

UNIVERSITY FOR DEVELOPMENT STUDIES

BALANCING INCOME WITH COST: AN ASSESSMENT OF THE FINANCIAL
SUSTAINABILITY OF GHANA'S HEALTH INSURANCE SCHEME

A STUDY IN TAMALE METROPOLIS

HUDU ISSAH

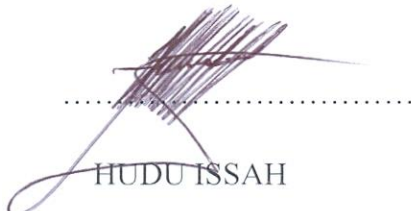


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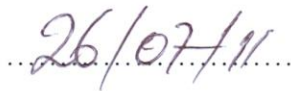
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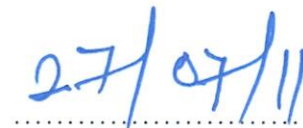
DECLARATION

I declare that except for references which have been duly acknowledged, this research work is my original work and has not been submitted whether in whole or part for any academic and or examination purposes at any other University.


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DEDICATION

I dedicate this work to the Almighty Allah whose divine guidance has made it possible for me to successfully complete this course and also to my lovely late mother, Mahama Ashetu Gaala.



ACKNOWLEDGEMENT

This work has been put together with the assistance of many people. My sincere thanks first go to the Almighty Allah for His guidance, protection and favour throughout this course.

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ABSTRACT

There is considerable interest at present in exploring the potential of social health insurance to increase access to and affordability of health care in Africa. A number of countries are currently experimenting with different approaches. Ghana's National Health Insurance Scheme (NHIS) was passed into law in 2003 but fully implemented from late 2004.

This research sought to undertake a critical comparative study of the income and the cost of operating Mutual Health Insurance Schemes in Ghana and its implication on the financial sustainability of the schemes.

The study employed both qualitative and quantitative methods of data collection. In this, both primary and secondary data were employed as a means of sourcing information.

The study revealed that there is an imbalance between expenditure and revenue which threatens financial sustainability of the schemes. The study equally found that people have taken a stand that "no premiums rise, no benefits reduction and the government has a duty to maintain the NHIS". Despite the fact that the public gave an absolute answer to reject any possible proposals of premium rise benefit package reduction; experience shows that financial sustainability and health coverage and quality is a trade-off issue and all possible reform has to mobilise public opinion and support because it touches everyone's life.

The study recommended among other things that the Scheme accepts and encourages installment payment of premium so that non salary workers and the perceived poor would be in the position to join the scheme and honour their financial obligations without any decipherable burden, NHIA should release funds early and regularly to the schemes, there should be intensive education of residents on the health insurance concept through Radio/TV announcements and effective collaboration with the religious bodies in activities such as one-on-one talks, dramas and community durbars.



TABLE OF CONTENTS

DECLARATION	i
DEDICATION.....	ii
ACKNOWLEDGEMENT	iii
ABSTRACT	iv
TABLE OF CONTENTS.....	v
LIST OF TABLES.....	x
LIST OF FIGURES.....	xi
LIST OF ACRONYMS.....	xiii
2.9 DEFINITION OF TERMS	xv
CHAPTER ONE.....	1
1.0 BACK GROUND TO THE STUDY.....	1
1.1 THE POLICY FRAME WORK.....	3
1.2 PROBLEM STATEMENT.....	5
1.3 RESEARCH QUESTIONS.....	8
1.4 OBJECTIVES OF THE STUDY.....	8
1.4.1 Main Objective.....	8
1.4.2 Specific Objectives.....	8



1.5	SIGNIFICANCE OF THE STUDY.....	9
CHAPTER TWO		10
2.0	LITERATURE REVIEW.....	10
2.1	DEFINITIONS AND TYPES OF INSURANCE.....	10
2.2	THE NEED FOR HEALTH INSURANCE.....	11
2.3	COMMUNITY-BASED HEALTH INSURANCE.....	13
2.4	ACCESS TO HEALTH INSURANCE.....	14
2.5	INSURANCE COST AND QUALITY OF HEALTHCARE.....	16
2.6	SUSTAINABILITY.....	17
2.6.1	Members Acceptability/Sustainability	17
2.6.2	Provider Acceptability/Sustainability.....	20
2.6.3	Financial Sustainability	21
2.6.4	Administrative Efficiency.....	22
2.6.5	Equity In Finance.....	24
2.6.6	Equity In Service Delivery.....	25
2.7	HEALTH INSURANCE IN AFRICA.....	32
2.7.1	Some Findings	35
2.8	HEALTH FINANCING IN GHANA.....	37
2.7.1	Evolution	37
2.7.2	Introduction of National Health Insurance.....	39
2.7.3	Coverage.....	40

2.7.4	Types of Health Insurance Schemes In Ghana.....	42
2.7.5	Administrative Structure of Schemes.....	43
2.7.6	Sources of Funding	44
2.7.6.1	Informal Sector Contribution.....	44
2.7.6.2	Formal Sector Contribution.....	45
2.7.6.3	Other Sources of Funds.....	45
2.7.6.4	Pooling of Funds.....	46
2.8	BENEFIT PACKAGE.....	46

CHAPTER THREE.....47

3.0 STUDY AREA AND RESEARCH METHODOLOGY.....47

3.1 DISTRICT PROFILE

3.1.1 Location.....47

3.1.2 Economic Activities.....48

3.1.3 Population.....48

3.1.4 Education

3.1.5 Climate.....49

3.1.6 Health Care System..... 49

3.1.6.1 Metro. Health Administration Level..... 49

3.1.6.2 Sub-District Level

3.1.6.3 Community Level.....50



3.1.6.4	Health Facilities.....	51
3.1.6.5	Staffing.....	51
3.1.7	HEALTH INSURANCE SITUATION.....	52
3.1.7.1	Challenges and Achievements.....	53
3.1.8	Ethnicity	53
3.1.9	Religion.....	53
3.1	RESEARCH DESIGN.....	54
3.2.1	Sources of Data.....	54
3.2.2	Secondary Data.....	56
3.2.3	Target Population.....	57
3.2.4	Study Design.....	57
3.2.5	Sampling Procedure.....	57
3.2.6	Data Collection.....	61
3.2.7	Data Analysis.....	61
CHAPTER FOUR.....		62
4.0	DATA PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS...	62
4.1	DATA PRESENTATION AND ANALYSIS.....	62
4.1.1	Background Characteristics of Respondents.....	62
4.1.2	Gender.....	62
4.1.3	Age.....	63
4.1.4	Occupation.....	64
4.1.5	Household Size.....	64
4.1.6	Number of Spouses.....	65



4.1.7	Education.....	66
4.1.8	Religion.....	68
4.1.9	Ethnicity.....	69
4.1.10	Energy for Cooking.....	71
4.2	PROPOSED EFFECTIVE MEANS OF COLLECTING PREMIUM.....	72
4.2.1	Non-Insured Financial Access To Healthcare.....	73
4.2.2	Main Reasons for Not Joining The Scheme.....	74
4.2.3	Balancing Premium With Claims From Health Facilities.....	75
4.3	CASE STUDIES.....	79
CHAPTER FIVE		84
5.0	SUMMARY, CONCLUSIONS AND RECOMMENDATIONS.....	84
5.1	SUMMARY	84
5.2	CONCLUSIONS.....	85
5.3	RECOMMENDATIONS.....	87
REFERENCES.....		89
APPENDIX 'A': INTERVIEW QUESTIONNAIRE THE SCHEME.....		98
APPENDIX 'B': INTERVIEW QUESTIONNAIRE FOR PROVIDERS.....		108
APPENDIX 'C': INTERVIEW QUESTIONNAIRE FOR THE INSURED.....		113
APPENDIX 'D': INTERVIEW QUESTIONNAIRE FOR NON-INSURED...		119



LIST OF TABLES

TABLE 3.1	:	NUMBER OF STAFF IN MHD, WEST AND CENTRAL HOSPITAL
TABLE 3.2	:	ESTIMATED NUMBER OF REGISTERED ADULTS PER CATEGORY FOR EACH SUB-DISTRICT
TABLE 3.3	:	POPULATION AND ESTIMATED NUMBER OF RESPONDENTS PER CATEGORY FOR EACH SUB- DISTRICT
TABLE 4.1	:	GENDER STATUS OF RESPONDENTS
TABLE 4.2	:	AGE DISTRIBUTION OF RESPONDENTS
TABLE 4.3	:	OCCUPATION OF RESPONDENTS
TABLE 4.4	:	HOUSEHOLD SIZE OF RESPONDENTS
TABLE 4.5	:	NUMBER OF SPOUSES OF RESPONDENTS
TABLE 4.6	:	INCOME AND COST OF TMMHIS FROM 2005-2008



LIST OF FIGURES

- Figure 4.1 : EDUCATIONAL BACKGROUND OF INSURED RESPONDENTS
- Figure 4.2 : EDUCATIONAL BACKGROUND OF NON-INSURED RESPONDENTS
- Figure 4.3 : RELIGIOUS AFFILIATION OF RESPONDENTS
- Figure 4.4 : OWNERSHIP OF HOUSEHOLD DURABLES BY BOTH INSURED AND NON-INSURED
- Figure 4.5 : OWNERSHIP OF HOUSEHOLD DURABLE ASSETS BY BOTH INSURED AND NON-INSURED
- Figure 4.6 : COOKING FUEL AS A PROXY FOR WEALTH ASSESSMENT
- Figure 4.7 : PROPOSED MOST EFFECTIVE MEANS OF MARKETING THE SCHEME
- Figure 4.8 : NON-INSURED REASONS FOR NOT JOINING THE SCHEME
- Figure 4.9 : SUGGESTED WAYS TO ENCOURAGE THE NON-INSURED TO JOIN
- Figure 4.10 : SUGGESTIONS FOR SUSTAINING THE SCHEME



LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	:	ACQUIRED IMMUNE DEFICIENCY SYNDROME
CBHIS	:	COMMUNITY-BASED HEALTH INSURANCE SCHEME
CHAG	:	CHRISTIAN HEALTH ASSOCIATION OF GHANA
CCS	:	CASH AND CARRY SYSTEM
CT	:	COMPUTARISED TOMOGRAPHY
CBS	:	COMMUNITY BASED SERVICE
CHPS	:	COMMUNITY-BASED HEALTH PLANNING AND SERVICE
CPHD	:	COMMUNITY PARTINERSHIP FOR HEALTH AND DEVELOPMENT
DANIDA	:	DANISH INTERNATIONAL DEVELOPMENT AGENCY
DFID	:	DEPARTMENT FOR INTERNATIONAL DEVELOPMENT
FFS	:	FEE FOR SERVICE
GOG	:	GOVERNMENT OF GHANA
GPRS	:	GHANA POVERTY REDUCTION STRATEGY
GHS	:	GHANA HEALTH SERVICE
GSS	:	GHANA STATISTICAL SERVICE
GDRG	:	GHANA DIAGNOSTIC RELATED GROUPING
HIV	:	HUMAN IMMUNO DEFICIENCY VIRUS



ILO	:	INTERNATIONAL LABOUR ORGANISATION
IPD	:	IN PATIENT DEPARTMENT
JHS	:	JUNIOR HIGH SCHOOL
LI	:	LEGISLATIVE INSTRUMENT
MHO	:	MUTUAL HEALTH ORGANISATION
MOH	:	MINISTRY OF HEALTH
MDGS	:	MILLENNIUM DEVELOPMENT GOALS
MHD	:	METROPOLITAN HEALTH DIRECTORATE
MHS	:	METROPOLITAN HEALTH SERVICE
MRI	:	MAGNETIC RESONANCE IMAGING
MIS	:	MANAGEMENT INFORMATION SYSTEM
MHMT	:	METROPOLITAN HEALTH MANAGEMENT TEAM
NHI	:	NATIONAL HEALTH INSURANCE
NHIC	:	NATIONAL HEALTH INSURANCE COUNCIL
NHIF	:	NATIONAL HEALTH INSURANCE FUND
NHIS	:	NATIONAL HEALTH INSURANCE SCHEME
NHIA	:	NATIONAL HEALTH INSURANCE AUTHORITY
NLC	:	NATIONAL LIBERATION COUNCIL
NGO	:	NON-GOVERNMENTAL ORGANISATION
NPP	:	NEW PATRIOTIC PARTY
OECD	:	ORGANISATION OF ECONOMIC CO-OPERATION AND DEVELOPMENT
OPD	:	OUT PATIENT DEPARTMENT
PHRplus	:	PARTNERS FOR HEALTH REFORM PLUS
PP	:	PROGRESS PARTY



PNDC	:	PROVISIONAL NATIONAL DEFENCE COUNCIL
SHI	:	SOCIAL HEALTH INSURANCE
SSNIT	:	SOCIAL SECURITY AND NATIONAL INSURANCE TRUST
SDHMT	:	SUB-DISTRICT HEALTH MANAGEMENT TEAM
SHS	:	SENIOR HIGH SCHOOL
SPSS	:	STATISTICAL PACKAGE FOR SOCIAL SCIENCES
TMMHIS:		TAMALE METROPOLINTAN MUTUAL HEALTH INSURANCE SCHEME
TBA	:	TRADITIONAL BIRTH ATTENDANT
UNMS	:	UNITED NATIONS MILLENNIUM SUMMIT
UNDP	:	UNITED NATIONS DEVELOPMENT PROGRAMME
USA	:	UNITED STATES OF AMERICA
VAT	:	VALUE ADDED TAX
WHO	:	WORLD HELATH ORGANISATION



2.9 Definition of Terms

Copayment: Some health insurance policies require policy holders to make a modest payment toward the cost of services for each visit to a healthcare provider. This payment is referred to as copayment. Copayments are usually less in value. Although the amount of money collected from copayments may contribute little toward the actual cost of medical services, the assumption is that it provides disincentive for abuse of the healthcare system. These policies also assume that unless patients pay something for the services they receive, they place little value on those services.

Premium: Insurance policies charge a certain monthly or annual amount, called a premium, to maintain an insurance contract. The premium is the payment an individual policy holder makes in exchange for the promise of financial assistance for medical costs. The premium charged for the insurance reflects the value of the benefits received.

Benefits Package: Each health insurance policy defines in detail the kinds of medical services covered. These policies must also explain limitations or exclusions of coverage for specific services. In addition, insurance policies define the kinds of medical care providers that are covered by insurance. For example, covered providers usually include physicians and hospitals, but the policy's terms may also include coverage for nurse practitioners, midwives, chiropractors, and naturopaths (Bennet, 1998). Almost all health insurance policies cover the cost of diagnostic tests, prescription drugs, and other items necessary to provide care in hospitals. Some policies also provide coverage for such things as prescription drugs to be taken outside of hospital settings.



