Dodson, made it possible to scale

the premium rate to age; previously the rate had been the same for all ages (Mehr, 1985 and Vaughn, 1986).

Insurance developed rapidly with the growth of British commerce in the 17th and 18th centuries. Prior to the formation of corporations devoted solely to the business of writing insurance, policies were signed by a number of individuals, each of whom wrote his name and the amount of risk he was assuming underneath the insurance proposal, hence the term 'underwriter'. The first stock companies to engage in insurance were chartered in England in 1720, and in 1735, the first insurance company in the American colonies was founded at Charleston, S.C. The Presbyterian Synod of Philadelphia sponsored the first life insurance corporation in America, for the benefit of Presbyterian ministers and their dependants. After 1840 with the decline of religious prejudice against the practice, life insurance entered a boom period. In the 19th century many friendly or benefit societies were founded to insure the life and health of their members, and many fraternal orders were created to provide low-cost, members-only insurance (Mehr, 1985).

According to Trupin (2008), the first country to provide health insurance on a national scale was Germany. The German chancellor Prince Otto von Bismarck obtained passage of a compulsory sickness-insurance law in 1883, which was financed by a state subsidy. Various types of national health insurance were adopted by other European countries thereafter, including Austria-Hungary later in the 19th century, Norway in 1909, Sweden in 1910, and Britain and Russia in 1911. After World War II (1939-1945), the growth of national systems of health insurance in Europe was extensive, although the amount of benefits, conditions of

eligibility, treatment of dependents, and provisions for maternity care varied widely (Trupin, 2008).

The British system of national health insurance, comprising social security and the National Health Service, was thoroughly organised after World War II and is one of the most comprehensive systems in operation. National health insurance is under the jurisdiction of the Department of Health and Social Security, which administers the payment of cash benefits for sickness and maternity. All employed and self-employed people up to the age of 65 are eligible for benefits, and the funds for the programme are derived from weekly contributions by employers and employees. Sickness benefits are payable up to pensionable age if a sufficient number of weekly contributions have been made. Maternity benefits include weekly allowances, before and after confinement, to women who ordinarily work, as well as certain cash grants. The Workmen's Compensation Act of 1897 in Britain required employers to insure their employees against industrial accidents. Public liability insurance, fostered by legislation, made its appearance in the 1880s; it attained major importance with the advent of the automobile.

2.4 Health Financing Mechanisms

According to World Bank (2006), total health expenditure in recent years amounted to 7.7% of gross domestic product in high income countries, 5.8% in middle income countries and 4.7% in low income countries. The government public share of total health expenditure represented 70%, 62% and 52% of the

total in high-, middle- and low income countries respectively. It is observed that as a country's economic development evolves over time the more it tends to spend through public health expenditure as the population demand for better social protection increases (Drouin, 2007). Thus governments as they grow would need to find the most effective ways, in terms of policies, to extend social protection to as many people as possible.

National health polices typically focus on improving the population's health and preventing diseases and health hazards so that their entire population can aspire to a healthy and happy life and thus productively contribute to the prosperous development of the country and its economy. According to Drouin 2007, the objectives of a national health system are usually established as the intention of the state and written in the context of national laws, policy documents and other sources that may not necessarily be confined to a single source and may have been adopted at different points in time. This constitutes the Health Plan of the nation which has been defined as a predetermined course of action that is firmly based on the nature and extent of health problems, from which are derived priority goals.

The scope of objectives of the national health system is eventually limited by the extent to which they are affordable in a national context as health objectives are competing with other government programmes. Scarce national resources need to be optimised and rationalised. Depending on the choice of financing mechanisms and sources, the achievement of national health objectives will be more or less independent of national budget constraints. Thus the achievement of national

health objectives is eventually achieved through the selection of an adequate method of financing as well as through the choice of an effective and efficient organisational delivery structure for health services and payment approach for health providers. In addition, other structural elements contribute to the achievement of health objectives, such as the regulatory frame work and programmes of public education (Drouin, 2007).

Health financing mechanisms are organisational options for a health financing system on how to offer financial risk protection to people against the costs of healthcare. The method of financing consists of the way in which financial resources are mobilized and how they are utilized. It is multifaceted as it relates to different factors including: the approach to mobilise financial resources; the institutional and organisation delivery structure; the allocation of resources and; the remuneration and incentive method for health providers. These methods include tax-based financing, social health insurance, private mutual health insurance, medical savings accounts/out-of-pocket payments and loans, grants and donations are recently the innovative financing methods (Carren, Evans, and Xu, 2007).

In tax-based financing, individuals contribute to the provision of health services through taxes on income, purchases, property, capital gains, and a variety of other items and activities. These are typically pooled across the whole population, unless local governments raise and retain tax revenues. Health services are purchased by government, usually from a mix of public and private providers. This system can be considered as one leading to the most effective manner for

national risk pooling across the whole population and redistributing between high and low risks and high and low income groups. It gives the potential for administrative efficiency and cost control. However, its potential to contribute to health care financing depends largely on macroeconomic performance and competing demands from other sectors, the quality of governance, the size of the tax base and human and institutional capacity of the government to collect taxes and supervise the system. In practice, government schemes often tend to be under funded which might lead to shortage of goods and services and to under-the-table payments and lack efficient governance (Carren *et al*, 2007).

In social health insurance, contributions from workers, the self-employed, enterprises and government are pooled into a single or multiple funds on a compulsory basis. The mana gers typically contract with a mix of public and private providers for the provision of a specified benefit package. Preventive and public health care may be provided by these funds or responsibility kept solely by the Ministry of Health. Within social health insurance a number of functions may be executed by parastatal or non-governmental sickness funds or in a few cases by private health insurance companies. Social health insurance has the advantage of generating stable resources, often has strong support of the population, provides a broad package of services, involves social partners in decision-making and implementation and redistributes between high and low risk and income groups. However, administratively, schemes are complex and governance and accountability can be problematic. Further, from a macro-economic point of view payroll contributions can reduce competitiveness and lead to higher

unemployment. This system can also lead to cost escalation if effective contracting arrangements are not kept in place (Drouin, 2007).

In private health insurance, premiums are paid directly from employers, associations, individuals and families to insurance companies, which pool risk across their membership base. Private insurance includes policies sold by commercial for profit firms, non-profit companies and community health insurers. Generally, private health insurance is voluntary in contrast to social insurance programmes that tend to be compulsory. It is worth noting however that, in some countries private insurance may also be compulsory for certain segments of the population (for example the formal, employed sector). Private health insurance is often preferred to out-of-pocket payments as it increases financial protection and access to health services for those able to pay. It encourages better quality and cost-efficiency of health care providers. This system is however inequitable without subsidised premiums or regulated insurance content and price and it is ineffective in reducing cost pressures on public health financing systems. In environments where the impact of financial risk protection mechanisms has a limited impact, community health insurance schemes are introduced to improve the protection. Contributions are not risk related, and there is generally a high level of community involvement in the running of such schemes (Drouin, 2007; Carren *et al.*, 2007).

Out-of-pocket spending (also user fees or cash and carry) on health services is the most common form of health financing in developing countries and represents a significant financial burden for households (Sekhri and Savedoff, 2004). Out-of-

pocket payments is the most direct option of all the health financing systems and it involves each person bearing his/her own health risk by paying directly to health care providers, one's own health care cost without sharing the burden. Payments are done at the point of service delivery. The other dimension of out-of-pocket payments is the Medical Savings Account (WHO, 2002). These are individual savings accounts which are restricted to spending on health or medical care. They are a relatively new method and they have been introduced to: encourage savings for the expected high costs of medical care; enlist health care consumers in controlling costs, and; mobilise additional funds for health systems. Only a few countries in the world (Singapore, USA, China, and South Africa) have experience with Medical Savings Account.

The final health care financing under consideration is loans, grants and donations. These are usually predominant in particularly low and middle income countries. Grants could be from international non-governmental organizations, bilateral and multilateral donor countries. For example in Africa, donor assistance averagely account for almost 20 per cent of health care expenditure and, in several countries, more than 50 percent (Schieber 1997). Criticisms against this form of financing are that there is no evidence to determine whether grants increase net expenditure on health services. In addition, long term financial sustainability of health care system cannot over depend on donor assistance as donor priorities are also changing. Lastly, grants also would have to be paid and as such put financial burden on future governments and generations.

The choice of method, however, will depend on the number, structure and performance of existing schemes, the political and cultural context, the size of the tax base, the size of the informal economy, the disease burden, the availability of infrastructure, the capacity to collect taxes and premiums, who bears the financial burden, the amount of resources available, who manages the allocation of resources and the possibility of enforcing legislation. For instance, in principle, the mobilisation of resources through tax-based financing requires that the target group to which resources are allocated and health expenditure incurred be the entire population.

To uphold the principle of health for all, the selected approach to financing health care should allow the collective pooling of risk that contributes to meeting the broader objectives of equity, solidarity and affordability. Equity takes place at different levels: equity in financing, equity in access to health care, equal level of health status and equity in terms of risk protection offered (Drouin, 2007). Also as stated by the World Health Organisation (WHO): "the most important determinant of how fairly a health system is financed is the share of prepayment in total spending. Out-of-pocket payment is usually the most regressive way to pay for health and the way that most exposes people to catastrophic financial risk" (Kasimu, 2009).

Based on solidarity principles, national (social) health insurance offers one of the most effective ways to extend protection to as many people as possible. According to the WHO (2004), public spending in 2003 through national health insurance programmes was particularly dominant among country-members of the

Organisation for Economic Co-operation and Development (OECD) and transition economies of Europe as well as in some Western Pacific and North African countries while private health insurance plays a key role in many Latin American countries and in the United States of America. In Europe, government and national health insurance account for 70% of total health expenditure on average while covering nearly 100% of the general population. It is noted that this takes account of the mandatory private health insurance coverage in the Netherlands and Switzerland. Personal coverage under national health insurance or other forms of coverage varies greatly across countries.

In general it is considered to be deficient in most developing countries. Nevertheless, it can be said that personal coverage is closely related to the level of per capita expenditure. Such per capita expenditure varies greatly between low, middle and high-income countries. Health spending financed from public, private and other sources ranges between US$1,527 in high-, US$176 in middle- and US$25 in low-income countries (Drouin, 2007).

According to the 2004 national health accounts of the WHO, the funding of health expenditure at the global level is characterised as follows:

- Governments contributed 33% of global health expenditure;
- Social health insurance schemes covered 25% of global health expenditure;
- Private health insurance accounted for 20% of global health expenditure; and
- Out-of-pocket expenditure and other private expenditure accounted for 22% of global expenditure.

The report indicated that the main finding from these statistics relates to the significantly high global share of out-of-pocket payments, namely as it is highest in low income countries, which is the concern of the ILO that the national health systems of too many countries in the low income category primarily rely on out-of-pocket payments for health expenditure and these leave the burden of health risk and expenditure on individuals whose families are most prone to enter into poverty if a member becomes seriously ill. This leads us to conclude there are inadequate of public measures to provide systematic health coverage to people, especially in poor countries.

2.5 Health Care Financing in Africa

According to Leighton (1995) financing health care has become very prominent for many governments in Africa. Whereas many forms of health financing mechanisms for Europe were focused on containing costs, in developing countries particularly Africa, health financing reforms have been motivated by growing demand for better health care at a time when governments, faced with shrinking resources, can no longer honor its traditional commitment to providing free care (Vogel, 1988; Vogel, 1990) classifies health financing reforms in sub-Sahara Africa into three strategies. These include:

- Raising revenue through cost recovery techniques (e.g., user fees, community-based social financing).
- Improving allocation and management of existing health resources.

- Increasing the role of the private sector in predominantly government-based health systems.

Given the inadequate and declining government financial support to health care system, many countries in the sub-region have concentrated their health financing reforms primarily on the first strategy, which is raising revenue through cost recovery techniques. Through this system, Ministries of Health have introduced most commonly used cost recovery approaches for public health services through user fees for services, medicines or both (Langenbrunner *et al.*, 2001). Other techniques practiced include community based health insurance, pre-payment plans and private health insurance.