Inpatient Care: These are services provided to client when they admitted for an overnight or more stay in a facility. This is the situation where patients spend beyond twenty-four (24) hours. Most health insurance policies cover the costs of inpatient care as long as that level of care is considered necessary to treat the patient's condition.

Outpatient Care: These are health services that are provided to clients within twenty-four (24) hours. Patients who do not require an overnight hospital stay receive outpatient care. Outpatient care could be provided in a doctor's office, a neighbourhood clinic or in a hospital if the patient is sent home the same day.

Deductibles: According to Nielson (2008), health insurance policy-holders pay a specified amount of money each year for medical services before the insurance policy pays anything at all. This amount is called the deductible. For example, a person who selects a policy with a \$500 deductible agrees to pay the first \$500 of medical costs in a given year. Likewise, the insurance company agrees to pay some or all costs that exceed \$500. Policies with a low deductible generally charge a relatively high monthly fee, called a premium, to maintain the insurance account. Policies may express the deductible in terms of per-person and per-family amounts.

Gatekeeper System: This is a system where clients are required to access the nearest primary healthcare facility as their first point of call.

Claims: This is where an accredited healthcare provider has provided services to insured clients and submitted a bill on behalf of such client to the financial intermediary (NHIS)

for reimbursement. It can be explained to mean notification to an insurance company requesting payment of an amount due under the terms of the policy.

Core Poor: Adults who are unemployed and receive no identifiable income and therefore unable to support themselves financially. (MoH, 2004).

Very Poor: Adults who are unemployed but receive identifiable and consistent financial support from a source of low income. (MOH, 2004)

Poor: Adults who are employed but receive low returns for their efforts and are unable to meet their basic needs. (MOH, 2004)

Middle Income: Adult who are employed and receive incomes which are just enough to meet their basic needs. (MOH, 2004)

Rich: Adults who are able to meet their basic needs and some of their wants. (MOH, 2004).

Very Rich: Adults who are able to meet their basic needs and most of their wants. (MOH, 2004)

Insured: Insured are the individuals buying the policy. In other words, these are individuals who have registered with the scheme, made up to date payment of premium and qualified or issued with an ID card to benefit from the scheme.

Non-insured: These are individuals who have either not registered with the scheme or have registered but yet to finish paying the premium.



Reinsurance: This is the system where central funds are set aside to recapitalize schemes as and when they run into the risk of underfunding due to unforeseen catastrophic events such as epidemics and natural disasters.

Cross-subsidization: This is a system where contribution is based on ability to pay. In this case, the rich pays more while the poor pays less. This is to ensure that all persons register and contribute to a situation where those with the risk of falling ill join the scheme. (MOH, 2004).

Risk-equalization: This is a situation where disease burden and mortality patterns serve as one of the basis for allocating financial resources to geographical areas of the country. (MOH, 2004).



CHAPTER ONE

1.0 BACKGROUND OF THE STUDY

Poverty reduction has become the central aim of the international community's development objectives. This is evident in the development goals set at the United Nations Millennium Summit (UNMS) in 2000, aimed at reducing the incidence of poverty in developing countries by 2015. One way to achieving this objective is through the provision of quality and accessible healthcare within the context of health related Millennium Development Goals (MDGs) 4 & 5 especially Maternal, Child Health and HIV/AIDS. Productivity is inextricable linked to the health of workforce of every country. It is therefore apparent that the success of any country in the fight to reduce poverty is contingent on the health status of its population or people.

Indeed, one of the major obstacles to the health of people is their ability to pay for health services. In recognition of this fact, there was no direct out of pocket payment at public health facilities in Ghana at independence, (GOG, 2003). Healthcare was financed entirely through government tax revenue. By 1970, however, the sustainability of "free" health care had become problematic as a result of economic downturns. To respond to the problem of health care financing, a statutory dispensing fee of 30np (New Pesewa) was introduced by the National Liberation Council (NLC) government but was immediately withdrawn as a result of heavy public outcry.

However, considering the cost of dispensed drugs to the government, the Progress Party (PP) government enacted the Hospital fees 1969 amendment Act 1970, Act 325 which sought to introduce fee for the generality of patients including civil servants.





The early 1980s witnessed even worse and unsustainable government's share in healthcare expenditure in Ghana as a result of serious economic crisis, the Provisional National Defence Council (PNDC), introduced taxes on the delivery of imported drugs and hospital equipment in 1983. For instance, government expenditure on the health sector had dropped to less than 20%. (GoG 2003). The effect of such low spending on healthcare led to a significant reduction in the capacity to produce and import drugs and consumables. This situation continued until user fees for all medical conditions except certain specified communicable diseases was introduced.

The exemption policy under the user fees system was badly implemented that those who were supposed to enjoy it never did, in practice. Guidelines for implementation were not provided and no conscious system was designed to prevent possible financial leakages. As a result, the standard of healthcare provision fell drastically resulting from acute shortage of medicine in all public health facilities. More importantly, the introduction of user fees resulted in the first observed decline in utilization of health services in the country. In spite of this, the government went ahead to institute full cost recovery for drugs as a way of generating revenue to address the shortage of drugs. The payment mechanism put in place was termed Cash and Carry System (C.C.S.). The implementation of this Cash and Carry System compounded the utilization problem by creating a financial barrier to health care access especially for the poor. This resulted in delays in seeking healthcare, non-compliance with treatment, and consequently pre-mature deaths.

As a result of the observed unprecedented drop in healthcare utilization in Ghana and the adoption of the MDGs, the government started to consider alternative measures to



address the challenges of the health sector. One of such measures was to remove the financial barriers to quality healthcare. In pursuance of this measure, the National Health Insurance Scheme (NHIS) was introduced through an Act of Parliament (Act 650) in 2003 to provide affordable and accessible quality healthcare for all residents of Ghana. National Health Insurance Scheme (NHIS) is a mechanism of healthcare financing adopted by a nation to enable citizens to contribute as a group in advance for health services in order to access health care when the need arises, without necessarily having to pay out-of-pocket at the health facilities.

1.1 The Policy Frame Work

In the context of Ghana's national health policy, health insurance is one option to obtaining additional resources for affordable healthcare. In the run up to the implementation of the health insurance scheme in Ghana, 80% of healthcare financing in the public sector was through tax revenue and donor funds: the remaining 20% was from internally generated funds through the cash and carry system. (Mohr, 2003). The fact that health insurance is to replace the 'Cash and carry' system of health care financing does not mean that tax revenue would not continue to form part of the overall health sector financing strategy. It is worth noting that health insurance does not abolish cost recovery but it replaces direct out-of-pocket payment at the point of service. The health insurance scheme is aimed at making the health goal of the government within the context of the Ghana Poverty Reduction strategy (GPRS) achievable and also to accomplish the targets set in the health Sector's Five-year Programme of Work, 2002-2006.



The National Health Insurance Scheme (NHIS) by design provides for three different categories of contribution for people depending on their income status. This ranges from the core poor who are exempted to the very rich who are supposed to pay GH¢48.00. (MoH, 2003). However, a bulk of the funding for the scheme comes from the National Health Insurance Levy and formal sector contributions.

A): Policy Goal, Objective and Vision

- The goal of the NHIS is to address the problem of financial barriers to healthcare access within the context of the Ghana Poverty Reduction Strategy (GPRS)
- The policy objective is to institute a National health Insurance Scheme (NHIS) which will ensure that, "within five years"; every resident of Ghana will belong to a health insurance scheme that adequately covers him or her against the need to pay out-of-pocket at the point of service.
- The ultimate vision of government for instituting the health insurance scheme in the country is to assure equitable and universal access for all residents for Ghana to an acceptable quality package of essential health care. (MoH, 2004).

Providing health care to improve the quality of life of the citizenry has been the major priority area for all successive governments of Ghana since independence. As such, various attempts have been made in this regard through the introduction of various health policy interventions over the years as a way of addressing the healthcare needs of the citizenry. Until 2003, the healthcare policy in Ghana was "pay-as-you-go" system referred to as the 'cash and carry system'. (MoH, 2003). This is a system where the patients are required to pay out of pocket directly for healthcare services received. The negative impact of this system on the health status of Ghanaians led to



the introduction of a prepaid healthcare financing mechanism known as the National Health Insurance Scheme (NHIS) introduced through the NHIS Act 2003 (Act 650) and the Legislative Instrument (LI 1809). The policy is premised on the principles of equity, risk pooling and risk equalization, solidarity and affordability.

The actual implementation of this policy started in October, 2004 with the setting up of district scheme offices in all the districts across the country to facilitate its implementation. One of the core responsibilities of the district schemes was to manage the claims that may arise out of the use of the health facilities by members of the schemes. The effective and efficient management of this function is critical to the financial sustainability of the scheme. This is because, the outcome of this process of claims management determines at any particular point in time how much genuinely is due a service provider out of bills submitted for reimbursement. With the limited sources of funding to the scheme vis-a-vis the ever increasing utilization amidst fraudulent activities uncovered through recent claims audit, the need to properly manage this function cannot be overemphasised.

1.2 Problem Statement

In line with the Ghana Poverty Reduction Strategy (GPRS II) the government has initiated a policy to deliver accessible, affordable and good quality health care to all Ghanaians especially the poor and most vulnerable in society. Productivity is inextricably linked to the health of workforce of every country. It is therefore apparent that the success of any country in the fight to reduce poverty is contingent on the health status of its population.

The goal of health service delivery is to improve the health of all people regardless of age, ethnicity, religious conviction, political affiliation and socio-economic standing.



This laudable goal is far from being achieved because of the 'cash and carry' system that had been in place previously which made it difficult for people to access health care. Indeed it is estimated that out of eighteen percent of the population who require health care at any given time, only twenty percent of them are able to access it (MoH, 2004).

As a result of the observed unprecedented drop in healthcare utilization in Ghana and the adoption of the MDGs 4 & 5, the government started to consider alternative measures to address the challenges of the health sector. One of such measures was to remove the financial barriers to quality healthcare. In pursuance of this measure, the NHIS was introduced through an Act of Parliament (Act 650) in 2003 to provide affordable and accessible quality healthcare for all residents of Ghana.

The National Health Insurance Scheme (NHIS) was established to improve financial access of the people especially the indigent through risk pooling and cross subsidization of enrollees. It is also intended to generate sufficient revenue and provide regular and predictable income to accredited health providers and to encourage sufficient use of resources. Thus, the scheme performs three major functions, namely revenue generation, risk pooling and purchasing of health services for enrollees (Kutzin, 2000).

The main sources of funding are premiums and processing fees charged by schemes and subsidies from central government (NHIA). The reliability and volume (amount) of this funding is very crucial to the sustainability of the scheme.

However, it is essential to note that the scheme has in recent times been met with a number of challenges that are capable of undermining the efficient performance of its functions. These include, delayed ID card issuance to the enrollees and re-imbursement to providers, inadequate subsidies from NHIA to district schemes, inequitable contribution mechanism, poor capacity of district schemes to generate adequate revenue internally to augment subsidy from National Health Insurance Authority (NHIA) and weak fraud control and detection system. (Andoh-Adjei, 2010)

The relatively small size of the schemes is an obvious weakness, given that the strength of such schemes lies in the large number of persons covered and the amount paid as premium. The area under study (Tamale Metropolitan Area) is a poverty endemic area which is predominantly made up of farmers, small scale traders and some formal sector workers. The non-formal occupational workers and their dependents outnumber those at the formal sector, yet their daily or periodic earnings are not much, and can be described as from 'hand-to-mouth'. Contributions from the non-formal sector where the culture of savings is very low or nil is difficult to get. In addition, the premium being paid is very low which accounts for the difficulty on the part of schemes to meet their financial obligations and this threatens the sustainability of the scheme. Therefore, the need to rope in all potential contributors in order to sustain the programme. Arguably, it is essential to state that schemes have absolute control over the funds generated internally which in no uncertain terms is inadequate to contain the cost of operating the schemes. Owing to this, schemes most of the time resort to NHIA for support which is erratic and very cumbersome in accessing. In the wake of which looms a serious financial threat on the scheme.



Consequently, a continuous and reliable source of funding is pivotal to the sustainability of the programme. There is, therefore, the need to assess the source and total amount available for funding activities of the programme, compared with the total cost of operating Health Insurance and ascertain how sustainable the scheme is.

1.3 Research Questions

- How can premium payment be enhanced?
- Has the in-formal sector workers taken advantage of the scheme?
- Does the premium collected commensurate with the claims submitted by health facilities?
- Is the scheme efficient? If no, how can we address the inefficiencies?

1.4 Objectives of the Study.

1.4.1 Main Objective

The general objective of the study is to examine the income and the cost of operating Mutual Health Insurance Schemes in Ghana and its implication on the financial sustainability of the schemes.

1.4.2 Specific Objectives

To be able to achieve the goal of the study, the following specific objectives are outlined.

1. To establish a realistic payment mechanisms for enhancing effective premiums collection.
2. To ascertain whether informal workers are patronizing the scheme.

3. To determine how premiums collected will commensurate with claims being paid to the health facilities.
4. To determine how inefficiencies can be eliminated from the Health Insurance in Tamale and beyond.
5. To make recommendation to policy makers.

1.5 The Significance of the Study.

The importance of this study cannot be overstated especially in the face of recent claims audit reports by the National Health Insurance Authority that revealed serious leakages in the claims management at the various schemes. The study would uncover the systemic lapses inherent in the entire management system and suggest practical ways of addressing them as a way of easing unnecessary pressure on the Health Insurance Fund.

The study will identify realistic payment mechanisms to enhance effective payment of premiums. The informal sector play very crucial roles towards economic growth and therefore policies and programmes that would facilitate their inclusion in the scheme must be identified and encouraged. Again, it is believed that inefficiencies can be eliminated from the Health Insurance System in Tamale and Ghana through the help of findings of this study. The final result will provide contemporary information on how to match claims with premiums paid. The study is envisaged to suggest modalities to help run the scheme effectively and efficiently in the Tamale Metropolis, in particular, and Ghana as a whole.

The study serves as a source of data for other researchers and policy makers.





CHAPTER TWO

2.0 LITERATURE REVIEW

This chapter deals with the review of available and existing literature on the research topic. It deals with an in-depth analysis and evaluation of work or articles that have been written on the research topic.