The second and third strategies, which are designed to improve efficiency and effectiveness of countries health systems is less widely used across many countries in the sub-region. As of 1994, about twenty African countries began health sector cost recovery reforms including Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia and Zambia who have made revenue raising the primary objective Lavy and Germain (1995). Cost recovery could be useful given the amount of revenue raised, use of revenue for intended goals and impact of use. According to The World Bank (1994) chances of success of cost recovery in sub-Saharan African countries are improved by some of these indicators;

- Introducing fees alongside quality improvements, especially assuring drug availability and ploughing fee revenues back into quality improvements that satisfy patients and keep them coming back.

- Establishing clear cost recovery objectives, understanding the people's demand and use patterns, and measures to cover costs of care to the indigent.
- Designing fee structures to encourage efficient use of services first at the lowest appropriate level, reinforce appropriate referral patterns, and promote use of cost-effective and preventive care.
- Avoiding common pitfalls such as failing to keep fees up to date, allowing too many exemptions, failing to collect from government for services provided to beneficiaries of government health plans or social assistance programs.

Given the emphasis on cost recovery in Africa, a question often times asked is whether cost recovery affects access to health care? It is argued that user fees create much less of a barrier to utilization than may have been expected, especially in the case of primary and preventive care services, particularly when other factors affecting demand for health services are taken into account. In a study conducted in Cameroon, it was found that the probability that a sick person would visit a government clinic was 25% higher when fees were charged and quality improvements were also made (Leighton, 1995).

However on the other hand, cost recovery could hinder access to health service for the poor in particular. Because poor households have less cash, they have less likelihood to borrow funds as well as sell off assets for cash to pay for health service. Evidence however is inconclusive on wealth and purchasing power of health by the poor, given that many studies conducted on fees and utilization did

look at income levels. Few studies however conducted in countries such as Cote d''voire, Kenya, Cameroon and Niger have suggested that the poor are more sensitive to the quality and time-price of health care than the non-poor but not necessarily to prices by user fee level (Nolan and Turbat, 1993).

Social and private financing is another funding source for health financing in sub-Saharan Africa includes. Social financing involves spreading risks and cost of medical care by pooling resources, usually through premiums or tax payments to central or local governments (Ndiaye, 2006). In sub-Saharan Africa, individual financing predominates in traditional health care, with social financing predominating in western medical care. Social financing health insurance is practiced in different forms in Africa; however generally, social financing is mainly in the form of government provided, tax-financed health services for the whole population (Vogel, 1990; Ekman, 2004). For example in Senegal and Mali, there is the compulsory social security for the entire formal sector. In Zaire, there is government mandatory employer coverage of health care for employees. Kenya practices the National Hospital Insurance Fund for formal employees. The employer-sponsored health insurance is practiced in countries such as Zambia, Nigeria, Liberia, Senegal, Zaire and Kenya (Vogel, 1990).

Other forms of social financing, not limited to the formal sector are also practiced in some countries including community-sponsored prepayment and rural insurance plans in Zaire (Bwamanda rural hospital insurance programme); Guinea-Bissau (community-level prepayment funds for primary health); and Kenya (Harambee movement funds for catastrophic illnesses). In Côte d'Ivoire,

Ghana, Kenya, Senegal, Zimbabwe, group and individual private insurance are practiced (Forgia and Griffin, 1993; Atim, 1998). Supporters of social financing emphasize that when successful, social financing can ensure equitable access to quality care through limiting benefits giving consideration to expected utilization patterns to keep premiums affordable (Filmer *et al.*, 1997).

2.6 Social Health Insurance and Community-based Insurance in Africa

The literature on health care financing provides insufficient distinction between user fees, health care prices, health care costs and health insurance. As a result, the role of user charges in social insurance schemes is widely misunderstood. A user charge is the price that consumers pay for medical care at the time of use. In a perfect market, a user charge is equal to the cost of care, i.e., it is the same as the value of resources spent to produce a unit of health care, e.g., the amount of care provided to a patient during a visit to a health facility. Thus, like other goods, health care has a true price. That is, the price that reflects the opportunity cost of the resources used to produce care, example, and a package of basic health services. This price is the same, regardless of the method used to finance health services. In a hypothetical case where the price of health care is equal to zero, social health insurance is unnecessary, because health care is equally accessible to all. The need for social health insurance arises because user charges for health services exist.

Social health insurance is a mechanism for paying user charges before the need for health care arises. Under a social health insurance system, all health facilities

have user charges for their services. It is these user charges that determine the amount of reimbursement that facilities claim from an insurance scheme. However, members of an insurance scheme do not notice these charges at the point of service use. In contrast, under a fee-for-service system, user charges are paid in full, unless they are subsidized. However, in a national health service, where health care is provided in a network of government clinics user charges need not exist. What exists instead is the cost of care, which is known to health facility managers. There is no need to display this cost to service users when it is being met entirely by revenue from general taxation. However, if part of the cost is being met by patients, user charges would exist in a government clinic.

Briefly, user charges necessarily exist when health care is being financed a through social health insurance scheme or by a system of user fees. However, user charges need not exist when service financing is through general taxation in a network of government health facilities unless there is cost-sharing between the government and service users.

Social health insurance schemes are national in scope while community-based schemes are localized and voluntary. Since a national or social health insurance scheme is compulsory, a country that adopts it must finance all health services using that scheme.

2.7 Characteristics of Social Health Insurance

Social health insurance pools both the health risks of its members, on the one hand, and the contributions of enterprises, households and government, on the

other. It enables a set of basic health care services to be accessible to all, irrespective of income or social status (Carrin, 2002).

The essence of social health insurance may best be conveyed by a description rather than a definition.

Social insurance has six key characteristics that distinguish it from other mechanisms for financing health services, namely (see Thompson, 2002, pp. 3-4):

- Compulsory payroll contributions to a common Fund, collected from employees and/or employers, but in some countries persons outside the formal sector are allowed to contribute voluntarily.
- The Fund is managed separately from the government budget or revenue from general taxation.
- Contributors have a say or voice in how the fund is managed and used
- Like any insurance scheme, the Fund covers members only, but since by definition, all citizens must enrol, the government pays contributions for the poor
- The Fund acts as a third party payer, i.e., it has a contractual relationship with health care providers to pay for services rendered to its members.
- The Fund has a defined package of health care and does not cover health care outside this package.

Implicit in the last attribute, is the fact that a social health insurance scheme must define a minimum package of care to which all members are entitled. The definition and the costing of the minimum package of care, is a continuing challenge in all countries concerned with equity in health care, and in health

outcomes. According to a variety of estimates, the cost of a minimum package of health services in Africa varies from US $ 14 to US $ 30 per capita (World Bank, 1993, cited in Mwabu, 2008)

The cost of the minimum package is important for implementation of a social health insurance scheme because it shows the level of resources that the scheme must mobilize in order to meet the health needs of the population. The mechanisms for mobilizing resources to finance the minimum package (e.g., level of contributions and social groups that are able to afford them) indicate whether or not the scheme also serves the social objective of equity in health care, with which all methods of health care financing must be reliable to be nationally acceptable. Thus, the sixth characteristic has implications for the size of the fund. Attributes (ii), (iii) and (iv) also affect the cost of the minimum package because they have efficiency and equity implications.

2.8 Prospects of Social Health Insurance in Africa

Based on the above characteristics, and the information provided in Thompson (2002), the following conclusions emerge about social health insurance schemes in English speaking Sub- Saharan Africa:

a) Since African countries have diverse social and institutional contexts and differ as well in their ability to mobilize resources for health care, a uniform social health insurance scheme is not workable for the whole continent. Examples of differences in national health insurance programs in Kenya and Tanzania and, in schemes proposed for Zimbabwe, Nigeria and South Africa are used to illustrate

practical difficulties of a uniform social health insurance scheme on the continent. In particular, the schemes differ in minimum packages in important ways. In Nigeria for example, the proposed scheme excludes HIV/AIDS from the minimum package, but includes preventive care such as family planning; in Tanzania, tuberculosis treatment is excluded, while in South Africa and Kenya, outpatient care is excluded; in Zimbabwe, no minimum package is defined. The governance structures also differ across schemes, with the insurance fund being managed by one organization in Kenya, while in Nigeria management by different organizations is preferred.

b. It is difficult, probably impossible, to scale up the existing national health insurance schemes to full coverage over the medium term (say 20-30 years) or to implement new full coverage schemes for the following reasons:

- The money raised through contributions from the formal sector through payroll deductions are insufficient to cover health care needs of the whole population. The payroll base is weak, covering a tiny proportion of the population. The current social insurance coverage ranges from 0.9% in Burkina Faso to 25% in Kenya.
- Sub-Saharan African countries have large informal sectors, where contributions cannot be collected through taxation. The insurance schemes have to rely on voluntary contributions, which are unreliable.
- Many of the schemes have design features that are cost escalating. For example, in the existing and proposed schemes, reimbursement is on a fee-for-service basis, a provider-payment system that increases unit costs thus

reducing the capacity of the scheme to increase coverage. Although this is a design feature that can be fixed, the managerial and institutional constraints that must be overcome in the process should not be underrated.

- The capacity to manage the schemes efficiently on a national scale in limited. For example, parastatal organizations in Africa are poorly managed, almost in all countries. A new parastatal dedicated to the management of an insurance scheme is unlikely to do better than the existing parastatals dedicated to other ends.
- The schemes are likely to worsen inequalities in health care by directing resources to health facilities that have the advantage of providing high quality care, such as the regional and national hospitals. Small-scale health facilities, such as health centres and district hospitals, which dominate health systems in Sub-Saharan Africa, may not have the capacity to claim reimbursements from a centralized insurance fund. Thus, such facilities would lack resources to provide adequate care to their clients.
- The large number of people living with HIV/AIDS in Africa complicates a national health insurance scheme and greatly increases its cost. For example, inclusion of people living with HIV/AIDS (a relatively small fraction of scheme members) has the implication that a large share of the scheme benefits will be received by a few people because ARV (antiretroviral) drugs are costly and must be taken regularly. Excluding HIV/AIDS patients is also ethically and politically difficult. There is no other region in the world where a social health insurance scheme faces

such a dilemma. However, to keep the contributions to social health insurance low, a separate program can be created for HIV/AIDS patients, which obviously would increase the complexity of the national health system.

Another barrier to scaling up of existing small social insurance scheme is that the services defined in a minimum package are unlikely to be produced or delivered in adequate quantities in a vastly expanded insurance scheme, thus discrediting it in the eyes of the public (see Carrin, 2002). Carrin (2002) notes that the above barriers to implementation or scaling up of a social health insurance can be overcome by robust growth, strong administrative capacities, formalization of an economy and greater voice of the populace in political and social affairs. Aptly noting that this is a long run "golden" basket of factors that facilitate the achievement of universal coverage, he wonders whether a country like South Africa, where the majority of the population is in favour of a social health insurance scheme (see Shisana et al., 2007) should wait for decades before implementing the scheme or extending its coverage. In the same vein, there is the question as to whether such a scheme should be abandoned, as implied in (b) above because it cannot be implemented now.

Using Asian experience, Carrin (2002) argues that there is a substitute for the distant 'golden basket' in the implementation or expansion of a social health insurance scheme. Specifically, a combination of (i) a family health insurance where a worker insures the whole family, with (ii) enhanced contributions to the scheme by government and donors and (iii) regulated, decentralized management

of the scheme would facilitate its implementation or scaling up. An obvious limitation of this approach is that family health insurance schemes are not viable in underdeveloped formal sectors, where wages for the majority of workers are barely above subsistence levels, and where contributions of governments to the schemes cannot be increased because tax bases are weak, as in much of Sub-Saharan Africa. Thus, the barriers noted in (b) above are still valid. A highly informative discussion of ways to speed up transition to full coverage (adequate basic health care for all) in the face of some of these barriers is in Carrin and James (2005).

In an interesting article, Ossei (2008), observes that the national health insurance scheme (NHIS) introduced or announced in Ghana in 2004 will help the country achieve health MDGs by "increasing public access to health care, improving the quality and efficiency of health care delivery and lastly, improving and increasing programs of education on curative and preventive health care."

However, whether or not these activities are capable of being scaled up is a different matter. Ossei is aware of this difficulty because he asks: "Is the NHIS sustainable over a longer period of time? Will poorer people eventually be priced out of the NHIS system over the longer period? What measures do we need to counter NHIS fraud and are the rural poor who are at least an hour away from a health centre enjoying the fruits of the NHIS?." Although the evidence to assess these issues is not yet available, conclusion (b) above still has force.

2.8.1 Mutual Health Organizations and Community-based Health Insurance

An extensive survey of mutual health organizations (MHOs) in West Africa, variants of community-based health insurance (CBHI) schemes in Eastern and Southern Africa (Huber et al. 2012), indicates the following:

- Access to health care for scheme members is good.
- Schemes have low coverage in target populations, i.e., the communities in which the MHOs operate.
- The provider-based schemes lack skills and health care technology to improve efficiency in service delivery.
- Resource mobilization capacities of the schemes are modest due to low coverage and low premiums.
- The majority of the schemes had little capacity to protect the health of the poorest segments of society, and these need government assistance.
- HMOs are promising models of improving access to basic health care but face great implementation difficulties.
- Governments are not capable of financing health systems alone.
- Health insurance schemes should be seen as playing a supporting role, not as an exclusive financing option.
- Like user fees, insurance schemes are means to top up existing government budgetary financing.

The limited evidence available from operations of MHOs and CBHIs in West Africa (Huber et.al, 2012) and East Africa (Ekman, 2004) suggests that these schemes have low coverage and the resources they mobilize for basic health care

packages are modest. Moreover, in a given country, only a few of these schemes exist. Thus, their role in financing interventions for achieving health MDGs are modest at best.

2.9 The Role of Health Insurance in Achieving Health MDGs

Investments on interventions for achieving health MDGs should have the first call on health budgets in Africa. These goals will not be achieved if sufficient investments are not made to make basic health care services broadly available to the population. However, the services can be available and still remain unused or under-utilized due to financial barriers such as the user charges. If health services are not used they will not improve health. Full, complete health insurance enables households to access health care services free of charge at the time of need. Under this financing arrangement, all households have equal access to health care regardless of ability to pay. Progress towards attainment of health MDGs has been made in countries where basic health services are broadly accessible to the poor. National health insurance facilitates such access. However, this form of insurance is by no means the only mechanism that can guarantee the poor access to basic health care and must therefore be considered against other health care financing alternatives such as general tax revenues and subsidized user charges (Mwabu et al, 2008).

It is helpful to explain again the basic ideas and practices behind health insurance. There are three parties to an insurance scheme: the insured (the payer of insurance premiums), the insurer (the intermediate receiver of the premiums paid by diverse

payers), and the service provider (final receiver of the amount paid in premiums for health services rendered to the insured). Three points are worth noting about a health insurance scheme.

First, the final amount that an insurer transfers to the service provider is less than the amount that the insurer receives in form of premiums. This is so because the insurer keeps part of that income to cover the cost of managing an insurance scheme (expense on bookkeeping and security). This management expense (the loading charge) is an extra cost to the premium payer (the insured) for any service he receives. Thus, insurance is more burdensome than direct payments such as user charges for health care.

However, the 'extra management cost' is more than justified by the fact that insurance guarantees availability of health care when needed. An individual is willing to pay for this assurance of treatment in the event of illness because of a commitment to being in solidarity with other people against the *risk* of not being treated when ill. In the absence of solidarity (pooling of individual risks), an insurance scheme is not possible.

The second point is that everyone must pay insurance premiums in order to receive coverage against the risk of not getting care when ill or injured. In this sense, medical cover under insurance depends on ability to pay. However, because people are in solidarity against poor health, society pays premiums for those unable to pay. The revenue from general taxation is used for this purpose. This insurance situation parallels the case where user fees are waived for those unable to pay. The only difference is that the waiver here occurs at the time of

service use. Thus, poor people must bear the risk that the waiver may not be given, in contrast to the insurance case where waiver is guaranteed.

The third point is that payments of premiums to insurers, the transfer of these payments to service providers, the management of an insurance scheme, and provision of quality service to members of the scheme require complex institutional and organizational arrangements. An insurance scheme can fail to emerge or to perform properly because certain institutions or organizations are lacking.

Moreover, many of the institutional and organizational structures associated with insurance schemes such as insurance law, insurance brokers, and code of ethics in public and private service take decades to develop.

To summarize, health insurance schemes eliminate the financial barrier to usage of basic healthcare. If the schemes are compulsory or national, all citizens have equal access to health care along a financial dimension. However, lack of money is not the only barrier to better health care or to any care. In many African settings for example, time and travel costs are major barriers to care. A national health insurance scheme may therefore not improve access to care if lack of money happens to be a minor consideration relative to time costs in consumer demand for medical care. A second nonfinancial barrier to access is lack of information about availability and quality of the services offered. A third barrier is under-valuation of health benefits of the services available. Thus, in reforming Access to basic health care, all forms of constraints to usage must be addressed.

2.10 Health Financing Schemes in Ghana: The Journey to NHIS

Financing health care has had a chequered history in Ghana, starting from free healthcare in public health facilities through to user fees (cash and carry) and currently the National Health Insurance Scheme (NHIS). Along the government financing schemes however were other private sector initiatives and community-based initiatives. For this discussion, public sector financing schemes to be considered shall include:

- The free health care system after independence
- The user fees (cash and carry) and its exemptions
- The pilot NHIS attempted in the Eastern Region ect, and
- Other public sector schemes for covering health care;

A review of the formation and challenges/constraints of private sector financing schemes and community-based financing schemes shall also be considered.

2.10.1 The Free Healthcare System at Independence

Following the country's independence in 1957, Ghanaians had free access to healthcare. All Ghanaians could seek medical attention in any government hospital or health centre and pharmacy at no financial cost to the individual. Thus healthcare was being financed principally by tax revenue (Senah, 1989). With time however, government expenditure on healthcare became quite high, especially between the late 1960s and the mid-1980s. For example, per capita health expenditure in 1970 was $10, compared to between $5 and $6 in the 1990s (Wahab, 2008). Tax revenue alone was thus no longer able to finance health care

services. Hospital fees were thus re-introduced in 1969 and continued in some variety until the introduction of the "cash and carry" system in 1985.

2.10.2 The User Fees and its Exemptions

The Hospital Fees Regulation, 1963 (L.I. 1277) was revoked and replaced in 1985 by the Hospital Fees Regulation, 1985 (L.I. 1313), mandating fees be charged for consultation, laboratory and other diagnostic procedures, medical, surgical and dental services, medical examinations, and hospital accommodation. By this system therefore one was required to pay out of pocket for healthcare at the point of service delivery (Atim et. al, 2001). This meant one had to provide money at a time when they were rather sick and unable to work for any income. The system therefore brought untold hardships especially on the poor, who could not afford the often high fees charged at health institutions. In the ensuing years therefore cash and carry decreased access to health care, particularly among the poor, resulting in a decline in the utilisation of basic health services (Sulzbach, Garshong and Banahene, 2005). Per capita OPD attendance fell from between 0.6 to 0.9 (proportion of population that utilized health care facilities) in the 1970s to about 0.3 to 0.4 in the 1990s.

To cushion the burden of out-of-pocket payment for health care, the government introduced an exemptions policy. The exemptions under the system were in two broad categories: full and partial including those in Table 1 below.

Table 2.1: Exemptions under Hospital Fees Regulation, 1985 (LI 1313)

Full Exemption	Partial Exemption
Leprosy and tuberculosis	Services to health personnel
Immunisation against any disease	Antenatal and postnatal services
Cold storage of dead body at request of any State department/agency	Treatment at child welfare clinics
	Meningitis, chicken pox, etc.

Source: Hospital Fees Regulations, 1985

By 1990, however the exemption policy had been expanded to cover six clearly defined facilities which included:

- Exemptions for disease of public health importance
- Exemptions for antenatal services
- Exemptions for children under five years
- Exemptions for the elderly (aged 70 years and above)
- Exemptions for paupers and indigents
- Exemptions for snake bites and bites by dogs suspected or confirmed to be rabid.

A number of reasons can be assigned for the introduction of exemptions in the policy. Data gathered showed that a need clearly existed to provide funding for the poorest and most vulnerable people in the society (Atim et al. 2001). For instance, data from the fourth round of the Ghana Living Standards Survey (GLSS) which covered the period from April 1998 to March 1999 shows that older people and young children were most vulnerable to illness or injury. However, only 39% of children aged five years or below had received, for

example, postnatal care. The Ghana Demographic and Health Survey (GDHS), 1998, show that at least 16% of pregnant mothers had never visited an antenatal clinic or had been there only once. These are all contributing factors to the high rate of infant and child mortality in the country, which, according to the GDHS (1998), stood at 57 and 108 per 1,000 live births respectively. The Core Welfare Indicators Questionnaire (1998), which also indicated the poverty levels in the country, revealed that about 27% of Ghanaians lived in extreme poverty, especially in the rural areas UNDP (2001).

However, implementation problems at the district level meant that a significant number of clients who qualified for exemptions continued to face barriers in accessing basic health care (Atim *et al*., 2001). Major among the implementation challenges and difficulties faced by health facilities, government and even beneficiaries included:

- Unclear or non-existent guidelines on how to implement the policy, including reimbursement procedures
- Uneven implementation leading to considerable variation within districts and between regions in the impact of the exemptions to target groups and health facilities
- Inadequate supervision and monitoring to ensure implementation of the policy
- Institutions claiming different amounts for similar services leading to differential average cost of exemption to the Ministry of Health (MOH)
- Frequent complaints that the budgetary allocation for exemptions was inadequate

- Delays in settlement of claims for exemptions to health facilities
- Abuse of the policy by persons not within the target group and even by health facilities
- Inadequate information to the public about the exemptions scheme.

These problems prompted some health care facilities, mainly mission hospitals, to introduce insurance schemes managed jointly by the facility and the community as a strategy to avoid the problems associated with paying for services at the point of care (Sulzbach et al, 2005).

2.10.3 The Pilot NHIS in the Eastern Region

The decline in health facility utilisation caused especially by the financial barrier created by the 'cash and carry' system made the system unpopular to residents and the government. This thus led the government to seek alternatives to financing healthcare in the country. The MOH therefore commissioned a study into the feasibility of establishing a National Health Insurance Scheme (NHIS). To this end various local and international bodies were invited to make recommendations to this effect and international bodies such as the International Labour Organisation (ILO), World Health Organisation (WHO), European Union (EU) and the London School of Hygiene and Tropical Medicine visited the country and provided technical advice. In August 1995, the MOH received definite proposals from a private consultancy group (Atim *et al.*, 2001).

The report recommended the establishment of a centralised national health insurance company to provide ''Mainstream Social Insurance Scheme'' for all

contributors to the Social Security and National Insurance Trust (SSNIT) and all registered cocoa farmers. The key designs of the scheme were

- Inclusion of non-profit and for-profit health facilities in the scheme
- Reimbursement by capitation
- Contribution rates equivalent to 5% of salary for formal sector employees or a fixed levy per ton of cocoa produced (equal to 7.19% of the producer price)
- Enrolees to register with a single preferred provider.

In 1997, the NHIS pilot project was formally launched in the Eastern Region. In that connection, a NHIS secretariat was set up at the headquarters of the Ministry of Health (Accra) to undertake the preparatory work and carry out the program. However amidst some constraints and challenges which included:

- Debates about the strategic direction of health financing policy generally and the pilot scheme in particular and for lack of consensus among the technocrats at the MOH about a government-run insurance scheme
- Lack of a clear definition of the role of the MOH in the whole process: an implementer, a facilitator or a promoter?
- Centralised administration and inappropriate management structures at lower levels
- Difficulty in determining appropriate design to address the large informal sector
- Inadequate mechanisms for community involvement and ownership to ensure sustainability

- Vertical implementation of certain components of the scheme, such as community education.

The implementation of the pilot scheme was aborted without actually even taking off.

2.10.4 Other Public Sector Schemes for Covering Health Care

Government in seeking to improve the health status of its workers and enhance conditions of service and job satisfaction established the Civil Servants Health Care Scheme, by which all civil servants were entitled to free medical care for themselves, their spouses, and up to four children. Funds for this scheme were allocated yearly under the General Government Services vote and were proportionately distributed among the regions according to the number of civil servants in each region (Atim et. al, 2001).

A member could benefit under the scheme by attending any government health facility if he/she was sick, and submitting an application with receipts of payments at the health facility for reimbursement through the Ministry/Department/Agency (MDA). These claims were compiled and sent to the regional level for vetting and payment of approved bills. It is of course worth noting, that there was no official ceiling on the total claim one could make in a year.