2.1 Definitions

2.1.1 Definitions and Types of Insurance

Insurance generally involves pooling of risks so that the costs of losses likely to be incurred from the occurrence of such risks are shared among those involved in the pool. Risk sharing or risk-pooling strategies when applied to health do not concern ill health itself, but its financial impacts. For instance, in a health system that uses cost recovery methods like user charges, health care costs are assigned to individuals using the relevant services. In health insurance, these individually assigned charges can be shared or pooled using prepayment arrangements (Bennett et al., 1998).

Donaldson and Gerard (1993:28) describe health insurance as a mechanism "whereby an individual, or family, could make payments to some risk-pooling agency (usually an insurance company) that guarantees for some form of financial reimbursement in the event of illness leading to the insured person incurring health care expenses." As is the case with other forms of insurance, health insurance schemes work better and are viable with a large number of subscribers together with varied and different risk groups.



Health Insurance has been identified as one way through which healthcare funding can be undertaken in order to reduce the financial burden on the poor. This is one of the objectives of health insurance. They list other objectives of health insurance as; to increase revenue, to reduce financial barriers to care (increase access to health care) and to improve efficiency in resource allocation and use.

Thus, health insurance implies protection against the risk that if expensive health care services are needed, the services will be available and of adequate quality, and the cost of using these services will not drive the family into poverty. Another implication here is an issue for equity since health care becomes accessible to all at the time of need (at least to all insurance members).

Social Health Insurance has a long history in Europe and is one of the main revenue raising mechanisms for health financing in a number of countries. Typically, in European social health Insurance Systems, both employees and employer pay into the funds and contributions for the unemployed from government or elsewhere are channeled through the sickness funds. Among developing countries, Latin American countries have the most extensive experience SHI (Mcintyre, 1997). However, in recent times, such schemes have been introduced in Asia, North Africa and Middle East (Ron et al., 1990).

2.2 The Need for Health Insurance

Health insurance protects people from financial loss caused by the high cost of medical care. The cost of a one-day stay in a hospital - excluding the cost of all other healthcare services - is very high in the world over, even in some parts of the United States. A hospital stay that includes the cost of surgery and other physician services



can easily produce bills exceeding the financial reach of the average man. Healthcare costs of this magnitude pose substantial risks to most families' financial well-being.

By combining or pooling the risks of many people into a single group, insurance can make the financial risks associated with healthcare more manageable. Experts can reasonably predict the healthcare costs of a large group, even though they cannot know in advance how much healthcare will be required by any given individual. Through insurance, each person who buys coverage agrees to pay a share of the group's total losses in exchange for a promise that the group will pay when he or she needs services (Jakab, 2001). Essentially, in agreement with Jakab, individuals make regular payments to the plan rather than having to pay especially large sums at any one time in the event of sudden illness or injury. In this way, the group as a whole funds expensive treatments for those few who need them, in the spirit of communism.

Many people believe that in addition to providing financial stability, health insurance can promote good health. Supporters of this idea like Ekman (2004), claim that by lowering the personal costs of services, insurance induce individuals to seek health-maintenance services more regularly than they otherwise would, thereby heading off potentially serious illnesses.

Some of the reasons for introducing SHI in sub-Saharan Africa according to DFID (2002) are: to organize the extensive out-of-pocket expenditure into something more equitable for poorer people, to simplify and improve efficiency of the many small schemes in the formal sector that have developed for middle and higher income groups and to improve efficiency of health care delivery through the creation of a strong purchasing function.



2.3 Community-Based Health Insurance Scheme

The term community-based health insurance or financing is a generic name or expression for a large variety of health financing arrangements. Community-Based health Insurance Schemes (CBHIS) are "autonomous, not-for-profit organizations based on solidarity between members that are democratically accountable to them ..." (Atim, 2000:9). The objective of CBHIS is to improve members' access to good quality health care through risk sharing based on their own financial contributions.

This kind of health insurance tends to have a strong community focus and ownership in contrast to the workplace focus of social health insurance schemes. CBHIA usually cover the non-formal sector i.e. people not employed in the official sector such as subsistence farmers, market women and petty traders, another non-formal health insurance scheme similar to this is Mutual Health Organization (MHO). These are mostly community based but could also be formed by an external organization (e.g. a hospital, a church, a donor) to assist a group of people to have financial access to health care. CBHI scheme's main pillar is solidarity or social cohesion, the mutual relationship created by people likely to be affected by a common risk, who contribute to a common fund from which a member is relieved when he\her needs to meet health care cost, CBHIS\MHOs use financing mechanisms based on a key health insurance principle, which is to enable people to pool their small contributions so that the most unfortunate ones among them shall have access to health care when they need it.

Names such as micro insurance, community health funds, mutual health organization, rural health insurance, revolving drug funds and community involvement in user-fee management have been used at different places to refer to similar schemes. What is



common to all these programmes is the predominant role of "collective action in raising, pooling, allocating, purchasing and supervising the management of health-financing arrangements." (Dror & Preker, 2002).

They are voluntary organizations and regulated based on the tradition of self-help and social mobilization. They generally do not cover the full cost of health care. Some, however, provide comprehensive care at all levels of the health system. In some other cases, benefits are provided at a central facility, such as a district hospital, or at scattered lower level facilities such as health centers and clinics. The management of these schemes is varied. While some are managed by a central government organization together with local officials, others have been implemented solely by autonomous community solidarity groups or by non-governmental organizations in cooperation with the community.

2.3 Access to Health Insurance

It is evident that millions of people lack health insurance in the world all over. For example, in 2007 the U.S. Census Bureau reported that as of 2006 about 47 million people in the United States (about 15.8 percent of the population) lacked health insurance coverage. Those without insurance are usually self-employed, work part-time, or work in low-wage jobs, so they lack access to low-cost, employer-sponsored group plans. Many of these workers cannot afford to purchase individual healthcare insurance, but they do not qualify for coverage under government programs for low-income Americans. For example, in the early 21st century almost half (47.5 percent) of full-time workers in low-wage jobs were uninsured. Nevertheless, even without



insurance, these individuals may be able to receive emergency care without charge or at reduced rates in government-run hospitals (PHRplus, 2004).

Although millions of people lack health insurance because they cannot afford it, many others cannot buy health insurance because insurers consider them as especially high risk of needing expensive healthcare. Insurers assess the risks posed by applicants for insurance and then group applicants into similar classes of risk. Americans for example, who are considered average or better-than-average risks, can usually purchase insurance policies at a relatively affordable price. When an applicant presents too much risk, however, private companies consider it difficult or even impossible to offer insurance coverage to that person. For example, some private companies will not offer coverage to an individual with a known predisposition to develop cancer because he or she presents a high risk of needing expensive treatment. Also, the few companies willing to insure such high-risk individuals will charge higher premiums to assume the risks. Increased premiums often make the insurance policy unaffordable to high-risk individuals. Even worse, occasionally no insurance company will offer a policy to a person who presents an exceptionally high risk of needing expensive medical care, such as a person infected with the virus that causes acquired immune deficiency syndrome (AIDS). (MoH, 2004)

Some insurance companies have introduced clauses to their policies that are designed to keep costs down by denying access to private insurance for anyone who already suffers from significant medical conditions. Introduction of preexisting condition clauses in insurance policies became especially widespread in the 1980s and early 1990s. Many workers found it virtually impossible to change jobs if any member of their families had a serious health problem because preexisting condition clauses in their new employer-sponsored plan would deny them access to insurance coverage.



The Congress of the United States addressed this problem by introducing the Health Insurance Portability Act of 1996, which requires most employer-sponsored plans to accept transfers from other plans without imposing a pre-existing condition clause (PHRplus, 2004).

2.4 Insurance Costs and Quality of Healthcare

According to Norman (2008), the costs of healthcare have increased dramatically for consumers and insurers, particularly during the 1980s and early 1990s. For example, in 1980 Americans spent \$247.3 billion on healthcare. By 1999 that figure had more than quadrupled to \$1.2 trillion.

Norman postulates that, one reason costs have risen is that Americans are living longer than ever before, and older people generally require more healthcare. In 1900 the average American had a life expectancy of about 50 years. In 2000 the average life expectancy was about 76 years. During the 20th century, the number of persons aged 65 or over increased 11 times. The elderly comprised only 1 in every 25 Americans in 1900, but represented 1 of every 8 Americans in 1994. When older Americans join an insured group, the whole group's healthcare risks-and costs-rise accordingly.

Advances in medical technology have also driven up the costs of healthcare and insurance. Medical procedures such as computerized tomography (CT) scans, magnetic resonance imaging (MRI) scans, and arthroscopic surgery are commonplace today, but they did not exist until the 1970s. Although such new technology sometimes allows healthcare providers to introduce less-invasive and less-expensive



treatments, more often it provides new but expensive ways to treat conditions that were previously untreatable.

Increased use of healthcare has also led to a growth in healthcare costs. Again, he concludes that people are more likely than ever to seek professional health services for medical problems. For example, in 1991 there were an estimated 669.7 million visits to doctors' offices, or 2.7 visits per person in America. In 1999 there were an estimated 757 million visits to doctors' offices, or 2.8 visits per person.

From the on-going discussion, it could be realized that people are mostly oriented to pursue medical care for minor ailments which hitherto were not considered a threat to one's health. Consequently, people now live longer. Many people today seek medical care for treatment of sexual impotence, attention-deficit hyperactivity disorder, and other problems that previously were not always considered health problems. Just as increased demand pushes prices up in other industries, increased demand for healthcare leads to escalating medical costs.

2.5 Sustainability

Sustainability is assessed jointly with level of funding since these are inextricably related. Hence sustainability is assessed from the following perspectives

2.5.1 Members Acceptability/Sustainability

As indicated earlier insurance generally thrives better with large numbers or high convergence. The need to embark on education and marketing to the target group before introducing SHI is paramount to achieve high coverage. The Scheme in Tanzania faced initial resistance and opposition owing to the fact that many people did not understand or even know it until deductions started reflecting on their pay



slips. In Kenya for example, vigorous marketing was considered a vital component in encouraging the informal sector to participate in the country's Social Health Insurance. Members' acceptability of the scheme is enhanced if they also receive an acceptable quality of health care (Bachmann 1994: Normand and Weber 1994; Kutzin, 1996).

A major advantage of Social Health Insurance (SHI) is the fact that it is mostly a payroll deduction. It is therefore more likely to win popular support than other mechanisms such as increases in general taxes since the latter usually affect prices of items in the country (Broomberg and De Beer, 1990).

Studies have shown that the mode of contribution to mandatory health insurance schemes is as important a factor as it is in voluntary schemes. For example, at Boboye in Niger, the whole population was included in their SHI by means of a mandatory pool tax. Because of that, membership was quite high. But Bennett and others (1997) found that where "compulsory" membership meet paying the premium on attendance at a health centre, coverage levels turned to be much lower-for instance, they found 33% at Molodo in Mali and 25% coverage for one scheme in India.

Incrementally adapting the benefit package in accordance with changing needs, values and economic circumstance contribute to the acceptability and hence, sustainability of a social health insurance system (Bamghausen and sauerbom, 2002). Bamighusen and Sauerbom (2002), advise countries embarking on universal health insurance system to start with packages limited enough to be financially viable, yet with services that are both relevant to needs as well as attractive to enrollees.



Evidence shows that all countries that have universal coverage started by covering subgroups of the population usually those in formal sector employment, and extended coverage gradually (Normand and Weber, 1994; Ritter, 1983).

The Korean experience shows it is possible to achieve universal coverage using a stepwise approach and in a relatively short period. Universal compulsory coverage was achieved 26 years after the establishment of the first voluntary fund through schemes covering the rural and the urban self-employed (Moon, 1998; Anderson, 1989).

The potential of SHI to generate revenue depends on the size of formal sector employment, the degree to which workers in the informal sector can be incorporated, and the income levels of economically active population.

Enrollment in insurance schemes either voluntary or mandatory is dependent on employment levels. The scheme that became compulsory as employment levels rose, as in Japan, Korea and Taiwan, had close to full coverage. Indeed, one of the most important lessons learnt is that all the developed countries achieved successful implementation of mandatory health insurance only when they were at relatively high levels of income, largely urbanized, and had large wage sector relative to informal sectors. As formal sector employment and or income levels increase, SHI becomes more stable and sustainable health care financing mechanism.



One disadvantage of SHI, however, is that it may lead to an increase in employers cost of labour since they have to make contributions for their employees. This may exacerbate unemployment or reduction in wages and salaries. Otherwise, employers may also shift this cost to consumers by increasing prices.

SHI can be an efficient source of health care finance if there are sufficiently large risks pools and adequate mechanisms for risk equalization when there are smaller funds acting as intermediaries. Since SHI is mandatory, it reduces adverse selection and leads to the creation of large risk pools than can be achieved in voluntary private insurance schemes (Ron et al., 1990).

Experience has shown that near universal coverage also requires substantial state involvement. Interventions to achieve this include regulation of funds and their redistribution to integrated systems (Ensor, 2001). Again, experience shows that those countries legislating for universality had already achieved coverage of the overwhelming majority of their population. This is determined by socio-economic and political factors, as well as the quality of health services available. When these factors are favourable, they encourage prospective members to join and keep their membership in the health insurance scheme. An aspect such as expanded opportunities for choice of health care providers by insurance members is crucial to their satisfaction.

2.5.2 Provider Acceptability/Sustainability

Weak regulation and inability to create appropriate incentives in health institutions to make them behave in a more efficient way will make SHI unsustainable (DFID,



2002). Also the quality of service members' of the scheme receive encourages them to continue to patronize SHI.

Sometimes health care providers turn to have bad debts from unpaid bills. In such circumstance, health care providers are willing to accept SHI as it turns to reduce their bad debts.

Acceptability of health insurance on the part of providers relates to their preparedness and readiness to develop and implement measures to support the programme effectively. Since insurance schemes in themselves do not offer health services, they depend much on the availability and quality of health services. Hence, health service providers will need to cooperate and collaborate well with insurance managers for any schemes' successful operation. This is crucial to the viability of the health insurance schemes

2.5.3 Financial Sustainability

Experiences from Croatia, Macedonia and Bosnia and Herzegovina show that SHI have been more successful at raising revenue for health in countries with stronger economies (DFID, 2002). However the revenue rose from the mechanism is not enough to support the whole health system and other mechanisms are still required.

As indicated earlier, it takes a long time for SHI schemes to evolve, hence taxation remains important even in countries that are officially financed by social insurance, few European countries rely on SHI to entirely finance their health systems. At most

SHI never accounted for more than 75 percent of the total health care expenditure (DFID, 2002)

Financial sustainability (sometimes referred to as level of funding) in this context refers to the capacity of health insurance schemes to provide sufficient level of finance to enable them function effectively over time without a substantial injection of external support. This implies that the mix of funding sources provides stability in finance over time and that there are adequate mechanisms to contain the growth of costs within the available funds (WHO, 1995).