Table 2:2 indicates the allocation of funds among the ten regions in Ghana. The allocations are computed according to the proportion of civil servants in each

region. The total amount is released annually to the Ministry of Health, which in turn allocates it to the various regional health administrations.

Table 2.2: Civil Servants Healthcare Scheme

Region	Allocation of Funds (%)
Greater Accra	30
Ashanti	14
Eastern	10
Western	9
Volta	7
Northern	7
Brong Ahafo	7
Central	7
Upper East	5
Upper West	4
Total	100

Source: Atim et. al., 2001

A major setback to the scheme was the undue delays in settlement of claims, which in some cases took as long as even six months to mature and painfully, might not even cover the total amount submitted for reimbursement. Also, some civil servants who did not have money at the point of sickness could not access health care as their mother MDA would only reimburse on submission of receipts of treatment. However some very serious abuses also came up with the system. Some employees who previously did not have any dependents suddenly came up with people they claimed to be their spouses and children. Also, some employees

in collusion with some health providers presented fraudulent claims (Atim *et al.*, 2001).

Along the Civil Servants Healthcare Scheme were health care financing schemes established by other sub-vented organisations/public service organisations. These bodies, some of which are the Ghana Institute of Management and Public Administration (GIMPA), Ghana Statistical Service, National Development Planning Commission, etc. made special internal arrangements for financing their staff's health care. In most instances the organisation made special arrangements with a designated hospital/clinic to treat staff and their dependents' ailments. Also a maximum ceiling existed for the cost of treatment beyond which the staff had to pay the difference. The major problem with this system was the fact that attendance was restricted to a particular hospital and so choice was limited. Further, if one travelled a distance away from the hospital location and fell sick then the scheme could not cover the staff as he/she would not have been treated within the designated hospital (Atim *et al.*, 2001).

2.10.5 Private Commercial Health Insurance Schemes

Beginning from 1993 when Nationwide Mutual Medical Insurance Scheme was established, a number of other private commercial schemes including Metropolitan Health Insurance Plan (MetCare), Ghana Healthcare Company (established by SSNIT), Provident Xpress Care Medical Plan and many others were established. These companies provided healthcare to both individuals and corporate entities. Each company offered a number of different benefit packages

attracting different premiums. For instance, MetCare offered four different benefit packages, namely: the Classic, Premier, Executive, and Prestige.

The main constraint with the successful operations of these schemes was the unavailability of a legal framework to guide the operations of the Schemes. In all cases companies resolved issues of abuse and fraud by members and/or service providers internally. At a more general level, the National Insurance Commission (NIC) forms the umbrella for all private insurance companies, to which fraudulent practices of huge dimensions are reported, and where the general insurance laws of the country apply.

Other constraints to the smooth operations of these schemes were the manual processing of claims which led to backlog of claims and so delays in payments, fraudulent claims submitted by service providers and/or subscribers, inadequate premiums due to under calculation of premiums by the companies, dissatisfied clientele, inappropriate management structures, etc. Following the introduction of the National Health Insurance Scheme in 2004 most of these schemes collapsed either due to technical and financial reasons or because they could not stand competition (Atim et al., 2001).

2.10.6 Community-Based Financing Schemes

These are a combination of Community Health Insurance Schemes, Social Financing Schemes based on health insurance tenets and Health Insurance Schemes set up and run by Non-Governmental Organisations (NGO's). The first to be established in the country was the Nkoranza Community Health Insurance

Scheme. Its formation was initiated in 1989 by the Catholic Diocese of Sunyani and it was eventually launched in 1992, having drawn inspiration from the famous Bwamanda scheme in Zaire (Atim et al., 2001). It is thus the oldest in the country and so served as a model for all types of mutual health insurance schemes in Ghana.

Consequently, many schemes were established by various bodies and/or communities to ease the financial difficulty faced by their members in accessing healthcare services. Some of these were the Damongo Health Insurance Scheme of West Gonja District established in 1994, Duayaw Nkwanta Dagaba Welfare Scheme in the Tano district established in 1995, Saw millers Credit Facility established in the Birim South district in 1997, Tiyumtaaba Welfare Association established in Tamale in 1998, GPRTU Health Scheme at New Juabeng established in 2000, Saboba/Cheriponi Health Scheme established in 2001, etc. Members of these schemes were several and varied, some being members of particular tribes, others belonging to particular jobs and others belonging to particular communities, with a mean membership size of 6,679 (Atim et al., 2001).

Services covered that were fully covered by most schemes were drugs, laboratory services, X-Ray services, admissions and complicated delivery. Family planning, normal delivery, and general Out-Patient Department (OPD) cases were usually not covered. Payment methods for claims on health care provision included direct payments to providers, reimbursement of members and other methods, which could be flat rate or a combination of the first two. Funds for payment of claims

and logistical and technical support came from member contributions and support from donors such as DANIDA.

A number of challenges also confronted the schemes and their survival and sustainability. Major among these were extremely low premiums, abuse by facilities and clients, managerial problems and most importantly low patronage leading to small membership to effectively pool resources.

Various researches on community health insurance have indicated varied reasons for low patronage to the schemes. Atim and Sock (1999) identified inappropriate registration periods, widespread misconceptions in the community about the schemes and massive adverse selection of members into the schemes as some factors contributing to low registration of members into the schemes. Further in a research report released by the ILO in March 2007, lack of public education on registration, distance of residents from health facilities, delays in issuance of membership cards were among factors that caused low patronage of the Dangme West District Mutual Health Insurance Scheme.

2.11 Challenges of Health Insurance Schemes in Developing Countries

Despite the fact that based on solidarity principles, national health insurance offers one of the most effective ways to extend protection to as many people as possible, establishing a social health insurance system is often beseeched with many problems, especially in developing countries. Major among the problems is low enrolment into schemes established under the system.

In Guinea-Conakry, a study on declining subscriptions in Maliando Community Health Insurance Scheme identified two main causes of the decline: poor quality of care offered to members at health facilities and problems of subscription affordability amongst poor and/or large families (Criel, B. and Waelkens, M., 2003). In a similar study conducted in Uganda in 2006 on two selected Community health Insurance Schemes: the Ishaka and the Save for Health Uganda (SHU) Schemes, Basaza, R., Criel, B. and Van der Stuyft, P. (2007) observed that despite the promotion of Community Health Insurance Schemes in Uganda since the mid 1990's, membership remained persistently low, with only about 30,000 people enrolled into the two schemes under study, comprising only about 2% of the catchment population. Moreover, the total number of schemes had not exceeded 13, being an addition of only about 3 more schemes to the first established schemes since 1996. The study pointed at a series of not mutually exclusive explanations for the under-achievement at both the demand and supply sides of the health care delivery. On the demand side the following reasons were identified:

- Difficulties for existing community groups to raise 60% of the membership or 100 families per village prior to enrolment
- Low level of community involvement in the management of hospital based community health insurance schemes
- Lack of trust in local financial organisations after previous depressing experiences with similar institutions

- Lack of information on and poor understanding of the notion of community health insurance
- And, problems in the ability to pay the premium.

For the supply side two main reasons were identified. They are

- The absence of a coherent policy framework to promote community health insurance amidst a backdrop of user-fee abolition in the public sector
- A lack of information, poor interest in and understanding of the notion of community health insurance by health professionals (health workers, district services managers and health planners).

Quality of care, unlike in the Guinea-Conakry case above, was not mentioned as a reason for low enrolment in the Ugandan research. Basaza et al (2007) observed that this could be because the main providers for both Schemes were church-owned, which were generally perceived to provide higher quality care than public facilities.

De Manuela, A., Sanon, M. and Sauerborn, R. (2006) in their study of the causes of low enrolment in the Nouna Health District in Burkina Faso, using in-depth interviews supplemented with focused group discussions also identified a number of factors. Principal among these were lack of adequate knowledge and poor understanding in respect of key features of the scheme, poor quality of care and general distrust of the proposition. Similar reasons were given for the low enrolment into the community health fund in the Hanang district in Tanzania, by Chee, G., Kimberly, S. and Kapinga, A. (2002). Employing focused group discussions and semi-structured interviews, their study concluded that the

explanation for low enrolment into Hanang Community Health Fund were the inability to pay the subscription fee, poor quality of care, poor education and limited mobilisation of community members to join.

However, in Gobah et al, (2011) in the study of Challenges of NHIS: a Cross-Sectional Evidence in the Akatsi District in the Volta Region of Ghana recommends registering the informal sector through existing groups and associations in which premium could be paid on installment basis through them and that, there is also the need to establish permanent and functional structures of arbitration to constantly engage the scheme management, healthcare providers and subscribers in order to minimize the mistrust and abuse of the system to curtail cost and improve service delivery.

Furthermore, A. Addae-Korankye (2013) stated that, to further benefit from the concept of risk pooling and social solidarity, government and national health insurance authority should enforce the application of the income classification category with the accompanying appropriate premium. Whereas provisions have been made for this, the practice has been different, with district schemes applying flat rates for premium payment across categories. This undermines the concept of social solidarity, where relatively richer persons pay higher premium for health insurance to help subsidize for the relatively poorer persons who would not have otherwise been able to purchase health insurance.

The country and for that matter the government should in addition to the traditional source of funding health care service can consider other forms of funding mechanisms like medical savings account.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Introduction

This chapter focuses on explaining the methods and procedures adopted in this study. It covers the approach and procedures involved in collecting the data for the research and include the study design, the population, the sample size and sampling, data collection tools and analysis of data.

3.2 Study Design

The study is both descriptive and explanatory. Descriptive research describes, records, and reports phenomena. Descriptive research can provide important fundamental information for establishing and developing social programs like the NHIS, but it is not primarily concerned with causes (Marlow, 2001). Descriptive research focuses on vital facts about people and their opinions and provides information on which to base sound decisions. Descriptive surveys interpret, synthesis and point to integrations and interrelationships among the various factors under study (Osuala, 1987).

Explanatory research on the other hand aims at providing explanations of events in order to identify causes (Marlow, 2001). It must of course be stated that this type of research often requires the formulation of hypothesis of the relationship among variables which may be obtained empirically. Explanatory research aims at explaining social relations or events, advancing knowledge about the structure, process and nature of social events, linking factors and elements of issues into

general statements and building, testing, or revising a theory (Sarantakos, 1997).These two designs have therefore been adopted to enable the identification of the "prospects and challenges of financing healthcare delivery through the NHIS in the District", record these with appropriate descriptions and properly explain the issues therein.

3.3 Study Area

The East Gonja District (EGD) is one of the 24 districts of the Northern region and has a total landmass of 8,340.10 square km constituting about 11.95% of the landmass of Northern region and it is at present the largest district in the country. Salaga, the administrative capital of the district, is situated about 114km (about 71 miles) southeast of the Regional capital, Tamale.

Source: Ghana Statistical Service

The district shares boundary with Nanumba North and South districts to the east; Tamale and Yendi districts to the north and; Kintampo and Central Gonja districts to the west and Kpandai District to the Southeast. It also shares boundaries at the southwest with Pru and Atebubu districts of the Brong-Ahafo regions being separated from the latter by the Volta Lake. However a sizeable portion of the district lies beyond the Volta Lake and can only be accessed through Brong-Ahafo region after crossing the Volta Lake.

Politically, The East Gonja District Assembly consists of 50 Assembly members with 35 elected and 15 appointed. The administrative capital is Salaga, which is centrally located in the district. Two members of parliament represent the district: one for the Salaga North constituency and the other for Salaga South constituency.

For easy administration, the East Gonja District has been zoned into six Area Councils with 35 electoral areas. The District Chief Executive is the Chief executive officer of the Assembly with both Administrative and Political responsibilities. The District Coordinating Director is the Chief Administrator of the Assembly. The 11 decentralised departments are all present and functional in the district.

The population of the district estimated from the 2010 Housing and population census stood at 135,400 with an estimated annual rate of growth 2.1% per annum living in 362 settlements. Of the working population about 2.5% are in the formal sector with the remaining 97.5% in the informal sector. The Agricultural industry is the largest, employing about 83.7 of the working group. The income level is generally low with 75% of the populace being below the poverty line ($120.00 per year). The populace is mainly rural constituting 88% with 12% urban settlement (GSS, 2010).

Table 3.1: Estimated Population (%) Proportions – 2014

Population group	District (%)	National (%)	Remarks
Informal active	46.2	39.9	Non-Exempt
Formal active	2.5	4.5	Exempt
Aged (70years +) & Pensioners	3.9	4.4	Exempt
Below 18 years	47.4	51.2	Exempt
Totals	100.0	100.0	

Source: East Gonja NHIS, 2014

Table 3.2 gives the distribution of the District's population across the six operational zones of Health Insurance (HI).

Table 3.2: Distribution of Registered Persons among Zones

Zone	No. of Settlements	No. of HI Communities	Population	No. insured as at Dec. 2014
Salaga	109	21	65,761	31,572
Kpariba	83	9	29,362	11,202
Kitoe	29	2	7,479	4,084
Kafaba	35	5	8,521	5,675
Makango	76	4	9,366	5,003
Abrumase	41	4	14,911	5,696
Totals	362	45	135,400	58,222

Source: East Gonja Health Insurance Scheme, 2014

3.4 Sampling Procedure

The research adopted a multi-stage sampling technique using a combination of cluster sampling, simple random sampling and purposive sampling techniques. Cluster sampling was employed to ensure that each zone was fairly represented, as each zone had some different characteristics that may impact on the study. Simple random sampling was used to select a number of health insurance communities from each zone, then a number of settlements from each health insurance community, number of individual respondents from each settlement and for all stages for the actual selection up to the selection of settlements, after which a sample size was set for the study using a predetermined confident level and interval.

On the basis of location, each zone was considered a cluster. Thus there were six clusters. A list of all health insurance communities with their settlements was produced per cluster (zone) to serve as the initial sampling frame. Simple random sampling was used to obtain five health insurance communities per cluster (zone). From each of the five communities, simple random sampling was again used to select a settlement, making a total of thirty (30) settlements from which 150 respondents ware picked as the final respondents. The procedure for the simple random sampling used to obtain the five health insurance communities per zone (cluster) is described below:

- A list of health insurance communities for each of the six clusters was compiled to serve as an initial sampling frame per zone.
- Numbered cards were used to replace community names so that each card corresponded to a name in the sampling frame of that zone.
- All the cards were placed in a closed box with a small opening to allow a hand in for a pick.
- The cards were mixed properly by shaking the box.
- A research assistant was appointed to pick a card from the box without looking inside. The box was then shaken to mix the cards after each pick until all five health insurance communities were chosen.
- Each card picked was then registered with the corresponding name in the sampling frame.

Similarly, simple random sampling was adopted for each health insurance community chosen, to select a settlement from which the final respondents were

chosen. Finally, the researcher set a sample size of one hundred and fifty (150) individuals, made up of ninety (90) non-insured and sixty (60) insured adults using the approach based on precision rate (margin of error) of 8% and a confident level at 95%. Thus from each of the chosen settlements, 3 non-insured and 2 insured individuals were selected as respondents.

In addition, purposive sampling technique was applied to select three key informants, the Public Relation officer of the district NHIA, Administrator of the Salaga Government District Hospital and a senior officer from the District Health Administration, were interviewed to elicit more information on the prospects and challenges of Financing Healthcare services through the NHIS in the District.

3.5 Data Collection Technique

An unstructured oral interview was used to elicit information from the key informants. Questionnaire was used on the other hand to extract information from the clients of the various communities selected in the sample. The questionnaire is made up of five (5) parts. Part A focus mainly on demographic information of respondents. Part B enquires of the availability of health facilities to respondents and their health seeking behaviours

. Part C assesses respondents' knowledge and perceptions about the National Health Insurance Schemes. Part D finds out the affordability of the premiums payable and the last part, part E assess the effectiveness of the Scheme structures kept in place to ensure access of respondents to the services of the Scheme.

3.6 The Pilot Study

The assistance of six (6) research assistance was sought to conduct the research, each one assigned to a stratum (zone) and was aided by NHIS community agents. These research assistances were trained on the administration of the questionnaire. They then conducted a pilot study in the Salaga Township for one day so as to ascertain if the questionnaire served its purpose by eliciting the required information and determining its consistency, accuracy, reliability and any ambiguity in any questions. A few corrections were made after the pilot study and actual field work then began across all selected communities.

3.7 The Main Field Work

Due to the large size of the district and the bad roads and inaccessibility of some of the chosen communities, the research was spanned to a one-week period, beginning from the 6th of July, 2015 to the 11th of July, 2015. Each researcher was given twenty-five (25) questionnaires to administer. Thus five questionnaires would be administered in each selected settlement. At the end of the field work out of the 150 questionnaires administered, there was one non-response (improperly administered) from among the insured clients. Thus there were responses from 90 non-insured and 59 insured persons.

3.8 Data Processing and Analysis Procedures

Information gathered from the research was screened and edited, and using the Statistical Package for Social Sciences (SPSS version 22.0.0), the data was

summarised and presented in tables and charts. This is use to determine the possible prospects and challenges that Financing Healthcare services in East Gonja District through the National Health Insurance Scheme.

CHAPTER FOUR

4.0 RESULTS AND DISCUSSIONS OF FINDINGS

4.1 Introduction

In this chapter, the results obtained from the field work are presented and discussed. Firstly, the background characteristics of respondents are discussed. This is followed by an examination of the level of confidence residents have in healthcare provision within the district. Then a discussion on the affordability of the premiums payable is considered. Next the appropriate season for payment of premiums is determined. Following this is a discussion to assess the level of confidence of residents in the Scheme and lastly the workability of Scheme structures kept in place to ensure access of residents to the Scheme is discussed.

4.2 Demographic Information of Respondents

The demographic characteristics of respondents considered in this study comprised their age, sex, marital status, religion, household size and structure, ethnicity and the educational status.

The age distribution of respondents is shown in Table 4.1 Out of the one hundred and forty-nine (149) respondents, 94.7% were between the ages of 18 to 59 years, being the group in active service in the country. Those above 60 years constituted only 5.3%, thus 5.3% of the respondents were on retirement from active civil service. The maximum age of respondents was 73 years, the mean age was 35.61, the modal age was 30 years and the minimum age was 18 years.

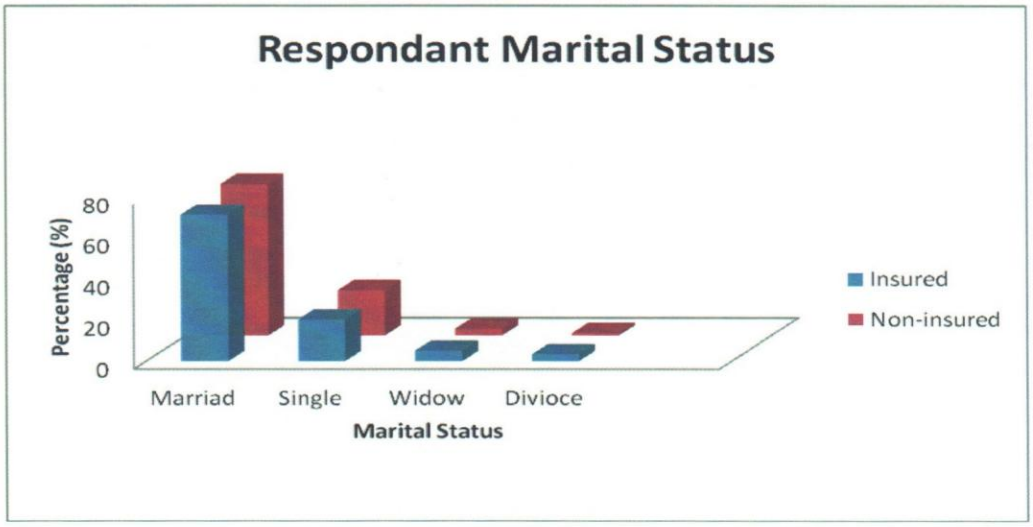
Table 4.1: Age Distribution of Respondents

Age (years)	Frequency	Percent	Cumulative percent
18-29	51	34.7	34.7
30-39	50	33.3	68.0
40-49	28	18.7	86.7
50-59	12	8.0	94.7
60-69	7	4.7	99.3
70+	1	0.7	100.0
		149	100.0

Source: Field work, August, 2015

With regard to sex, out of the 149 people interviewed, 58.7% were males whiles 41.3% were females. This is shown in the Figure 4.1. Married people constituted 72.7% of the respondents, single persons constituted 21.3%, 4.0% were widowed whiles the remaining 2% were divorced or separated. Within the group of insured respondents, 71.2% were married, 20.3% were single, 5.1% were widowed and 3.4% were divorced. Similarly, among the non-insured group interviewed, 73.6% were married, 22.0% were single, 3.3% were widowed and 1.1% was divorced.

Figure 4.1: Respondents Marital Status



Source: Field work, August, 2015

The mean household size was seven (7), which was in conformity with that established by the 2010 Population and Housing Census. The mode of the distribution of household sizes was 5 and this constituted 13.8%, followed by household sizes 4, 6 and 8, each of which was 11.3%. Families among the 59 insured respondents who had household sizes above 6 constituted 47.5% and that of the non-insured was 48.6%.

In response to religious affiliation, 44.7% said they were Christians, 43.3% were Muslims, 7.3% were in Traditional religion whiles the remaining 4.7% had no religion.

The ethnic background of respondents was very wide, but limiting this to the categories in the questionnaire, the major groupings among the respondents were the Kokombas, Gonjas and the Other Guans, with Kokombas having the highest percentage of 22%. The least in the respondents were the Akans and the Hausas,

each of whom constituted 2.7%. Figure 4.2 throws more light on the ethnicity of respondents.

Figure 4.2: Ethnicity of Respondents

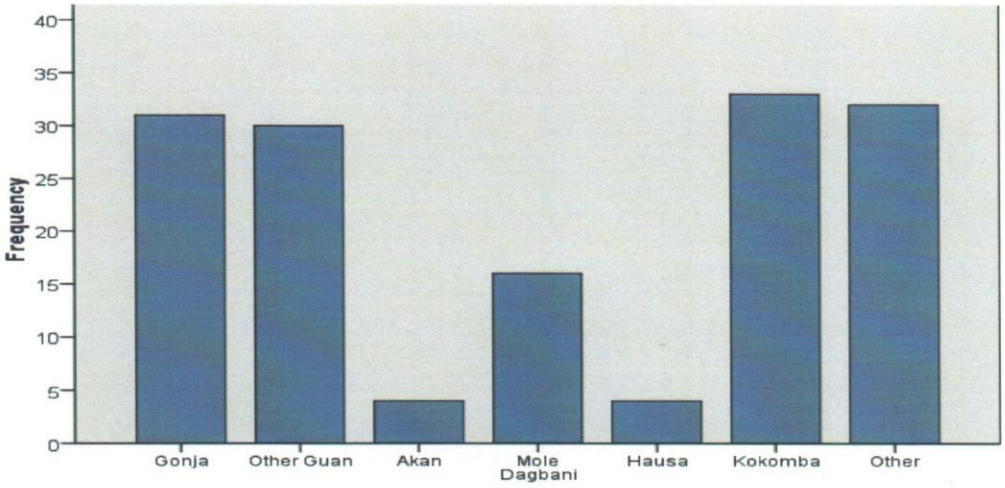


Table 4.2: Respondents level of Education

Educational Level	Frequency	Percent (%)
None	80	54.0
Primary	12	8.0
Middle/JHS	30	20.0
Secondary/SHS	21	14.0
Tertiary	5	3.3
Non-Formal	1	0.7
Total	149	100.0.

Source: Field work, August, 2015

Table 4.2 depicts the levels of educational attainment of respondents. Fifty four percent (54.0%) of respondents had no form of formal education. Eight percent (8.0%) had education up to the primary level, 20.0% had received up to Middle school/JHS education, 14.0% had Secondary education and only 3.3% had received tertiary education. The remaining 0.7% received Non-formal education. It could thus be deduced that majority of the respondents were non-illiterate.

Table 4.3 shows the incomes of various categories of respondents. The largest single group of the non-salary workers was farmers (60.1%). The self- employed constituted 23.3% whiles salaried workers followed with 7.3%. There were 2.6% students and 6.0% unemployed.