2.5.4 Administrative Efficiency

SHI tends to have relatively lower administrative cost, as compared to voluntary commercial private insurance schemes, which increases the net revenue generating potential. The level of administration costs is influenced by a range of factors such as "the number of SHI members (given the economies of scale in insurance administration), whether there is a single insurance fund or a number of smaller intermediaries. The extent of computerization of membership and provider information" (McIntyre, 1997).

An aspect that affects SHI costs is the payment mechanism adopted to reimburse health care providers of the insurance scheme. Fee-for-service (FFS) for example, as practiced in Germany in the 1960s led to cost escalation (Rosewitz & Webber, 1990). There is ample evidence from countries like South Africa, South Korea and China that fee-for-service remuneration leads to an expansion in overall service volume and



rising health care expenditures because of supplier-induced demand (Kutzin 1997; Moon, 1998).

Another problem is the threat of moral hazard in mandatory insurance. A number of strategies have been adopted in different countries to contain costs in SHI. South Korea and Taiwan used out of pocket cost-sharing in the form of annual deductible co-payments and strict price controls to try to control moral hazard, but these mechanisms did not seem to solve the problem (Gertler, 1998).

The development of good management practice as well as of a trust relationship between administrators and beneficiaries are crucial elements for the long-term survival of schemes (Feng et al., 1995; Liu et al., 1995). Self-governance may serve both as a source of stability and sustainability as well as a means of decentralizing and democratizing the health care system.

Small, informal, voluntary health insurance schemes may serve as learning models for fund administration and solidarity. The creation of legal frameworks, formalizing these schemes and eventually making them compulsory can be an important step towards establish universal social health insurance (Bamighausen and Sauerborn, 2002). In the OECD countries, indigenous mechanisms for risk pooling existed in all countries and attempts to extend coverage built on these systems. This is again exemplified in the integration of the friendly societies into the administration of national insurance after the First World War in Britain and incorporation of the *mutuelles* in France (Ensor, 2001). Such a design makes use of existing structure and avoids establishment of new ones, which will increase costs.





Splitting service provision and the purchasing of health function is known to improve efficiency. However, in countries where highly centralized control has been the norm splitting through a division in organizational responsibilities with a country's Ministry of Health can prove difficult (Ensor, 2001)

2.5.5 Equity in Financing

Equity in health insurance financing depends on the progressivity or otherwise of contribution mechanism used. If a SHI has a flat rate contribution, irrespective of income levels, it is said to be the most regressive.

In some Social Health Insurance schemes (SHI), contributions are a fixed proportion of salaries. Others have gone further to progressively structure income-related employer and employee contributions (Normand and Weber, 1994). They are either set as a proportion of wages (e.g. 2 percent for low income earners increasing to 6 percent for the highest income earners) or a fixed amount of specified wage categories. These are more progressive methods which improve equity in financing. Governments often heavily subsidize schemes for civil servants. This therefore represents a cross-subsidy from poorer-tax payers to relatively prosperous elite.

Also where private insurance schemes are run alongside public schemes, it could lead to 'cream skimming' and erode cross-subsidization. For example, in Chile, while health insurance is mandatory people have the option of either joining the public health insurance, which is income rated, or private insurance, which is risk-rated (Sapelli, 2004). The relatively lower income and relatively higher risk people opt for public health insurance (cheaper but less quality health service) whilst the relatively



higher income and people with low risk join private health insurance for better quality health service, the system thus encourages inequity. Perhaps equity could be improved if all contributions were risk-rated and the public subsidizes those whose premiums exceed certain limits (e.g. as in Netherlands) (Sapelli, 2004). Alternatively, SHI could disallow people from opting-out and joining private schemes.

Equity in finance is also considered to be a function of the ability to pay, and can be interpreted as those with different abilities to pay should make appropriately different contributions, i.e. vertical equity, and that persons or families of the same ability to pay make the same contribution, i.e. horizontal equity (Wagstaff and Van Doorslaer, 1993; Kutzin, 2001). Thus equity in finance was evaluated on the bases of progressivity of the financing source. The study considered an individual's ability to pay as against actual direct and indirect payment made for health insurance. This involved an examination of the ways in which contribution was made to determine whether they were progressive or regressive relative to individual or household ability to pay. Inequity exists where the contribution system is not progressive, thus low-income individuals or households pay more of their income than high-income people.

2.5.6 Equity in Service Delivery

The design of a mandatory health insurance scheme has equity implications; experience from South Korea indicated that high co-payments will reduce equity in service utilization within the insured group (Yang, 1991). In order to be sustainable, proponents of SHI advise using incremental approach in operating SHI/NHL. But an incremental approach may in fact, lead to more inequity. For one, revenues in a SHI system traditionally flow from formal wages and salaries. As a result, the population



groups likely to be covered last are the most vulnerable segments of the society: those without income (the unemployed, retirees, and family dependants) or those with income that are valuables and hard to assess (urban informal workers and farmers). Thus, a stepwise passage to universality may result in decreased access to health care for the uninsured in the interim periods of partial coverage (which may be quite long if political will is lacking or socio-economic conditions are unfavourable).

In view of this, critics of the system argue that SHI creates a two-tier health system with differentiation in access to health services on the basis of contribution status (Ensor 1995; Kutzin 1995). Those who are covered by the SHI get quality of health care (Hoare and Mills 1986; Bachmann 1994). The problem is worsened if SHI members use private health service providers. It is likely that health personnel in the public sector would be attracted to the private sector leading to understaffing in public sector, hence, poor quality of service to the rest of the population. To reduce this effect, Abel-Smith (1991: 1997) has recommended sufficient trained health personnel as a prerequisite for SHI.

Another problem with the incremental approach is what current members of social health insurance schemes may be opposed to including other groups in the insurance cover. This is so because those yet without insurance are likely to be low income and high risk people. Hence, those who are currently insured would likely pay part of the price of including these groups in the form of higher insurance contributions (Barnighausen and Sauerborn, 2002).

However, SHI has the potential in promoting equity in service delivery. It may release scarce resources from the public sector, which can be used to provide



improved health services for the non-insured population (Shaw and Griffin 1995). Thus, despite the disparities, the non-insured will still receive better and more services than when there is no SHI.

Also if SHI is introduced for all formal sector employees, it can improve equity in the receipts of health care within the insured group (Griffin and Shaw 1996; Kutzin 1996). This happens because all categories of income earners (low and high income earners) would be entitled to the same benefit package all things being equal. Bachmann (1994) argues that there may be fewer health services located in low income residential area which can increase the indirect costs of obtaining health care and therefore deter low income earners from using as much health care as high income earners. However, it is likely these low-income earners would use more service than previously as SHI usually reduces the direct costs of care.

The most equitable approach may be National Health Insurance (NHI) (universal coverage), but even then effective coverage (i.e. receipt of care) is likely to be lower for the poor and people who are economically disadvantaged. (Bachmann, 1994). In developing countries, universal coverage is also unlikely to be economically feasible owing to high unemployment levels.

Equity in health service delivery was also evaluated in terms of vertical and horizontal equity. Evaluation of vertical equity of health services provision requires that persons with unequal need be treated in an appropriate dissimilar way with horizontal equity requires that person with equal need be treated equally (Wagstaff and Van Doorslaer, 1993).



In practice however, equity in health service provision can be evaluated on a geographic and socio-economic basis. Equity on a geographic basis implies that people with equal capacity to benefit from health care should receive equal treatment, despite personal characteristics that are not related to capacity to benefit, such as residence (Wagstaff and Van Doorslaer, 1993).

Equity on a socio-economic basis implies that citizens with different socio-economic status when ill should receive the same treatment regardless of their influence in society and ability to pay (Wagstaff and Van Doorslaer, 1993). Thus the study examined whether service delivery and utilization reflected the need for services rather than the income level or other factors of patients.

Kutzin (2001) suggests that health-financing mechanisms need to reflect the objectives of health systems. According to him, health insurance especially must provide access to health care with financial risk protection, which he termed the "function of health insurance." Seven main functions in health financing arrangements identified by Kutzin (2001) are considered. These include: source of funding, contribution mechanisms, pooling of funds, allocation mechanisms, types of organization, purchasing of health services and benefit package. These are briefly explained below.

Sources of Funding: The main sources of funds for health care are individuals and corporate entities (through direct and indirect taxes) and external donors. Government is the most important source of funds and may increase the level of health expenditure by either reallocating funds for other sectors to the health sector or



the health sector or increase her expenditure generally. Usually, it is not easy to re-allocate funds from other sectors and is equally difficult, especially in low-income countries, for governments to increase general expenditure. Likewise, an increase in tax rates has the potential to reduce employment levels and hence lead to an actual loss of tax revenue. Thus, governments have to be cautious in their desire to increase funding for health care.

Contribution Mechanism: These are usually direct and indirect taxes, payroll taxes, voluntary prepaid contributions, grants and loans. These are influenced by the level of economic development such as levels of employment and income (Kutzin, 2001).

Pooling of Funds: This refers to mobilization of funds for health from various sources into a common 'pot'. Resources in this single fund (pool) will be allocated to the relevant agencies to cater for health care costs; it is an "accumulation of prepaid health care revenues on behalf of a population" (Kutzin, 2001: 176). Pooling of funds is a means leading to equitable and efficient distribution of health resources. If each region or district is left on its own, more endowed areas may accumulate more funds and have access to better health care whilst poorly resourced areas are denied such facilities.

Allocation Mechanisms: This refers to distributing health funds from central (higher) level to lower levels (regional/provincial, districts) for the purchase or provision of health services for their respective populations. Allocation may be done following historical data (expenditure patterns) or based on more sophisticated needs based criteria to cater for differences in health needs of the relevant populations. The latter is said to be more efficient and equitable as it reflects the health needs of the people.



Types of Organisation: This relates to ownership of the health insurance scheme; whether it is government, private for-profit or private-not for profit (NGO). This has implications for how the organization is run. Most private for profit organizations tend to adopt means of avoiding high risk people. In such a situation, government may need to regulate schemes' operations to ensure equity (Kutzin, 2001).

Purchasing of Health Service involves actual "buying" of health services for the population. Thus, arranging and paying for health service costs for the people in a locality or in a health insurance scheme. The purchasing functions if not well conducted may encourage supplier-induced demand; however "active purchasing" could be used to regulate provider behavior and enhance efficiency.

Benefit Package is the set of health services that an insurance member can access.

This is the main motivation for most people to join health insurance schemes. The benefit package can therefore be designed to attract prospective insurance members by including most needed services. However, control measures need to be put in place to avoid excessive use of services.

Nations all over the world have been trying to or have already launched Health campaigns which seek to promote efforts to improve the health of their citizenry. The goal is to ensure that health is included in social policies at all levels of governance. Perhaps, emphasis is being put on the treatment of diseases rather than protecting health in the first place as described by the U.S.A. Director of Centre for disease Control and Prevention, Julie Gerberding (Gevec 2006).

Health insurance is a scheme designed to pay the costs associated with healthcare. Health insurance plans pay the bills from physicians, hospitals, and other providers of



medical service. By doing so, health insurance protects people from financial hardship caused by large or unexpected medical bills.

The financing of health services has become an increasingly critical and urgent issue in many developing countries particularly in Sub-Saharan Africa.

According to Nielson, (2008), people obtain health insurance from private organisations or from government agencies. He declared that, all industrialized countries other than the United States have government funded national health insurance systems that provide health insurance for virtually everyone. Countries with national health insurance generally consider access to health care to be a basic right of citizenship (Nielson, 2008).

Health care in sub-Saharan Africa is increasingly financed by direct payments from the population. Mutual health insurance plans are developing to ensure better risk sharing. However mutual health insurance cannot fully resolve all equity issues. The low resources available for contribution and the limited availability of care services especially in the public sector cannot guarantee the quality of care necessary for the development of mutual health insurance. National governments must not forget their responsibility especially for defining and ensuring basic services that must be accessible to all.

Health financing reforms in most low-income countries promote social and micro

2.6 Health Insurance in Africa
health insurance, in order to reduce direct spending by patients. Three phases of development can be distinguished in African countries: at first, schemes were developed only for the formal sector, then micro health insurance targeted the informal sector, and finally, health insurance was included in larger plans to reach



universal coverage. The impact of health insurance is, as yet, difficult to assess. If beneficiaries have a better access to health services, the financing of health sector is particular, in public facilities. In spite of their limits, social health insurance schemes continue to be implemented, but as a part of hybrid financing system, fitting with the abilities of low-income countries, (Letourmy, 2008).

A cautious approach is recommended taking into consideration the lessons learned in other regions accompanied by a careful ongoing evaluation especially regarding the ability to pay by the poorer sections of the population. Providing for equity in health care should be an important guiding principle. It therefore appears necessary to find an appropriate mix of public and private sector interventions with elements of cost sharing for services and drugs, insurance schemes and more efficient use of available resources.

In most African countries, access to health care is reserved to employees of the public and private sectors. There is no health insurance for the rest of the population most of which is often poorer than the salaried workers of the public and private sectors. Workers of the informal sector and rural areas account for over 90% of the workforce in Africa but find themselves in a peculiar situation of vulnerability resulting from the often difficult working conditions, lack of a long-term view and poor access to health care.

Out-of-pocket payments, most often in the form of user fees, remain the principal means of financing health care across low-income countries. Often, such payments have resulted in decreased utilization of health services, particularly among the poorest (Gilson 1997; Palmer 2004). Catastrophic out-of-pocket payments for care,



such as payments for hospitalization or surgery, can push entire households into poverty as mentioned by Doorslaer (2006). Lack of prepayment or health insurance mechanisms is a key precondition for catastrophic payments for care (Xu 2003). In recent years, a growing number of governments and international donors have promoted Mutual Health Organizations (MHOs) as a means for providing financial risk protection. MHOs, also known as community-based health insurance or community-based health financing schemes, are voluntary membership organizations providing health insurance services to their members. MHOs are typically owned, designed and managed by the community that they serve (such as a district, a trade association, or a hospital catchment area), and differ from commercial insurance organizations in that they are always not-for-profit and are based on the principles of mutual aid and social solidarity (Bennett et al., 2004). They are increasingly being advocated as an alternative to user fees and a way to improve access to health care in low-income countries.

Since the late 1990s, MHOs have been growing in number and in membership at a rapid pace in sub-Saharan Africa and other regions of the world (Bennett et al., 2004). In West and Central Africa, the number of MHOs grew from seventy-six (76) in 1997 to more than eight hundred (800) by 2004 (Gamble-Kelley et al., 2006), and MHO based health insurance is now part of the national health financing strategy in Benin, Ghana, Rwanda, Senegal and Tanzania. While MHOs typically cover a small percentage of their target population, the potential contribution of MHOs to improving financial access to health care for the informal sector and rural populations is attracting increased attention from governments and donors (WHO 2001). However, the role that MHOs can play in overall health system financing has been the subject of continuous debate among health financing experts. Some argue that MHOs can only



play a small-scale role in health financing in low-income countries (ILO 2002), while others advocate MHOs as a promising approach that can complement public and donor financing, or serve as a step towards national health insurance (Carrin 2003).

The evidence base on the impact of MHOs on utilization and out-of-pocket payments for health care is still limited (Preker et al., 2002). Debates are ongoing on whether MHOs include the poor and the socially excluded segments of the population. Some studies have found that MHOs tend to exclude the poor (Bennett et al., 1998), while others have found that MHOs are inclusive of the poorest (Ranson et al., 2006).

Another group of studies did not find a significant association between enrolment and households' socio-economic status (Schneider and Diop 2001) or showed mixed evidence for this relationship (Jowett 2003). In a survey of the literature on the impact of community health insurance published in the 1990s, Jakab and Krishnan (2001) found mixed evidence on social inclusion in MHO schemes, while a later literature review by Ekman (2004) found strong indications that such schemes tend to exclude the poorest.

A number of studies provide evidence that MHO membership is associated with higher utilization of modern health care, in the form of outpatient visits or hospitalization (Criel and Kegels 1997; Atim 1999; Schneider and Diop 2001; Jutting 2004). At least one study found the surprising result that MHO members were less likely than non-members to seek care when ill (Gumber 2001).

There is growing but still limited evidence on the effect of MHOs as a vehicle for reducing out-of-pocket health care expenditures, particularly the catastrophic expenditures associated with hospitalization or surgery. The available evidence indicates that MHO members tend to have lower out-of-pocket payments compared



with non-members (Schneider and Diop 2001; Jiitting 2004), and MHOs that cover inpatient care can reduce the percentage of hospitalizations resulting in impoverishment (Ranson 2002). The literature reviews by Jakab and Krishnan (2001), and Ekman (2004) also concluded that there is consistent evidence that MHO membership is associated with lower out-of-pocket payments for health care.

However, very few of these studies are based on household or individual level data and limited number use quantitative techniques, in particular regression analysis (Ekman 2004). Studies that are based on administrative data from MHOs or health facilities typically lack data on important differences in factors such as health status and socio-economic profile between (1) MHO members and non-members, and (2) those who seek and those who do not seek health care. If such factors are associated with utilization of care and with MHO membership, results on the impact of MHOs on utilization that do not account for them may be biased. Omission from a study sample of those who do not seek care when ill (both MHO members and non-members) would further distort the effect on utilization and out-of-pocket payments attributed to MHO membership.

2.6.1 Some Findings

Atim, Grey, and Apoya (2001) found that many aspects of MHOs impinge directly or indirectly on their viability as institutions. They concluded that while MHOs possess some managerial and administrative skills, major problems remain in the area of institutional development and the skills required for MHO-specific tasks. These tasks included: setting premium rates, determining benefits packages, marketing and communication, using Management Information System (MIS), determining the



appropriateness of care provided and its pricing, contracting with providers, accounting and bookkeeping, monitoring and evaluation and collecting dues.

Theoretically MHOs seem to be an interesting solution with great potential to enhance access to quality health care, to mobilize funds, improve efficiency in the health sector, encourage dialogue and democratic governance for the health sector and thus contribute to the social and institutional development of society.

Looking at the results of about ten (10) years of MHO development, it seems to be that the communities take up the idea only with great difficulty (Criel, 2000). But despite the many problems involved in implementation, the majority of the promoters are still convinced that the concept is useful and that there is simply no alternative.

Governments are incapable of financing the health system by taxation alone. MHOs can contribute to the correction of some of the negative effects on the accessibility of the health care system caused by the introduction of user fees. Health insurance ensures community participation in health, care costs on a more equitable basis than fee for services.

But for Bennet (1998), health insurance should not be seen as a source of finance in poor communities, where there is simply not a lot of additional money available. Cost recovery levels will be limited under rural schemes. Bennet argues that well designed schemes have an even greater potential in improving health system performance, particularly quality of care and efficiency, than in raising additional finance. Insurance schemes should be seen as a supporting strategy, not as an exclusive financing alternative. Like user fees, they should be seen as a means to top-up existing government budgetary financing (Bennet, 1998).



2.7 Health Financing In Ghana

2.7.1 Evolution

At independence, Ghana provided free health care services to its population through public health facilities. There were no out-of-pocket payments in these facilities and care was financed solely from tax revenues. However, this was not sustainable in light of the needs of other sectors of the economy, and the government had to find alternatives to this financing mechanism. In the 1970s nominal fees were introduced, but these proved insufficient to meet the needs of the health sector. By the middle of the 1980s full cost recovery for drugs, known as "cash and carry," was introduced (MoH, 2004).

However, 'cash and carry' decreased access to health care, particularly among the poor, resulting in a decline in utilization of basic health services. To cushion the burden of out-of-pocket payment for health care, the government introduced an exemption policy. The policy exempted children under the age of 5, pre-natal care for pregnant women, and health care services for the indigent, the elderly (those above 70 years), and for disease-specific services. 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. For example, in some hospitals, decision making was decentralized and exemption practices were inconsistent, so that exemptions would be granted for some but not all services (MoH, 2004).

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



(i.e., user fees). Schemes such as Nkoranza and Dangme West were established in the early 1990s and became models for other communities to replicate. The subsequent growth in mutual health organizations in Ghana was noteworthy. Whereas 47 MHOs existed in 2001 (Atim, Grey, & Apoya 2001), this number tripled to 159 by 2002, and it continued to rise to 168 MHOs by 2003. However, less than 40 percent of MHOs were functional at that time, and the combined total coverage they extended to the population was just (one) 1 percent (Atim, Grey, & Apoya 2003).

Recognizing the problems that the cash and carry system posed to accessing health care, the government of Ghana declared its intention to abolish the system, and began exploring the feasibility of introducing a national health insurance scheme to be managed at the district level. The goal of such a scheme would be to assure equitable and universal access to health care for all residents of Ghana (MoH, 2004).

Foreshadowing the implementation of such a program, the Ministry of Health's Programme of Work for 2002-2006 stated that: The Ghana Poverty Reduction Strategy commits the Ministry of Finance to increase allocation of resources to the Ministry of Health, and reallocation of resources within the Ministry in favour of the deprived regions. The government is committed to removing financial barriers to treatment due to out of pocket payments at the point of service. Prepayment mechanisms were developed to replace fee for service. The exemption schemes which took care of the vulnerable reviewed to make it more accessible (MoH, 2004).

Owing to the problems associated with the "cash and carry" (user fees) system of financing health care in Ghana, the government of the day sought to abolish the user fees system when the Party came into power in 2000 and to replace it with a National Health Insurance Scheme. After a series of consultation and studies with health development partners such as WHO, DANIDA, and GTZ as well as other relevant



national agencies, the government realized it would not be feasible to establish a single National Health Insurance fund (Ministry of Health, 2002). This was because about 70% of Ghanaians are in the non-formal sector of the economy and at least 40% of the Ghanaian population lives below the poverty line and may not be able to afford high premiums (Ghana Living Standards, 2000). This meant that traditional mechanism for organizing communal contributions needed to be examined and factored into the design of the health scheme. A ministerial Task Team on Health Care Financing was established March 2002 to conduct further studies and recommend an appropriate scheme for Ghana. The Team's proposals were submitted to the Parliament of Ghana and in 2003, an Act of parliament was passed to establish and regulate health insurance operations in the country (Act 650, 2003).

2. 7.2 Introduction of National Health Insurance

In August 2003, the government of Ghana moved from planning to action by passing the National Health Insurance Act, Act 650. Its primary goal was to improve access to and quality of basic health care services in Ghana through the establishment of mandatory district-level MHOs or district-wide insurance schemes. The policy objective is that: within the next five years, every resident of Ghana shall belong to a health insurance scheme that adequately covers him or her against the need to pay out-of-pocket at the point of service use in order to obtain access to a defined package of acceptable, quality health services. (Government of Ghana, 2004).

In addition to providing guidance on the structure of the district insurance schemes, the Health Insurance Act provides the legislative framework for the establishment of a regulatory body, the National Health Insurance Council (NHIC). The role of the NHIC is to register, license, and regulate health insurance schemes and to accredit and

monitor health care providers operating under the schemes. It plays a key role in guiding implementation efforts and management of the National Health Insurance Fund. The Health Insurance Act stipulates three types of schemes: District Mutual Health Insurance Schemes, Private Commercial Health Insurance Schemes, and Private Mutual Health Insurance Schemes. A Legislative Instrument, outlining the regulations for implementation at the district level, was approved and published in January 2005. One of the key regulations that it specified is the annual premium, set at a minimum of 72,000 cedis per adult. In a typical two-parent family with three children, the entire family would be covered for 144,000 cedis per year. (Government of Ghana 2004).

2. 7.3 Coverage

The NHIC developed the benefit package, which is intended to cover basic health care services, including outpatient consultations, essential drugs, inpatient care and shared accommodation, maternity care (normal and caesarean delivery), eye care, dental care, and emergency care. Certain public health services historically provided for free, such as family planning and immunizations, will be covered under the NHIS. District MHOs must adhere to the defined benefit package.

Some services deemed either unnecessary or too expensive are excluded from coverage. These include cosmetic surgery, drugs not listed on the NHIS drugs list (including antiretroviral drugs), assisted reproduction, organ transplantation, and private inpatient accommodation.

To mobilize additional funds to support implementation of the district mutual health insurance schemes, the government of Ghana instituted a National Insurance Levy of 2.5 percent on specific goods and services. In addition, 2.5 % of the 17.5% social



security contributions paid by formal sector employees is automatically diverted to support the NHIS and formal sector employees and their dependants automatically be enrolled in their district scheme. It is anticipated that approximately 80 percent of the NHIS be financed by these taxes. For those in the informal sector, community health insurance committees categorized residents into social groups based on economic status, and those identified as 'core poor', exempted from paying premiums (Government of Ghana 2004).

Under the Health Insurance Act, local district assemblies have the responsibility for initiating the district mutual health insurance schemes. Specifically, district assemblies are tasked with promoting the schemes, identifying human resources to provide technical support for the establishment of the schemes, and carrying out social mobilization. The district health insurance schemes are mandated to operate exclusively for the benefit of their members.

Although numerous MHOs have existed in Ghana, and indeed in other West African countries, the Health Insurance Act marks the first attempt effort in the region to institute a nationwide insurance scheme with the ambitious goal of achieving universal coverage.

Using fundamental elements of mutual health insurance schemes, the set up district wide mutual health insurance schemes were designed to be financially and structurally independent entities and to form its own risk pool. As the National Health Insurance Act came to effect in 2004, many (but not all) micro health insurance units decided to change their structure to become district wide mutual health insurance schemes. Within just five years, the district wide mutual health insurance schemes



covered (end of 2007) over 8 million people in Ghana representing over 42% of the entire population (Pro MHI Africa, 2009).

2. 7.4 Types of Health Insurance Schemes in Ghana

The National health Insurance is modeled around the exiting community-based health Insurance Schemes although provisions have been made to accommodate other forms of health insurance schemes.

According to Act 650 (2003), the following types of health insurance schemes may be established and operated in the country:

a) District mutual (community-based) health insurance schemes: this type of scheme operates in the whole district and membership is open to all residents of that district

b) Private commercial health insurance scheme: this is a private for-profit company and may not be restricted to a particular location within the country. Membership to this scheme is also open to all Ghanaian residents.

c) Private mutual (community-based) health insurance schemes: This could be any group of people coming together to form their own mutual health insurance scheme. It could be a church, an association, a club etc. and usually membership is open to only members of the organization concerned.

However, for any insurance scheme to operate in Ghana, it needs to be registered either as a company limited by guarantee (in the case of district mutual or private



mutual) or in the case of private commercial health insurance scheme, as a limited liability company.

The government of Ghana supports directly the District Mutual Health Insurance Schemes. In effect, private mutual health insurance schemes and private commercial ones may be established but will not enjoy any subsidies from government. It is however, compulsory for anyone living in Ghana to belong to a health insurance scheme (Act 650, 2003).

Thus by that position, Community-Based or District Health Insurance Schemes have become the main focus of government health insurance. Indirectly, Ghanaians are compelled to join the District Health Insurance Scheme, in that, opting to join any other scheme implies losing government's resources, which are to be financed by Ghanaians' own taxes and contribution as will be explained in due course.

2. 7.5 Administrative Structure of District Health Insurance Schemes

In Ghana, health insurance schemes in general are to be regulated by the National Health Insurance Authority (NHIA), which has its headquarters in the national capital, Accra with its Regional Offices in the ten regions of Ghana. According to Act 650 (2003: 6), the NHIA has "the overall function of formulating and providing policy guidance and overseeing the implementation of the National Health Insurance Programme. "The Authority will specifically manage the National health Insurance Fund (NHIF), including "collection, deposit, investment, administration and disbursement and oversee the operations of health insurance schemes including licensing and regulating schemes as well as being responsible for the accreditation of providers". (Act 650, 2003)



At the district level, the highest authority of the insurance scheme is the Health Insurance Assembly which is made up of all members of the scheme in good standing. The scheme is administered through a governing body (Board of Trustees) and by a Scheme Manager. The governing body has responsibility for the direction of the policies of the scheme and appointment of employees. Members of the governing body are between seven and fifteen persons and elected by a general assembly. The chairman of the governing body is to be elected from among the membership to the body. The scheme manager is either an individual, corporate body or a committee and is responsible for the day-to-day administration of the scheme. The staff complement is regulated and determined by Act 650 (2003) and subject to the discretion of the NHIC. (Act 650, 2003)

The basic complements of staff are:

The Scheme Manager

Publicity and Marketing Manager

Claims Manager

Accountant

MIS Manager

Data Entry Clerk (Ghana Health Service, 2004)

2. 7. 6 Sources of Financing

2. 7.6.1 Informal Sector Contributions

Premium rates are based on one's ability to pay. Community health insurance committees are to identify and categorize residents into social groups to enable



individuals in each group know their premium rates. The social groups are the core poor, poor, middle income and the rich. The core poor (indigent) are exempted from paying any premium. Those in the paying categories pay no less than seven cedis, twenty pesewas per annum (Ghana Health Service, 2004).