Across the categories, the highest average monthly income over the last 12 months was about GH¢620.00 whilst the lowest was GH¢40.00. The mean average monthly income for the farming group was GH¢63.51, that of the self-employed was GH¢68.11, and for the salaried workers and the unemployed it was GH¢124.73 and GH¢65.63 respectively. The overall mean average income across the categories was GH¢69.39. About 80% of the farmers earned an average monthly income of less than GH¢100.00

Table 4.3: Occupation and Average Monthly Income

Aver. Monthly income	Farmer/Fisherman	Salaried Worker	Self- Employed	Unemployed	Other	Total
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
<=100.00	79 (88)	6 (55)	28 (80)	6(75)	4(80)	123(82)
100.01-200.00	5 (6)	4 (36)	6 (17)	2 (25)	1 (20)	18 (12)
200.01-300.00	4 (4)	0 (0)	1 (3)	0 (0)	0 (0)	5 (3)
300.01-400.00	1 (1)	0 (0)	0 (0)	0 (0)	0 (0)	1 (0.7)
400.01- Above	1 (1)	1 (9)	0 (0)	0 (0)	0 (0)	2 (1.3)
Total	**90 (100)**	**11 (100)**	**35 (100)**	**8 (100)**	**5 (100)**	**149(100)**

Source: Field work, August, 2015

4.3 Level of Confidence of Residents in Healthcare Providers

This section examines the availability of health facilities, patronage of these facilities and the confidence of respondents in these facilities to provide them with quality and affordable health care. To elicit the needed information, respondents were asked about the availability of a health facility and its nearness to their home, the nature of illness suffered and the amount spent to treat it at the facility. Questions were also asked about the difficulties encountered at the facility and the perception of the quality of service provided by the facilities.

The study showed that 58% of the respondents had a health facility located within or at least near their community. This is fairly so as there are about twenty (20) health facilities distributed across the district, with some of the facilities even having branches in other communities. Most of the health facilities also embarked upon outreach programmes and so reached out fairly well to the residents.

Regarding facilities available and used by respondents, respondents were asked to select as many facilities as applied to them from the seven alternatives provided in the questionnaire. Table 4.4 illustrates the number of facilities available to clients. The table is constructed from multiple responses and so the total response is 361. All respondents had at least one (1) facility available for use, 32.1% said two facilities were at their disposal, 19.7% had three facilities at their disposal and 6.7% had up to four facilities at their disposal. From Table 4.4 , majority of the people (30.2%) had access to a government facility, 29.5% also had access to a chemical shop, followed by 18% with access to mission clinics whiles 14.4%

said they had access to a herbalist with 3% each for a Man of God and a shrine. The least was 1.9% who said they had access to a private clinic.

Table 4.4: Availability of Healthcare Providers

Facilities available	Respondents	Respondents (%)
Government Clinic	109	30.2
Chemical Shop	106	29.5
Mission Clinic	65	18.0
Herbalist	52	14.4
Man of God	11	3.0
Shrine	11	3.0
Private Clinic	7	1.9
Others	0	0.0
Total	361	100.0

Source: Field work, August, 2015

When asked if respondents or their relatives fell sick over the past 12 months and whether they used the National Health Insurance Scheme when they fell sick, 78.7% said they or their family members had suffered one form of sickness or the other. Of the 118 who fell sick, 67.8% were acute conditions whiles 32.2% were chronic conditions. The study also revealed that out of the 118 that fell sick, 73.7% of them used a government clinic to seek treatment, 45.8% used a chemical shop, and 37.3% used a mission clinic whilst 18.6% used herbalist. Furthermore, out of the 118 respondents that suffered some ailments, 44% of them accessed healthcare via the National health insurance Scheme with the majority, 56%, using cash and carry and other methods to cover the cost of healthcare.

Amongst the 52 that used the National health insurance scheme, 23.1% said they encountered difficulties using the system. 'Poor medical services and maltreatment (e.g. inappropriate language and extortion) by nurses and payment for some drugs were cited as the main problems encountered. The 66 respondents that used methods other than health insurance to seek treatment at health facilities paid treatment costs ranging from GH¢12.00 to GH¢804.03. The mean payment per person was GH¢56.70. This, clearly was far above the minimum amount payable (GH¢15) as premium under the National health insurance scheme and so still throws the challenge on the need to find out why they were not registered with the Scheme.

Table 4.5 shows the distribution of distances of nearest facility from respondents. The table measures physical accessibility of clients to facility. From Table 9, 64.4% had the nearest facility located within 4 kilometres from their homes, 24.9% had the nearest facility within 4 to 8 kilometres whilst about 10.7% had the facility over 8 kilometres from their home. The mean distance travelled to reach a health facility was 4.12 kilometres and this is well within the national standard of a maximum distance of 7km for one to travel to reach a facility.

4.5: Distribution of Distance to Nearest Facility

Distance (km)	Number of respondents	Percent of respondents
Less than 2	68	45.0
2 - 4	29	19.4
4 – 6	19	12.8
6 – 8	18	12.1
Over 8	16	10.7
Total	150	100.0

Source: Field work, August 2015

An assessment of the performance of provider facility services was done by the respondents (both insured and non-insured). Table 4.6 illustrates the ratings beginning from very good, good, fair to bad.

Table 4.6: Assessment of Services Provided by Health Facilities

Rating	Number of respondents	valid percent (%)
Very good	26	17.6
Good	95	64.2
Fair	17	11.5
Bad	10	6.7
Total	148	100.0

*There was one non-response

Source: Field work, August 2015

Amongst the 148 persons that responded, 17.6% rated their services as very good, 64.2% rated their services as good and 11.5% rated them as fair or satisfied. Only a relatively small proportion, 6.7%, said their services were poor. In general

therefore about 93.3% of the respondents can be said to be satisfied with the services of the health facilities. This confirms the assertion of a key informant that, the providers did their best to provide the best of quality of care to their patients and so did not believe that quality of services they provided could deter clients from registering with the Scheme. In the case of insured patients, he said, special care and attention was given to them just to ensure that almost all patients were encouraged to register and join the Scheme. Deductions from above are also in conformance with the findings by Basaza *et al.* (2007) in their research in Uganda which indicated that quality of care was not mentioned as a reason for low enrolment.

This view was however contrary to that of the Marketing Manager/Public Relations Officer (PRO) of the Scheme who claimed that quality of care by the health providers was a deterrent to joining the Scheme by residents, and of course, also contradicts findings in Guinea-Conakry (Criel, and Waelkens 2003) and in Burkina Faso (De Manuela *et al.*, 2006) that quality of care was one of the most important reasons for low patronage of the scheme.

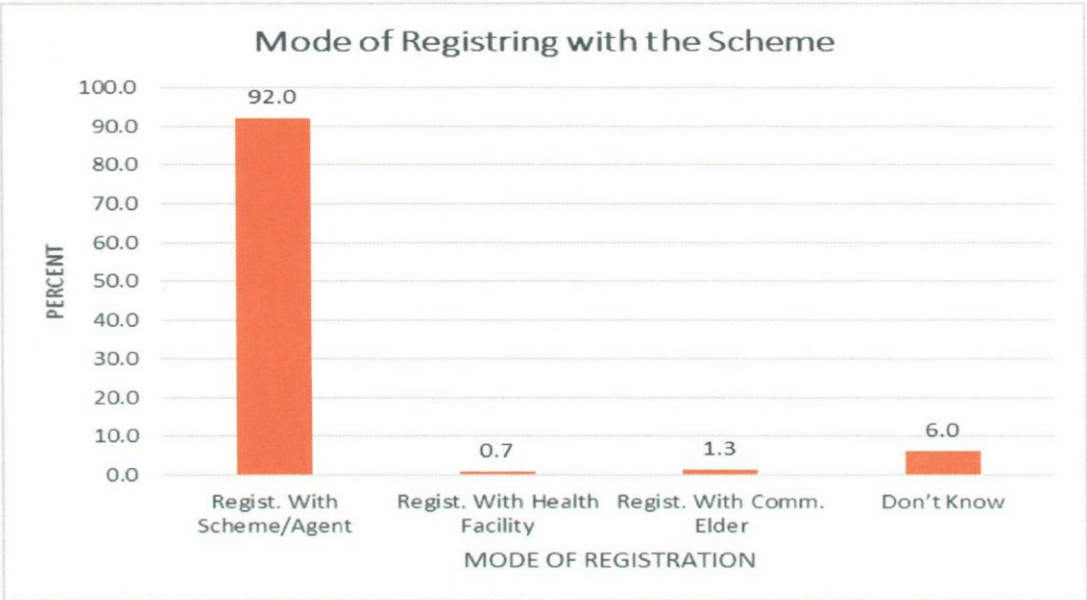
4.4 Knowledge of Residents on NHIS

The data collected brought to light that all respondents were aware of, or at least, had heard of the existence of the NHIS. This section examined the level of knowledge and understanding of respondents on the national health insurance scheme and how it operates. To do this, residents were asked if they had ever heard of the Scheme, how to join the Scheme and the categories of people that

could join the Scheme. They were also asked of the categories of people exempted, the appropriate methods of information dissemination and what should be done to enhance enrolment.

On the question of whether respondents had heard of the National Health Insurance scheme, all respondents indicated they had heard of the Scheme. Figure 4.3 shows the distribution of respondents' answers on how one could join the Scheme. As showed in the figure, 92.0% of respondents said one could join the Scheme by registering with an NHIS Agent. Six percent did not know how to join the Scheme, 1.3% said one could join by registering with a community elder whilst 0.7% said one could join by registering with a health facility.

Figure 4.3: Mode of registration with the Scheme



Source: Field work, August 2015

When respondents were asked about the categories of people that could join the Scheme, 90.7% of respondents said all Ghanaians could join the Scheme, 6.7%

said they did not know whilst the remaining 2.6% said only adults could join the scheme.

To further determine the extent of knowledge of the scheme, respondents were asked to tick multiple responses about exempt categories from the following: informal sector workers, SSNIT contributors, children under 18 years of age, the elderly above 70 years, the core poor, none of these and don't know. Table 4.7 shows the distribution of 309 responses given by the respondents on the various categories exempts listed.

Table 4.7: Categories Exempted from Paying Premiums

Category	Frequency	Percentage (%)
Adults above 70 years	120	38.8
Children under 18 years	113	36.6
Core poor	47	15.2
Don't know	24	7.8
None of these	3	1.0
SSNIT Contributors	2	0.6
Total	309	100.0

Source: Field work, August 2015

Out of a total valid response of 309, 91.2% chose SSNIT contributors, children under 18 years, those above 70 years and the core poor as those in the exempt group. Those who said they did not know the exempt categories were 7.8% whilst those whose responses were 'none of these' constituted only 1.0% of the responses. This gives a very clear indication of a good knowledge of the exempt groups in the scheme. This is also a confirmation of a key informant's assertion

during an interview that each year, officers from the Scheme, aside the regular visits by the collection agents, visited every one of the 535 settlements at least twice for education on the NHIS policy developments and picture-taking exercises.

When questioned on what the Scheme should do to encourage more people to join, Table 4.8 illustrates the responses. From the table, 36.9% of the respondents said the premiums should be reduced, 26.1% said there should be continuous community education on the policy and 20.8% said identity cards should be produced on time. The latter is believed to be a concern as there have been general delays in producing and distributing identity cards to qualified persons, particularly due to under staffing of the Scheme.

Table 4.8: What the Scheme should do to Encourage more People to Join

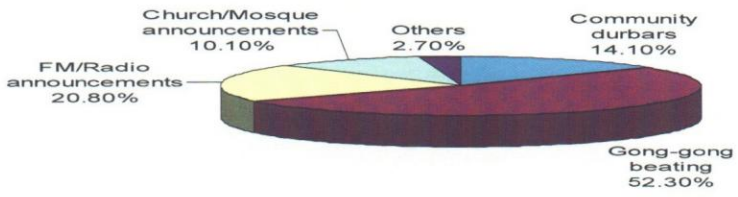
Suggestion	Frequency	Percent (%)
Reduce premiums	55	36.9
Continuous community education	39	26.1
Produce I.D. Cards on time	31	20.8
Regular visits by Scheme Officials	12	8.1
Don't know what to do	12	8.1
Total	149	100

Source: Field work, August 2015

One important area which will assist to increase the coverage of the Scheme in terms of membership is marketing of the scheme to the non-insured. Figure 4.4 illustrates the distribution of responses on which method is best for information

dissemination within the district. Both the insured and the non-insured were of the view that 'gong-gong' beating (52.3%) will be the most effective means of disseminating information about the Scheme. This was followed by FM/Radio announcements (20.8%), community durbars (14.1%), Church/Mosque announcements (10.1%) and other means (2.7%). Indeed the key informant believed that the easiest and most effective means of educating the residents would have been the use of FM Radios if they were available, unfortunately however only one was in the district with even limited coverage. He therefore said they used a combination of 'gong-gong beating', car announcements, church/mosque announcements, community durbars and a bit of regular announcement and talk shows on radio to reach residents with all information about the scheme.