2. 7.6.2 Formal Sector Contribution

For those in the formal sector (both private and public), 2.5% of their contribution to the Social Security and National Insurance Trust (SSNIT) is taken monthly as their health insurance contribution, thus workers in the formal sector become automatic members of the National Health Insurance, but they have to register with their respective District Health Insurance Schemes. (LI 1809, 2004 and Act 650, 2003)

All contributors' premiums cover their children and dependants below the age of eighteen (18) years. This means anybody from birth up to seventeen years of age does not pay a premium but is entitled to full benefits as with contributors. Other categories of people exempted from premium contribution are those above the age of seventy years and former SSNIT contributors on retirement. All adults have to register as members and contribute (so spouse is not a dependant).

2. 7. 6.3 Other Sources of Financing

The government has introduced a two and half percent (2.5%) sales levy as an earmarked fund for health insurance in Ghana. Other sources include the exemption fund (from the government health budget), which was used to pay for the cost of special health services and health care cost of indigents as well as donor's contributions.



2.7.6.4 Pooling of Funds

With the exception of contributions from the informal sector, all the other funds is collated to form the National Health Insurance Fund (NHIF). The National Health Insurance Council (NHIC) administers the NHIF and it is to be used to finance exemptions for the poor as well as for reinsurance of schemes, cross-subsidization and risk equalization through an allocation formula.

2.8 Benefit Package

The National Health Insurance Act (ACT 650) and the Legislative Instrument (LI 1809) (GOG, 2003), set out the minimum benefit package to members of health insurance schemes. These include general put-patient services, inpatient services, oral health, eye care, maternity care and emergencies, only a few specialized services such as HIV antiretroviral drugs, VIP accommodations, etc are excluded from the health insurance benefit package. According to LI (2004), the benefit package covers about 95% of all essential / common health problems in Ghana.

CHAPTER THREE

3.0 STUDY AREA AND RESEARCH METHODOLOGY

3.1 District Profile

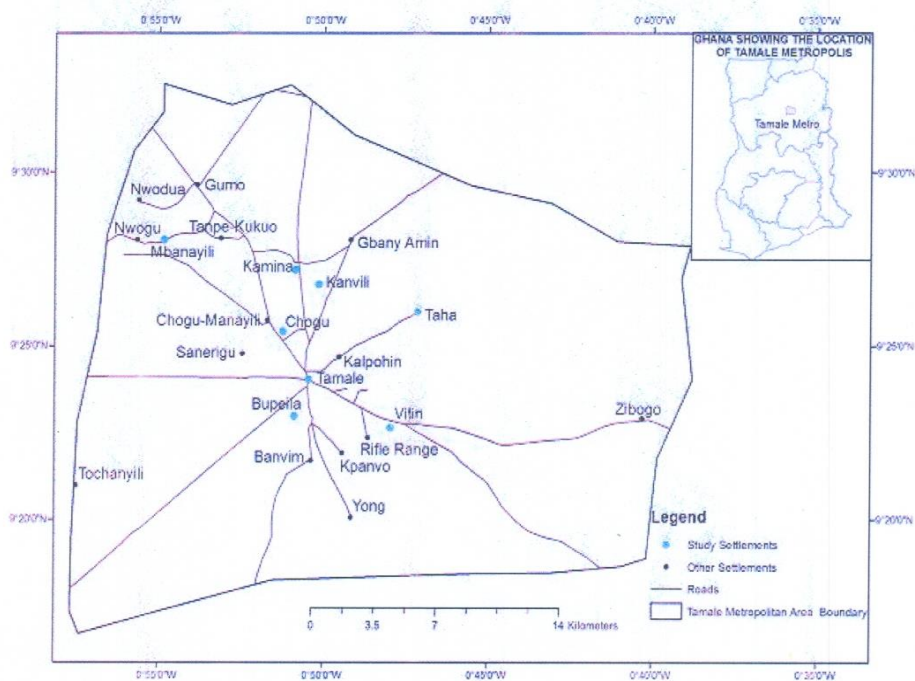
Tamale District is one of the twenty (20) Administrative and Political Districts in Northern Region. It serves as Metropolis and Regional capital.

3.1.1 Location

It is located in the centre of the region, approximately 175km east of longitude 1° west and latitude 9° north. Savelugu/Nanton District bound it to the north, to the south by Central and East Gonja Districts, to the east by Yendi Municipality and to the west by Tolon/Kumbungu and West Gonja District.



Map of Tamale



Source: (Geography Department, University of Ghana, Legon, 2010)



3.1.2 Economic Activities

The employment scene in Tamale is dominated by petty trading, crafts and other manufacturing, institutional workers and professionals (largely teachers).

Farming is the main source of livelihood in the Metropolis. About 18.5% of the economically active population is engaged in farming. Major crops cultivated include maize, tubers, citrus, all farming is rain-fed. There are several small scale enterprises located throughout the Metropolis. These include oil extraction (shear butter), and services such as sewing, barbering and hairdressing.

3.1.3 Population Characteristics

The Metropolis has a total population of 366,535 (projected at 2.9% regional growth rate from 2000 census). The actual growth rate of the Metropolis is 3.5%, which is higher than the regional and national growth rates of 2.9% and 2.8% respectively.

It has a surface area of 1,011 sq. km., which forms about 13% of the total land area of the Northern Region. Its population density stands at 363 persons per sq. km.

3.1.4 Education

Tamale is the principal center of education in the north of Ghana. Currently there are a total of 742 basic schools within the metropolis. This comprises 94 Kindergartens, 304 Primary, 112 Junior High and 10 Senior High Schools. The rest are technical/vocational institutions, two (2) colleges of Education, a polytechnic and two universities --One public and the other private.

In the Education Ridge neighborhood in the north western part of the city and covering an area of about 3 km, 20 schools ranging from kindergartens through junior high and senior high schools, teachers' training colleges, the Tamale Polytechnic and a university are located. The Central Administration of the University for Development Studies is located in Tamale. The numerous trees lining the streets in this part of the city give it a tropical rainforest outlook.

3.1.5 Climate

The Metropolis experiences a single rainy season from April/May to October, with peak in July/August, which is influenced by the moist South Westerly winds. It records a mean annual rainfall of 1, 100 mm with only 95 days of intense rainfall. The dry season is from November to March, which is influenced by the dry North Easterly (harmattan) winds. Maximum day temperature range from 33°C to 39°C and minimum night temperatures range from 20°C to 22°C.



3.1.6 Health Care System

Health services in the Metropolis are managed at three (3) levels:

1. Metropolitan Health Administration level
2. Sub-district level
3. Community level

3.1.6.1 Metropolitan Health Administration Level:

At this level of administration, the Metropolitan Health Management Team (MHMT) is responsible for overall planning, monitoring, supervision, evaluating, training, co-coordinating of all health programmes in the Metropolis. It is also

responsible for conducting operational research and linking up with other agencies and NGOs in health provision and promotion.

3.1.6.2 Sub-District Level:

To facilitate running of health programmes, the Metropolis has been demarcated into six (6) sub-districts, each with a management team known as the Sub-district Health Management Team (SDHMT). The six sub-districts are:

- Bilpeila Sub-district
- Choggu Sub-district
- Sagnerigu Sub-district
- Taha/Kamina Sub-district
- Tamale Central Sub-district
- Vittin Sub-district

The SDHMTs are responsible for programme planning and implementation of health activities in their various sub-districts, some of them include; Conduct integrated static and outreach activities such as immunization, reproductive health, disease control, growth monitoring, health education/promotion and clinical care.

Training and supervision of community based health workers such as traditional birth attendants (TBAs), community based surveillance (CBS) volunteers, village Health Committees.

3.1.6.3: Community level: Health services are provided at the community level by sub-districts staff supported by TBAs, CBS volunteers.



3.1.6.4: Health Facilities

The metropolis has thirty-seven (37) health facilities excluding the Teaching Hospital.

These are made of 21 government facilities, 1 community initiated clinic, 13 private facilities and 2 quasi-government facilities.

3.1.6.12: Staffing

Table 4: Number of staff in MHD, West and Central Hospital

Category	MHD			West Hospital			Central Hospital		
	2006	2007	2008	12006	2007	2008	2006	2007	2008
Med. officer	1	1	1	1	1	1	1	1	1
Med. Assist.	2	3	4	2	3	3	2	3	3
General Nurses	3	2	2	17	2	18	4	6	16
Auxiliary Nurses	26	33	45	17	10	9	4	5	9
Midwives	20	20	21	6	6	17	10	12	18
Health Assist.	5	4	4	7	7	7	4	4	4
Others	24	31	35	33	36	46	9	18	23
Total	81	94	112	73	83	101	34	49	74
Health extension	-	-	192			74			99
Casual workers	12	11	11	4	4	12	-	-	4

Ghana Health Service (MHD) (2009)





3.1. 7 Health Insurance Situation

According to statistics at the Tamale Metro. Mutual Health Insurance Scheme (TMMHIS) offices, as at the end of July, 2009, 312,387 persons being 85.2% of the target population have registered as members of the scheme. Again, the service utilization by the insured was 913,701 (TMMHIS,2009).

At a maiden meeting of stakeholders in March 2004, an eleven (11) member Implementation Committee was formed to champion the course of establishing the scheme. The group worked around the clock to put the initial pillars of the scheme in place. The members were representatives from the Metro. Assembly, Metropolitan Hospital (West End Hospital), Tradition Authority and others. The scheme was named as "**Tamale Metro. Mutual Health Insurance Scheme**".

The Tamale Metro. Mutual Health Insurance Scheme is a district scheme with a thirteen member (13) board appointed from the various institutions in the Metropolis such as the traditional authority, Metro Assembly, Metro Health Directorate, Metro Education Office, Local Council of Churches, Islamic Council, NGOs, and a representative from the scheme's Management Team.

The Tamale Metro. Mutual Health Insurance Scheme formally started operations following the recruitment of a six (6) member management team to take over the management of the scheme from the implementation committee in October, 2004. The management team is made up of a Manager, an Accountant, a Claims Manager, Management Information System (MIS) Manager, Public Relations Officer (PRO) and a Data Entry Clerk. This team was supported by fifty (50) community collectors.



3.1. 7.1 Challenges and Achievements

Staff strength is low especially at the Claims and MIS departments to facilitate data processing and payment of claims.

Again, subsidy from the NHIA is woefully inadequate as the TMMHIS is always indebted to providers, due to this. Presently, the scheme pays about GH ¢ 400,000.00 every month as claims, but the subsidy from the authority is not enough to contain cost of running the scheme.

Finally, the politicization of the scheme is advertently affecting the staff of the scheme as their daily operations are always viewed with suspicion and accusations.

In spite of these challenges the scheme has chalked some successes since over 80% of the people in its area of jurisdiction have been covered. This was partly achieved through effective collaboration with all stakeholders and Radio Stations in the catchment area.

3.1.8 Ethnicity

In urban Tamale where there is ethnic diversity, the Dagombas still constitute almost 80% of the total population. Almost all the people in Tamale rural are Dagombas. (Ghana Statistical Service, 2000).

3.1.9 Religion

Islam is the predominant religion in the Metropolis with about 84% of the population affiliated to it. Christians constitute 13.6% (with Catholics forming 43.7%), traditional worship about 1.6% and others forming less than 1%.



3.2 Research Design

The principal focus of this study is to critically examine the income and the cost of operating Mutual Health Insurance Scheme in Ghana and its implication on the financial sustainability of schemes. In undertaking this research both qualitative and quantitative methods of data collection were employed.

3.2.1 Sources of Data

In this, both primary and secondary data were gathered using the following instruments.

- Observation
- Interviews (Structured and Unstructured)
- Questionnaires (both open & closed ended)

The researcher spent quality time both at the health facilities and the scheme office to interact with personnel who prepares NHIS claims from the facilities for onward submission. At the facilities, the researcher closely observed how NHIS clients were being attended to. He visited the NHIS units in the various health facilities to actually observe how claims were being prepared for submission to the scheme for reimbursement. Thereon, the researcher visited the scheme and spent some time at the claims department. Here, he observed how claims were being processed for payment. Observation was used because it offered the researcher firsthand information. It was also interactive so the researcher had the real feel of what happens on the ground.

Structure interviewer - administered questionnaires (Onwujekwe 2001) were administered to 735 heads of households to obtain relevant cross-sectional primary data for analysis. This heads of households were seen as potential users of health



insurance who generally make decisions about the use of household income and influence healthcare seeking behavior hence their willing to pay is pivotal to the sustenance of NHIS. The main arguments in favour of the use of personal interviews to collect data rather than postal questionnaires or telephone interviews are that interviews improve response rate and provide opportunities to check the subjects' understanding of the questions (Cairns, 1994)

Three (3) research assistants were used as interviewers. Two post- secondary trained teachers and one HND holder were trained as research assistants to help with the conduct of interviews. They were selected based on their understanding of the local dialect so that they could translate the questionnaires to the illiterate and semi-literate respondents who could not read and/or comprehend the English version of the questionnaire. Using local people to conduct the interview was to avoid compliance bias since respondents are likely to be more at ease to talk to people they can easily communicate with instead of strangers. Two days orientation was organized by the researcher for the interviewers. The first day was to explain the objective of the study and the survey instrument to them and offered them the chance to attempt translation into the local dialect so as to find out if they could translate to elicit the required response. They were also thought how to establish conducive rapport with the respondents so as to make them feel free to give genuine responses. After the first day of the training, each interviewer was given a copy of the instrument to take home for further study so as to raise any questions or concerns they might have in the second day of the orientation. They were however not told what was going to happen in the second day in order not to prejudice their minds. The second day of the orientation was divided into short sessions where each interviewer interviewed the other two in turns before finally interviewing the researcher. They researcher tried as much as



possible to play the devil's advocate by being difficult. This was to offer the researcher the opportunity to observe how they (interviewers) would conduct the interviews on the field. Finally the interviewers were asked to write a report on how they conducted the interviews with emphasis on any problems encountered. This was to offer the researchers the opportunity to know about the problems they might have faced on the field.

The survey instrument, questionnaire, was designed so that it could be used to collect both qualitative and quantitative data from respondents for analysis. The questionnaire used for the data collection contained

- Series of questions seeking information on the socio-economic and demographic characteristics of respondents such as income, sex, age, religion, educational level, occupation, marital status, and how they rank health insurance.
- Questions that determine how much the respondents were willing to pay for quality healthcare using national health insurance; and questions finding out whether respondents were willing to contribute more to National Health Insurance Scheme and how much they would be willing to pay as their annual premium. Copies of the survey instrument are attached as appendix.

3.2.2 Secondary Data

Several sources of secondary materials were consulted to gain an insight into the current practice, theories, definitions and conclusions of similar researches that were used to affirm or dismiss some of the assertions about Mutual Health Insurance Schemes. Specifically, secondary data was sourced from institutions that have conducted research on Mutual Health Insurance Scheme. Institutions such as: Ghana

Health Service (GHS), National Health Insurance Authority (NHIA), Community Partnership for Health and Development (CPHD), SEND-Ghana, DANIDA, other NGOs working on health and other research works from books, magazines, bulletins and newspapers.

3.2.3 Target Population

The population included all employed and unemployed adult residents (above 18 years) in the Tamale Metropolitan Area. Specifically, the population included the managers of the Tamale Metro. Mutual Health Insurance Scheme (TMMHIS), Health Providers, Insured and Non-insured residents in the metropolis.

3.2.4 Study Design

The research was both quantitative and qualitative involving combination of description and case study. It was a descriptive study because it aimed at providing background information on the payment of premiums and how they were matched with claims put in by the health providers. It was a case study because the research involved studying cases (existing inefficiencies) peculiar to the scheme as well as gave more in depth information and suggestions as to their elimination.

3.2.5 Sampling Procedure

Since it was not possible to interview each and every individual and all communities in the Metropolis on the topic of study, a sample procedure to select the sample that represents the population was adopted. In this regard, the following sampling methods were employed: Cluster sampling was used to obtain the respondents from each sub-district and social class. In terms of health insurance, people are categorized into six



(6) social classes based on whether they are formal or informal contributors. The six classes are: informal, Social Security and National Insurance Trust (SSNIT) contributors, SSNIT pensioners, Children under 18 years, Over 70 years and indigents. The informal sector contributors include people who are self-employed, farmers and other private sector contributors. Over 70 years are adults who have lived above seventy (70) years and Indigents are adults who are unemployed and receive no identifiable income and therefore unable to support themselves financially.

Due to unavailability of time and resources and the homogeneity of the target population it was agreed that 0.2% of the entire Tamale population be interviewed taking into consideration the population of each of the six sub-districts. Tables 3.1 & 3.2 show the estimated number of registered adults per category for each sub-district and the population and estimated number of respondents per category for each sub-district respectively.

Table 3.2: ESTIMATED NUMBER OF REGISTERED ADULTS PER CATEGORY FOR EACH SUB-DISTRICT

SOCIAL CLASS	NO. OF INSURED & UN-INSURED (ADULTS) FOR ENTIRE TAMALE DISTRICT	Proportion Per Category	Bilpeila	Choggu	Sagnerigu	Taha/Kamina	Tamale Central	Vitting
Informal	114,279	0.48	18,284	8,000	12,571	13,713	55,997	5,714
SSNIT contributors	36,045	0.15	5,767	2,523	3,965	4,325	17,662	1,802
SSNIT pensioners	5,386	0.02	862	377	592	646	2,639	269
Non-insured	54,148	0.23	8,664	3,790	5,956	6,498	26,533	2,707
Over 70 years	19,212	0.08	3,074	1,345	2,113	2,305	9,414	961
Indigents	9,079	0.04	1,453	636	999	1,089	4,449	454
Total	238,149	1.00	38,104	16,671	26,196	28,578	116,693	11,908

Source: field data, August, 2010.

Table 3.3: POPULATION AND ESTIMATED NUMBER OF RESPONDENTS PER CATEGORY FOR EACH SUB-DISTRICT

Sub-district	Total Population	Percent age per Sub-district	No of respondents to be interviewed	Informal	SSNIT contributors	SSNIT pensioners	Non-insured	Over 70 years	Indigents
Bilpeila	58,702	0.16	118	56	18	3	27	9	4
Choggu	25,683	0.07	51	25	8	1	12	4	2
Sagnerigu	40,358	0.11	81	39	12	2	18	7	3
Taha/Kamina	44,027	0.12	88	42	13	2	20	7	3
Tamale Central	179,777	0.49	360	173	55	8	82	29	14
Vitting	18,345	0.05	37	18	6	1	8	3	1
DISTRICT	366,892	1.00	735	353	111	17	167	59	28

Source: field data, August, 2010.

This decision was taken because the contributors within each social class had similar characteristics and it is hoped that this percentage would ensure a fair and



proportional representation of the respondents within each social class and sub-district.

In order to obtain membership data on adults for the various sub-districts, estimates for the sub-districts were statistically derived. The percentage per sub-district was first drawn from the population figures for Tamale district. This was used to estimate the number of registered members for each sub district per category by finding the product of the number of insured and non-insured adults for the entire Tamale District and the percentage population per sub-district. For example, since Bilpeila district occupies 16% of the entire Tamale District, to approximate the number of registered Informal adults in Bilpeila we multiplied the number of insured and non-insured adults for Tamale District by the percentage Bilpeila occupies.

$$\text{Estimated population of Bilpeila} = 238,149 \times 0.16 = 38,103.84 \approx 38,104$$

With a total population for each sub district known, the proportion of each category for the entire Tamale district is calculated for by dividing each social class category by the total number of insured and non-insured adults for the entire Tamale District population. (see Table 3.1). For instance

$$\text{SSNIT Contributors} = 36,045/238,149 = 0.15$$

$$\text{Over 70 yrs} = 19,212/238,149 = 0.08$$

The percentage per category is incorporated again to apportion the sample size of 735 for each sub district. i.e. Bilpeilla (118), Choggu (51), Sagnerigu (81) etc. In order to derive the sample size or the number of respondents for each category within a particular sub district we employed a simple calculation of multiplying each





proportion per category by the number of respondents for each sub district. This produces estimates for each sample size per category per sub-district. (See Table 3.2)

Purposive sampling was employed to select respondents from the TMMHIS office and the Care Taker Committee of the scheme. These comprised five (5) from the TMMHIS office [the Scheme Manager, Accountant, Claims Manager, PRO and MIS Managers], two (2) Care Taker Committee [the chairman and any other member], and ten (10) from the service providers. This technique was adopted because the study units from these categories were relevant to the study and may be omitted if probability - sampling method was used.

In all, the above sampling techniques gave a total sample size of seven hundred and fifty-two (752) for the study.

3.2.6 Data Collection

Data was obtained from both primary and secondary sources. The primary data was obtained mainly through administration of questionnaire and interview guides. The secondary data was obtained from, Metro. Assembly, Metro. Health Directorate, Tamale Metro. Mutual Health Insurance, library search and information from population and housing census reports.

3.2. 7 Data Analysis

Data was analyzed using both quantitative and qualitative methods. The former included descriptive and inferential statistics showing frequencies and percentages which were transformed into tables for easy understanding. Statistical Package for Social Sciences (SPSS) and Microsoft Excel programme were used to ascertain if any relationship existed between the variables employed in the study.

CHAPTER FOUR

4.0 DATA PRESENTATION, ANALYSIS AND DISCUSSIONS OF FINDINGS

4.1 Data Presentation and Analysis

4.1.1 *Background Characteristics of Respondents*

The background characteristics of respondents gave a reflection of the social structure of their society. It influences the attitudes, lifestyles and economic status of respondents. An insight into the background characteristics of respondents therefore would play a key role in appreciating the degree at which they would respond to changes in mutual health contributions or premium in the study area.

Some relevant background characteristics assessed included the gender of respondents, their age, and number of wives, household size, occupation, education, religion and ethnicity. Also household resources such as buildings, energy for lighting and cooking, availability and accessibility of health facilities, access to markets and the staple food of households.

4.1.2 *Gender*

From the study, 56.2% of respondents were females and 43.8% were male as shown in Table 4.1. This collaborates the findings of the Ghana Statistical Service (GSS 2002), and TMMHIS statistics of 2009 that females form over 54% of the membership and that they are the vulnerable sex and would do anything to have a safe health security. This is also because most of them are either single parents or mostly responsible for taking sick children to the health centers and would rather use their health insurance to cater for the children.





Table 4.1: Gender Status of Respondents

Sex	Sample Frequency	Percentage %
Male	322	43.8
Female	413	56.2
Total	735	100.0

Source: field Survey, August, 2010.

4.1.3 Age

The potential workforce of any nation is driven from its adult working population.

The major age range for respondents from the study was from 30-60 years, taking as much as 60.3% of the total respondents (Table 4.2).

Table 4.2: Age Distribution of Respondents.

Age (yrs)	Frequency	Percentage %
18-29	197	26.8
30-41	255	34.7
42-60	188	25.6
Above 60	95	12.9
Total	735	100.0

Source: field Survey, August, 2010.



4.1.4 Occupation

According to the study the predominant occupations are the civil/public servants, farmers and trade and commerce workers, pooling 34.3%, 23.3 and 14.1% respectively of the total number of respondents (Table 4.3). This is in sharp contrast to that of the Artisan, Drivers and Clergy which collectively pooled 7.9% of the total sample. Full-time students and unemployed respondents pooled 20.4%.

Table 4.3: Occupation of Respondents

Occupation	Frequency	Percentage (%)
Farmer	171	23.3
Trader	104	14.1
Driver	19	2.6
Artisan	21	2.9
Civil/public servant	252	34.3
Clergyman/woman	18	2.4
Full-time students	53	7.2
Unemployed	97	13.2
Total	735	100.0

S
ource: Field Survey, August, 2010.

4.1.5 Household Size

Households in Ghana are still traditional in spite of modernisation and erosion of the external family household composition. Traditionally, family sizes have been large, reflecting status and prestige as well as source of labour on farmlands. Large household sizes have been economic assets in a labour intensive subsistence economy like Ghana. But from the study, majority of households had a household size of four,

with a percentage of 23.3 for the study (Table 4.4). The distribution could be described as normal because respondents who were single registered 10.4% rose and peaked at four family in a household and descended to 15.7% for those with six members and above. The reduction in family sizes could be due to out-migration or because people are more informed on family planning.

Table 4.4: Household Size of Respondents

Household size	Frequency	Percentage (%)
1	76	10.4
2	129	17.6
3	146	19.9
4	171	23.3
5	97	13.1
6	87	11.8
7 and above	29	3.9
Total	735	100

Source: Field Survey, August, 2010.

4.1.6 Number of Spouses

Usually the structure, composition and size of households differ among various ethnic groups in Ghana. Polygamy is a common practice among rural households to help sustain traditional patterns of high fertility. However from the study, typical of an urban setting depicts 44.5% of households had one spouse, 12.7% had two spouses, 4.1% had three spouses and whiles only 1.7% had three spouses, 37.0% were single (Table 4.5). The high degree of monogamy could have caused the low household sizes observed earlier.



Table 4.5: Number of Spouses of Respondents

Number of wives	Frequency	Percentage %
NA*	272	37.0
1	327	44.5
2	93	12.7
3	31	4.1
4	12	1.7
Total	735	100.0

*Source: Field Survey, August, 2010. *-(respondents: unmarried, widowed)*

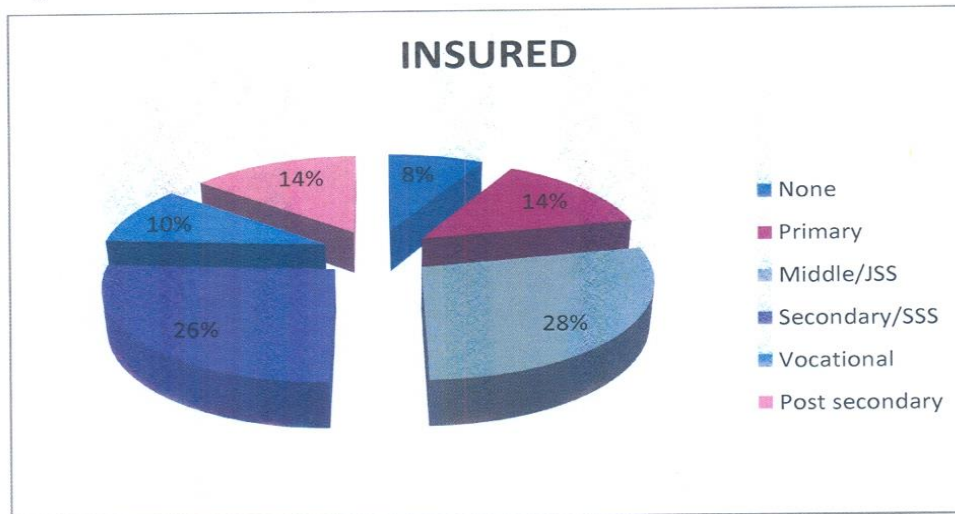
4.1. 7 Education

Investment in human resource development starts with education. Education does not only broaden one's perspective on global and national issues but also allows individuals to gain access to better opportunities and enhance understanding and appreciation of issues within their proper context. Having increasing proportions of inhabitants with higher education therefore will ensure informed decisions concerning their families and make meaningful contributions to issues relating to their health.



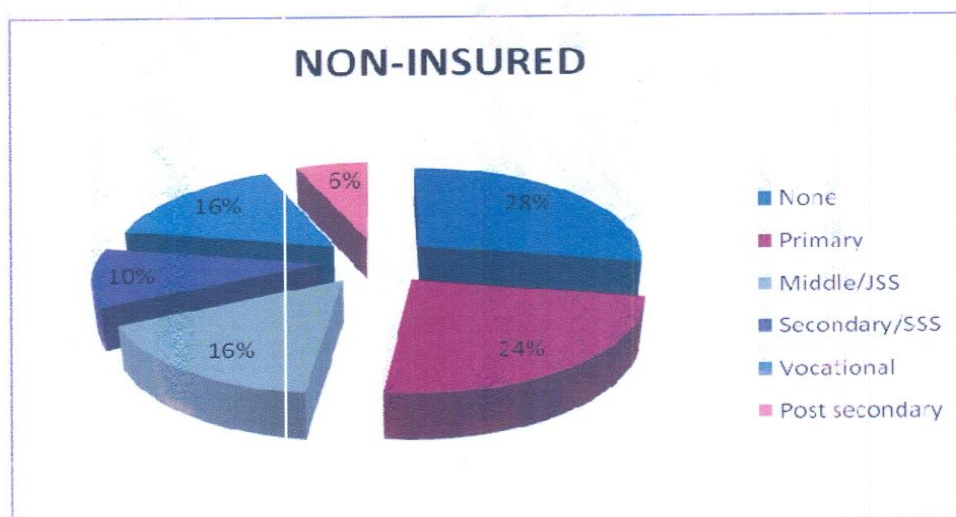
From Figures 4.1 and 4.2 below, whilst 4.1 depicts the exploded chart of the insured, 4.2 shows that of the un-insured. Approximately 64% of the insured have had some appreciable level of education for instance, Middle/JHS (28%), Vocational (10%) and Secondary/SHS (26%). Whilst about 42% of the un-insured had pre-tertiary education, thus, Middle/JHS (16%), Vocational (16%) and Secondary/SHS (10%). At the tertiary level whilst the insured pooled 14% the un-insured pooled only 6%. This comes to confirm that education has an influence in the way people appreciate policies and programmes like the NHIS.