Figure 4.4: Suggested Methods of Information Dissemination



Source: Field work, August 2015

By the results presented in figure 4.4, residents have exhibited that they have in-depth knowledge about the Scheme and so awareness about the scheme was good

enough. Awareness could therefore not be a reason for the low enrolment into the Scheme. This finding however contradicts the poor education problem identified in the studies conducted in Tanzania (Chee *et al.*, 2002) and Uganda (Basaza *et al.*, 2007).

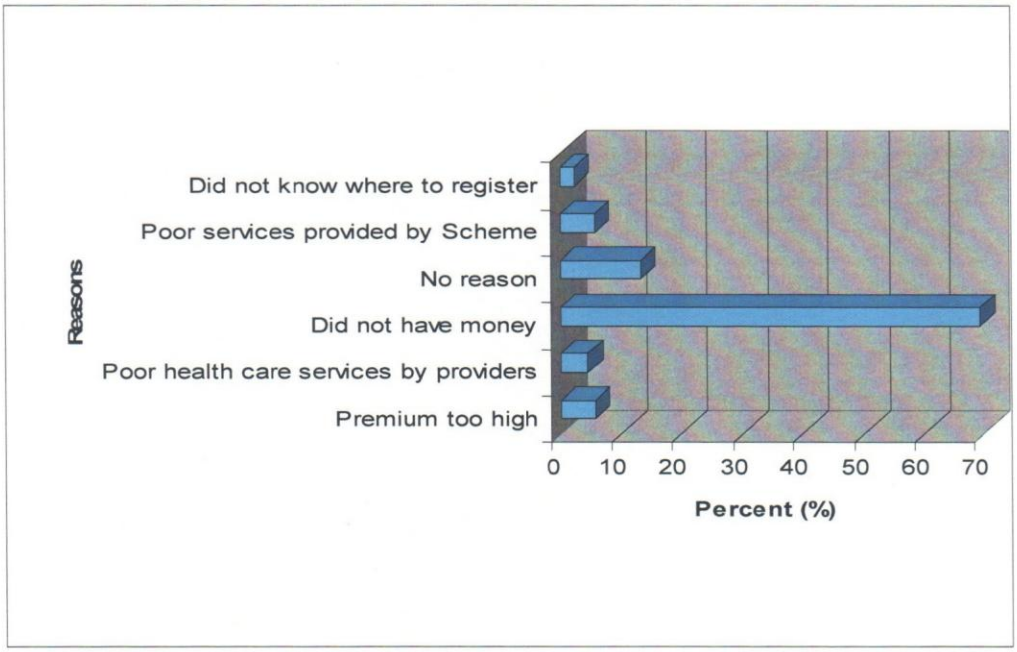
4.5 Premiums Payable and Appropriate Season for Payment of Premiums

To determine the affordability of the existing premiums to residents and also enquire the preferred season for residents to pay their premiums, respondents were asked whether they had joined the Scheme or not with the reasons thereof, if insured how much they paid as premiums, which period of the year they found most appropriate for the payment of premiums and how much they proposed for the Scheme to charge as premiums.

Answering the question of whether one had subscribed to the Scheme, 39.6% said they had subscribed to the Scheme whilst the remaining 60.4% said they had not subscribed. Of the 59 that joined the Scheme, 47.5% said they joined so as to enable them gain access to quality health care at an affordable cost, 25.4% said they joined for fear of future uncertainties in their ability to cater for their health care needs, 20.3% joined because the national health insurance scheme is a good policy and so the need to embrace it and the remaining 6.8% said they were influenced by friends/ family to join the Scheme.

The most predominant reason that the 90 non-insured gave for not joining the Scheme was 'did not have money' (69.2%). Figure 4.5 throws more light on the various reasons for not joining the Scheme.

Figure 4.5: Reasons for not Joining Scheme



Source: Field work, August 2015

A high premium' was cited by 5.5% of them and another 5.5% blamed it on poor quality of services provided by the Scheme. 'Poor quality of health care by health facilities' was mentioned by 4.4% whilst 13.2% could not give any reason why they had not joined the Scheme, and, 2.2% did not know where to go and register. It is important to explain here that the 'did not have money' respondents alluded to the fact that the premiums payable were very reasonable and fair except that there was generally too much poverty for which reason they were unable to pay to join. This confirms the statistics from the 2010 Population and Housing Census that over 75% of residents in the district live below the poverty line of $120.00 per annum.

During an interview with the key informant, similar explanations were given. He said during some focused group discussions held by the Scheme, most residents

appreciated the fact that the premiums were reasonable with some even believing that it was too low, considering the benefits that accrued to registering with the Scheme, yet they also complained of difficulty in paying the amount due to high levels of poverty.

Difficulty in paying the subscription fee was equally cited by Criel et al. (2003) in their study in the Maliando Community Health Insurance Scheme in Guinea Conakry, De Manuel *et al*. (2006) in their study in the Hanag Community Health Fund in Burkina Faso and Basaza et a*l*. (2007) in their study in the Ishaka and the Save for Health Uganda Schemes in Uganda.

Of the 59 people registered with the Scheme that responded to whether they themselves paid their premiums, 78% said they paid their premiums and the remaining 22% said they did not pay the premiums. Five of the 13 people that did not pay premiums said they were SSNIT Contributors, three were SSNIT Pensioners, two were indigents and three said their relatives paid the premiums on their behalf. Thus 76.9% of those who did not pay were exempt persons. Of the 46 who paid their own premiums, Table 4.9 gives details of the responses on amounts paid as premiums.

Table 4.9: Amount Paid as Premium

Amount Paid (GH¢)	Frequency	Percent (%)
7.20	6	13.0
10.00	23	50.0
11.00	2	4.4
12.00	9	19.6
13.00	2	4.4
20.00	2	4.4
22.00	1	2.1
30.00	1	2.1
Total	**46**	**100.0**

Source: Field work, August 2015

The amount paid, which ranged between GH¢7.20 to GH¢30.00, had a mode of GH¢10.00 and a mean of GH¢11.33, which is well within the Government approved range of premiums: GH¢7.2 to GH¢48.0 (L.I. 1809, 2004)

Asked which period was most suitable for payment of premiums and the reasons for the chosen period, 35.0% of respondents chose July to September with the main reason that the period was the harvest season for their farm products. Twenty-four percent of respondents said anytime within the year was suitable, 19.0% said January to March was most suitable, 17% chose October to December as the most suitable season and 5.0% said April to June was most suitable. Table 4.10 gives details of the responses with the accompanying reasons for the chosen responses.

Table 4.10: Most Suitable Period for Payment of Premiums and Reasons for Period

Period	Why is the chosen period most suitable				
	Harvesting season	Payment is made on my behalf By a relative/friend	As and when I get Money	Don't know why	Total
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
Jan-Mar	22 (23)	0 (0)	1 (8)	6 (18)	29 (19)
Apr-Jun	4 (4)	1 (17)	2 (17)	0 (0)	7 (5)
Jul-Sep	52 (54)	0 (0)	0 (0)	0 (0)	5 (35)
Oct-Dec	19 (19)	4 (66)	1 (8)	1 (3)	25 (17)
Any Time	0 (0)	1 (17)	8 (67)	27 (79)	36 (24)
Total	**97 (65.1)**	**6 (4)**	**12 (8.1)**	**34 (22.8)**	**149(100)**

Source: Field work, August 2015

Of the reasons given for choosing a particular period for payment of premiums, harvesting season accounted for 65.1% of responses, 22.8% did not have a reason for their chosen period, 8.1% chose their period based on when they had money in their hands and lastly 4% said they chose their period because their premiums were paid for them by their friends or relatives. The harvest period indicated by respondents extends all year round. This is so because of the varying maturity periods of the various crops cultivated in the district. This notwithstanding, majority of the crops is harvested within July to November every year.

Response from a key informant on his view on the appropriate season for payment of premiums was that the Scheme operated an all year registration system and so there was no period within the year that registration of residents was closed. He said however that higher registration numbers were observed from August to November every year and he attributed this to the maturity and harvest of many crops, especially yam, maize, groundnuts and beans. During this period, he said, farmers who constituted over 70% of the residents were better off financially, as they could dispose off their produce and raise more money.

When respondents were asked to propose an amount for premium, wide ranging proposals were given, with a maximum amount of GH¢100.00 and a minimum of GH¢0.00. With a total response from 149 persons, 28.2% proposed GH¢5.00 as premiums, 24.2% proposed GH¢10.00 and 8.7% proposed GH¢6.00. In general, 86.0% suggested figures between GH¢5.00 and GH¢12.00 as premiums. The mean of the proposed figures was GH¢8.60 and the median was GH¢7.00. The mean and median of the proposed figures above are well within the established

premium range of GH¢7.20 and GH¢48.00 by the scheme. It can then be deduced that residents appreciate that current premiums chargeable are fair and reasonable except that high poverty levels makes it difficult for them to raise the premiums to join the Scheme.

4.6 Level of Confidence of Residents in the Scheme

In assessing the level of confidence of residents in the Scheme, residents were asked to indicate their nearness to the collection agents / Registration centres, the frequency with which the agents visited them, and for the insured only whether they obtained their identity cards on time and, whether they would continue to be members of the Scheme. In addition, residents were asked to, in their own opinions, rate the services provided by the Scheme and to provide the reasons for their ratings and finally, residents were to compare 'cash and carry' to health insurance in terms of financial access to health care and affordability.

The study indicated that the farthest distance from a Collection Agent / Registration centres was 14 kilometres with the closest distance being 10 metres (0.01km). The mean distance taken to reach an agent was 1.39km, which indicates fairly that, residents had a reasonable access to the health insurance structures (Registration centres). Also, in answering how regularly the staff and or agents visited respondents in their communities, Table 4.11 give details of responses. As clearly indicated the in Table, 56.0% of respondents indicated that they do get constant reminders from the scheme and or it agent on a daily basis, whiles 31.3% said their agents/staff only visit them weekly preferably on market

days, only 9.4% said they only see the scheme staff and agent monthly and 3.3% claimed their agents never visited them. When the insured were asked how timely they received their cards, thirty-six out of the fifty-nine insured respondents (61.0%) said they received their cards within the stipulated period whiles twenty-three (39%) said they did not receive their cards on time.

Table 4.11: How often Scheme Staffs Visit a Community

Visitations	Frequency	Percent (%)
Daily	83	56.0
Weekly	47	31.3
Monthly	14	9.4
Not at all	5	3.3
Total	149	100.0

Source: Field work, August, 2015

A key informant indicated that there was a collection agent for each of the 63 health insurance communities together with a committee of four persons to assist the collection agent in the performance of their duties. These collectors, he said were chosen directly from the communities by the community members and so the community could exercise control and monitor their activities and could easily change any non-performing collector. Thus communities that have non-performing collectors could be communities that do not themselves bother about the success of NHIS in their areas. Generally therefore, he said, most collectors were performing above average and this is complemented by the regular visits of

officials from the Scheme office to all communities to undertake community education and Registration exercises.

Asked whether they would like to remain members of the Scheme, all fifty-nine insured respondents responded in the affirmative. To confirm and validate the responses given in the first four questions asked about the Scheme structures and performance, members were asked to rate the services offered by the Scheme by the scale very good, good, fair and bad. Table 4.12 illustrates the responses given. In their response, out of a total of 149 that responded to the question, 91.3% rated the Scheme's services as being good or even better as compared to out of pocket payment (cash and carry). Two main reasons have influenced these responses: the Scheme has been very beneficial and the premiums are reasonable and appropriate.

In their response to which of the two systems of healthcare financing: health insurance or 'cash and carry', was better in terms of accessibility and affordability, 96.0% of respondents said health insurance was better. Only 2.7% opted for 'cash and carry' whiles 1.3% could not make a decision.

Thus clearly, the scheme structures kept in place have ensured fairly very well, easy accessibility of residents to the scheme and majority of residents have confidence in the scheme.

Table 4.12: Rating Scheme Services

Reasons	Ratings of Scheme Services				
	Very Good. No. (%)	Good No. (%)	Fair No. (%)	Bad No. (%)	Total No. (%)
Delays in issuing ID Cards	0 (0)	2 (3)	4 (50)	2 (40)	8 (5)
Scheme officials and Agents don't visit Communities Regularly	1 (2)	1 (1)	3 (38)	2 (40)	7 (5)
It's been very Beneficial to members	44 (76)	57 (73)	0 (0)	0 (0)	101 (68)
Premiums are Reasonable and Appropriate	7 (12)	15 (19)	0 (0)	0 (0)	22 (15)
Don't know why	6 (10)	3 (4)	1 (12)	1 (20)	11 (7)
Total	**58 (100)**	**78 (100)**	**8 (100)**	**5 (100)**	**149 (100)**

Source: Field work, August, 2015

CHAPTER FIVE

5.0 SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter gives an outline of the study and it comprises the summary of findings from the analysis. It also presents conclusions derived from the findings and finally, on the basis of the findings and conclusions, recommendations are made.

5.2 Summary of Findings

The goal of the study was thus to identify the prospects and challenges of NHIS in the East Gonja District as a healthcare financing mechanism.

Key findings from the research include:

1. 93.3% of all respondents were satisfied with the level of care provided by the health facilities and the average distance travelled to reach a facility was 4.12kms.
2. All respondents had heard of the Scheme and over 90% had some form of detailed information about the Scheme.
3. Though respondents appreciated the benefits of the Scheme considering the applicable premiums, lack of money still remained the major reason why many were not joining the Scheme.
4. In assessing the services provided by the Scheme, residents were very satisfied with the performance of the Scheme as 91.3% of respondents

rated the services of the Scheme as good. On physical accessibility to Scheme structures and services, respondents travelled an average distance of 1.39kms to reach a collection agent and or registration centre, and finally.

5. There was no limitation as to the period during which one could register to join the Scheme. The Scheme runs an open registration system that allowed one to join at any time one decided to.

5.3 Conclusions

In conclusion, the study determined that;

- There is high awareness among residents of the district and they have a very fair knowledge and understanding about the NHIS. Thus low awareness as suggested by the conceptual framework is not a contributing factor to the prospects and challenges of the Scheme.
- Residents were satisfied with the level of quality of care provided by the health care providers within the district and so have confidence in these facilities.
- Lack of money was identified as a major reason why respondents did not join the Scheme. This is in conformance with the conceptual framework that poverty could lead to low enrolment into the Scheme thus a very uncompromising challenge.

- The Scheme operated an open registration system whereby one could register and pay premiums anytime within the year. Payment period was therefore not a barrier.
- The scheme provided good physical accessibility to residents as residents travelled only a mean distance of 1.39km to reach an NHIS Agent or office to solve their problems. Thus inaccessibility of scheme structures and quality of services provided by the Scheme were not a challenge to the scheme.
- And finally, residents were generally satisfied with the level of services provided by the Scheme

5.4 Recommendations

Based on the findings from the study, the following are recommended to enhance the operation of the Scheme:

- Enhanced information dissemination, 'gongon beating' (or even car announcements through the towns and villages) should be effectively utilized and announcements through social gathering, mosques and churches should be adopted as regular means of education. Other methods such as community durbars and use of other FM Radios from neighbouring districts to reach parts of the district that could access such Radio stations would go a long way to help.
- Residents appreciate the fact that the premiums are reasonable except that their poverty levels are too high to enable them join the scheme. Thus if

the government could introduce more social intervention policies that could raise the incomes of the residents in the district, more persons would move above the poverty line and be able to pay the premiums and join the scheme.

- Also the government should expand the bracket for the indigent and other exempt groups and give clear identification guide lines so as to enrol more of the persons below the poverty line.
- Poor quality of service rendered by health facilities was cited by only 4.4% non- insured as one of the reasons for not joining the Scheme. 23.1% Insured respondents mentioned maltreatment by health personnel at the facility level and generally poor medical services offered by certain health facilities. These are very serious allegations that the health facilities need to work at to ensure that patients do not carry these bad perceptions about the quality of services they offer.
- The Scheme should enhance its services by ensuring that Scheme officials continue with the frequent visits to all communities and ensure continuous education across the length and breadth of the district. This way, residents may be well convinced to consider joining the Scheme. The Scheme should also ensure that residents continue to receive their identity cards within the stipulated or promised periods to boost further confidence of residents in the scheme.

- The free enrolment of School children under the school feeding and uniform should be done every term instead of once in a year as was told by the key informant from the Scheme
- Second cycle Schools and Training institutions should be added to the free school enrolment policy or given rebate to encourage them to join or renew expire membership.
- On-the-job and Client Relation training of health personnel in the health facilities should be encourage.

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APPENDICES

APPENDIX 1:

QUESTIONNAIRE

UNIVERSITY FOR DEVELOPMENT STUDIES

SCHOOL OF BUSINESS & LAW STUDIES

Dear Sir/Madam,

This study is in partial fulfilment of the requirement for the award of a master's degree in the University for Development Studies. It is mainly for academic purposes. The success or objectivity of the study depends upon your truthful, honest and accurate responses. It will therefore be appreciated if you can spend some amount of your time to provide relevant responses to these questions. All responses will be treated confidentially and identities anonymously.

Thank you.

A. DEMOGRAPHIC INFORMATION:

1) Age .....

2) Gender: (Tick √) 1. Male ☐ 2. Female ☐

3) Marital Status: (Tick √)
   1. Married 2. Single 3. Divorced 4. Separated 5. Widowed

4) If married, do you have more than one wife or is your husband married to more than one woman? 1. [Yes] 2. [No] .....

5) Number of people in your household .....

6) How many of the household members are below 18 years? .....

7) Religion .....

1. Traditional 2. Islam 3. Christianity 4. No religion 5. Other

8) Ethnicity .....

1. Gonja 2. Other Guan 3. Akan 4. Mole Dagbani 5. Hausa 6. Kokomba 7. Other

9) Level of Education .....

1. None 2. Primary 3. Middle/JSS 4. Secondary/SSS 5. Tech. / Voc. 6. University/Other Tertiary 7. Non-formal 8. Other

10) Main Occupation .....

1. Farmer/Fisherman 2. Salaried Worker 3. Student/Pupil
4. Self-employed/Businessman/Trader 5. Retired 6. Unemployed
7. Other

11) Average Monthly Income over the last 12 months: GH¢

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B. HEALTH FACILITIES AND HEALTH SEEKING BEHAVIOURS

12) Do you have access to a health facility in this town or village? …

1. [Yes] 2. [No]

13) What types of facilities are available to you? (Tick all boxes that apply)

1.Government Clinic/Hospital	
2. Mission Hospital/Clinic	
3. Private Clinic	
4. Chemist/Pharmacy	
5. Herbalist	
6. Man of God (Mallam/Pastor)	
7. Shrine	
8. Others	

14) How far is the nearest health facility from your home? .....

15) Have you or a member of your household been sick in the last 12 months?

1. [Yes] 2. [No] .....

16) If yes, was it a chronic condition or an acute illness? .....

1. Chronic 2. Acute

17) If yes to Q. (15), what medical facilities did you use (tick all boxes that apply)

1.Government Clinic/Hospital	
2. Mission Hospital/Clinic	
3. Private Clinic	
4. Chemist/Pharmacy	
5. Herbalist	
6. Man of God (Mallam/Pastor)	
7. Shrine	
8. Self-medication	
9. Others	

18) Did you use health insurance at the facility you attended? 1. Yes 2. No
If yes proceed, else go to Q. (21).

19) Did you encounter any difficulties in using the Scheme when you went to the health facility? 1. Yes 2. No

20) If yes to Q. (19), what were the difficulties?
1. In-active Card 2. Joining Long Queue 3. Abuse by Health worker(s) 4. Others Specify

21) If no to Q. (18), how much did you spend on the average at the facility?
1. GH¢ 1 – GH¢ 50 2. GH¢ 51 – 100 3. Others Specify GH¢ .....

22) From your opinion, how would you rate the services provided by the health Facility (ies) you usually use? (Tick √ as appropriate)
1. Very Good 2. Good 3. Fair 4. Bad

C. KNOWLEDGE OF HEALTH INSURANCE /PERCEPTIONS

23) Have you heard of the National Health Insurance Scheme?
1. [Yes] 2. [No] (Tick √ as appropriate)

24) How does one become a member of the Health Insurance Scheme? .....
1. By registering with the Scheme/Agent 2. By registering with a health facility 3. By registering with a community elder 4. Don't know how

25) Which category of people can join the Scheme? .....
1. All Persons in Ghana 2. Only adults 3. Only Government workers
4. Only non-government workers 5. Children only 6. Don't know

26) Which categories of people are exempted from paying premiums?

(Tick √ all boxes that apply) .....

1. Informal Sector workers	
2. SSNIT Contributors	
3. Children under 18years	
4. Those Above 70 years	
5. The Core Poor	
6. None of these	
7. Don't know	

27) Have you subscribed to the Scheme? 1. [Yes] 2. [No] .....

28) I f yes to Q27, what is/are your main reason(s) for joining?

1. Future uncertainties 2. Influenced by Others
3. Easy Access to Scheme/Agent 4. Affordable Health Care

29) If no to Q. (27), what is your main reason for not being a member of the Scheme? .....

1. Premium too high 2. Poor health care services by Health Provider
3. Health provider too far 4. Did not have money 5. Poor services provided by Scheme 6. Do not know where to register 7. No reason

30) What should the Scheme do to encourage you to join? .....

31) Which methods of dissemination do you consider most effective for marketing social programmes, especially health insurance, in your community? .....

1. Community durbars 2. Gong-gong beating. 3. FM/Radio Announcements
4. Church/Mosque Announcements 5. Other

D. PREMIUMS PAYABLE

Questions 32 to 34 are for the insured only.

32) If you subscribed to the Scheme, did you pay your own premium?

1. Yes 2. No

33) If yes to Q. (32), how much did you pay as premium? GH¢.....

34) If no to Q32, why did you not pay?

1. SSNIT Contributor / SSNIT Pensioner/Aged 2. Other Exempt group 3. Indigent 4. Paid by relatives/Friends

35) What period of the year do you consider most appropriate and/or suitable for paying premiums? .....

1. [Jan-March] 2. [April –June] 3. [July –September]
4. [October – December]

36) Why is the period chosen in Q. (29) the most suitable for you?

.....

37) How much would you propose as premium for a year? GH¢ …

E. SCHEME SERVICES AND STRUCTURES

38) How far is the Health Insurance Agent from your location/settlement? .....(km/m)

39) How often does he visit your location/settlement?

1. Daily 2. Weekly 3. Monthly 4. Not at all

Questions 40 and 41 are for the insured only.

40) Do you get your identity cards within the stipulated three-month period?

1. Yes 2. No

41) Will you continue to be a member of the Scheme? 1. Yes 2. No

42) In your opinion, how would you rate the services provided by the Scheme?

1. Very Good 2. Good 3. Fair 4. Bad

43) Give reasons for your answer in Q(42)

.....

44) Comparing the Health Insurance Scheme to 'Cash and Carry', which system makes health care more accessible and affordable? .....

1. Health Insurance 2. Cash and Carry 3. Do not know

APPENDIX 2:

INTERVIEW SCHEDULE FOR KEY INFORMANT - NHIA EAST

GONJA DISTRICT OFFICE

1. What categories of people are exempted from paying premiums?
2. What methods do you use for dissemination of information to the residents?
3. How frequently do you or your agents visit the communities to register clients or solve other client problems?
4. How much do you charge as premium per head?
5. What period within the year, do you register clients?
6. How do you assess the relationship between your Scheme and its health providers?
7. How do you assess the quality of services of the health care providers?
8. Has the Scheme improved upon access to quality health care for residents?
9. What percentage of the population was registered into the Scheme by December, 2014?
10. Was it satisfactory? If not what accounts for the low registration?
11. In your own view,

(i) What are the prospects of Financing Healthcare services in the District?

(ii) What are the challenges of Healthcare services in the District?