Figure 4.1: Educational Background of Insured Respondents.



Source: Field Survey, August, 2010.

Figure 4.2: Educational Background of Un-insured Respondents



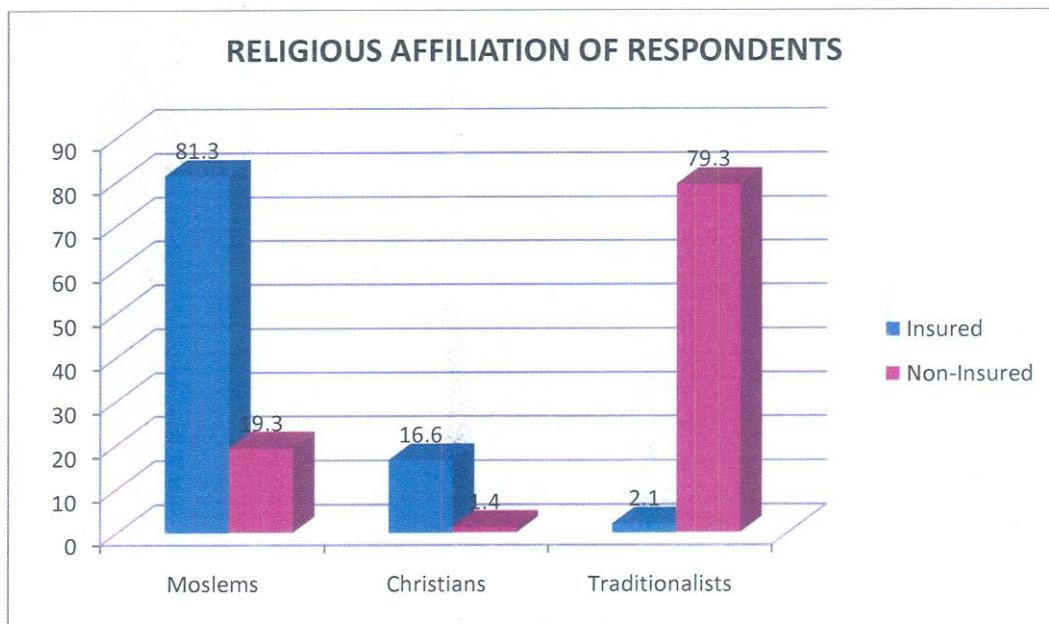
Source: Field Survey, August, 2010.

4.1.8 Religion

Religion is a very effective vehicle for change in attitude and behaviour because it shows people's beliefs, attitudes and general perspective of life. Respondents' attitude towards health insurance therefore could be influenced by their religious practices.

Religious assessment of the respondents show that majority were Moslems 81.3% of the insured, 16.6% were Christians and 2.1 % claimed to be either traditionalist or of no religious affiliation. The non-insured on the other hand had 19.3% as Moslems while 1.4% as Christians and 79.3% as either traditionalist or of no religious affiliation. This confirms the thinking that region is capable of influencing people's attitude, beliefs, behavior and general perception of life of which health is not an exception.

Figure 4.3: Religious Affiliation of Respondents



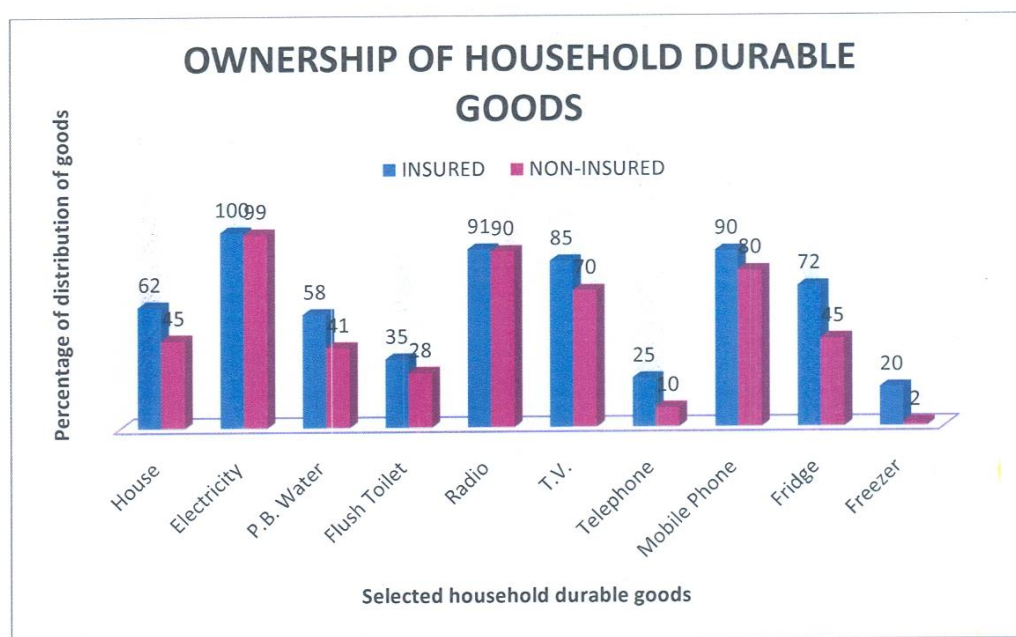
Source: Field Survey, August, 2010.

4.1.9 Ethnicity

Majority of the respondents were Dagombas, 87.4% for the insured and 78.8% for the non-insured. The Gonjas were the next in line with about 12% in both cases, with the rest for the Mamprusi, Asantes, Ewes, Hausas and the other tribes.

In assessing the respondents' ability to pay their premiums for that matter their economic situation, some selected popular household goods and assets were used to determine that. Figures 4.4 and 4.5 showed the differences between the ownership of these popular goods of the insured on one hand and the non-insured on the other.

Figure 4.4: Ownership of Household Durable Goods by Insured and Non-insured



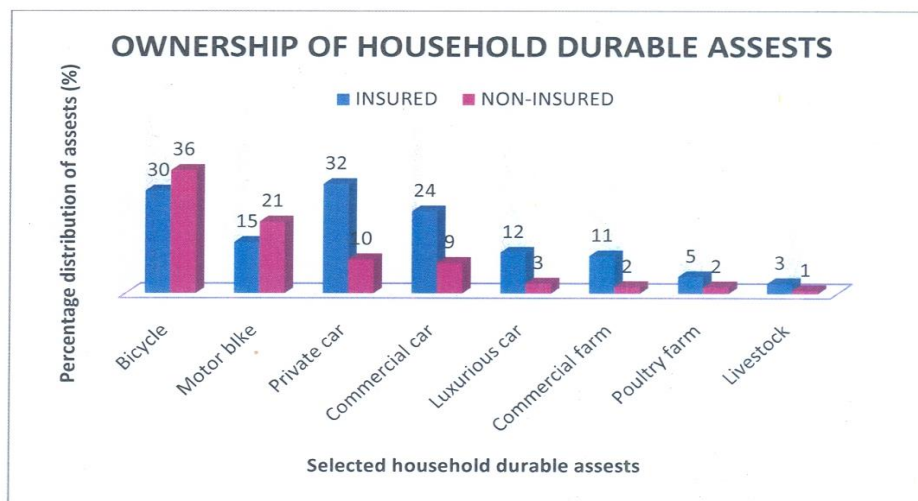
Source: Field Survey, August, 2010.

From Figure 4.4 above, it is evident that differences between ownership of these goods were not so prominent with the exception of ownership of houses, fridges and freezers which could be described as luxury to the non-insured at the time of the study. In the case of houses, 62% of the insured had houses of their own and the non-



insured pooled 45%. 72% of insured respondents as against 45% of non-insured for fridges, and 20% as against 2% for freezers, for the insured and the non-insured respectively. However, almost all the respondents had electricity in their homes. This showed that enrolment in the NHIS and for that matter access to affordable healthcare still remains pro-rich.

Figure 4.5: Ownership of Household Durable Assets by Insured and Non- insured.



Source: Field Survey, August, 2010.

The case is however different with the household durable assets where very prominent differences were registered between ownership by the insured and the non-insured. Ownership of assets such as private, commercial and luxurious cars revealed a great difference between the two variables: 32%, 24% and 12% respectively, in favour of the insured. However, the situation was different with assets such as bicycles and motorbikes where the non-insured registered ownership of more or higher percentage than their insured counterparts.



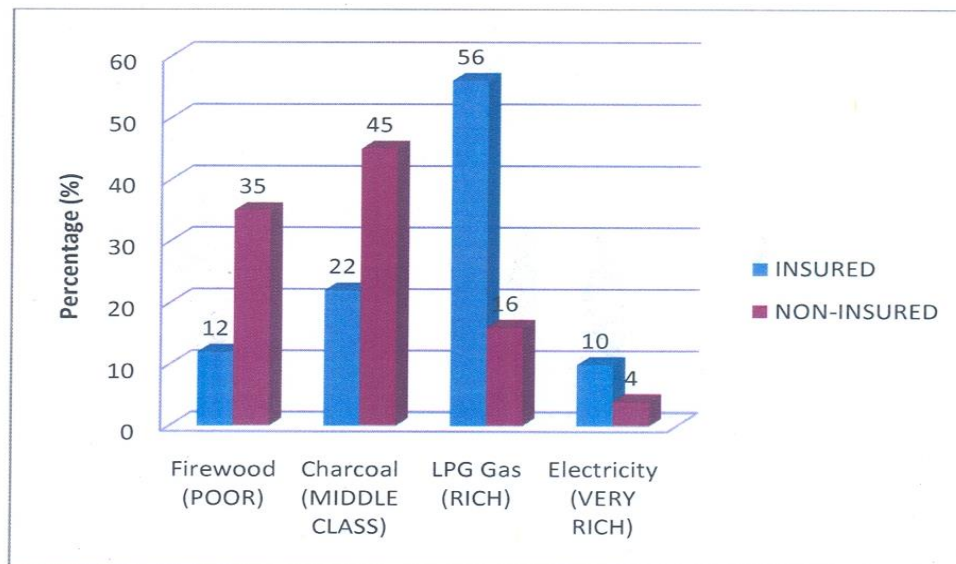


In all other durables, farms and livestock the normal trend of the insured dominating in percentage ownership prevailed. Accordingly, with a little caution it could be concluded that the insured are relatively well-off as compared to the non-insured perhaps, a substantiation of UNDP (1997), conclusion that, access to social assets is unevenly distributed, and poorer communities often lack basic social services that are more plentifully available in richer countries.

4.1.10 Energy for Cooking

The main source of energy for cooking and heating among households of respondents was also used to further assess household wealth. Both the insured and the non-insured were asked of the normal fuel used for cooking in their households. It is suggested that in most communities people are categorized or classified according to the type of fuel one normally uses. Firewood users are classified as being poor, charcoal users as middle class, LP Gas users as rich and electricity users as very rich.

Figure 4.6: Cooking Fuel as a Proxy for Wealth Assessment



Source: Field Survey, August, 2010.

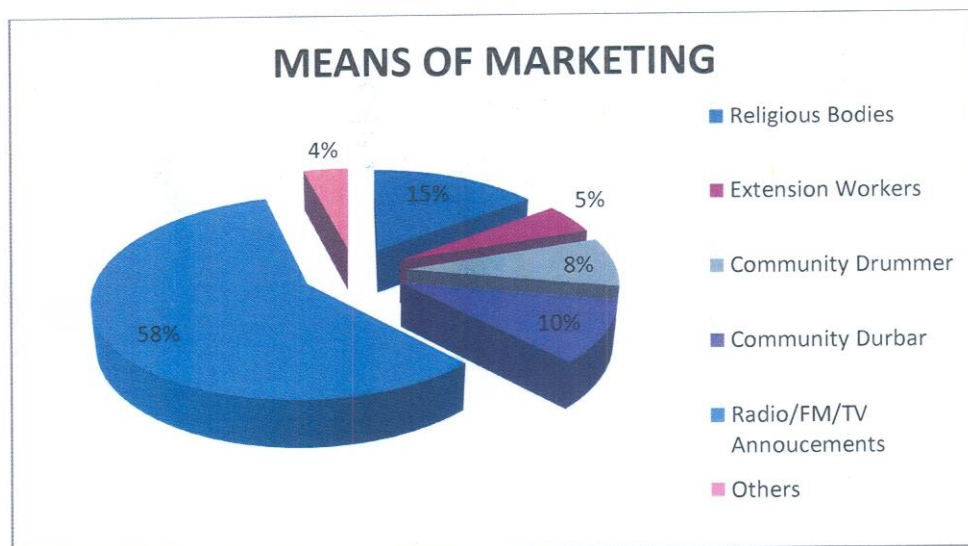


Figure 4.6 depicts that majority of the non-insured were either poor or belong to the middle class. This is evident of the fact that as high as 80% of the respondents either use charcoal or firewood as fuel for cooking. Conversely, only 34% of the insured belong to these two lower classes according to the study. The picture is somehow different considering the upper two social classes. This is because whilst 66% of the insured are found to be using either LPG gas (56%) or electricity (10%), only 20% of the non-insured use the two fuel sources for cooking. This shows that membership of the NHIS at present has a pro-rich bias. From figure 4.6, it is deduced that in relation to benefits, although membership of NHIS is supposed to be universal, in practice there are many barriers to joining (economic, geographic, organizational and cultural) and so membership remains partial and in some ways skewed against marginalized groups.

4.2 Proposed Effective Ways of Collecting Premium

In an attempt to deduce effective payment mechanisms to enhance payment of premiums by the informal sector, respondents were asked to rank different modes of disseminating the benefits of the scheme to the public. The respondents were of the view that Radio and TV announcements (58%) will be the most effective means. Religious bodies, in a form of churches and mosques visitations and engagement of members in one-on-one discussion came second with 15%, followed by use of community durbars (10%), community dramas (8%) and the involvement of extension health workers (5%) and others as shown in figure 4.7 below.

Figure 4. 7: Proposed Most Effective Means of Marketing the Scheme



Source: Field Survey, August, 2010.

4.2.1 Non-Insured Financial Access to Health Care

From the data available at the health facilities about 60% of the non-insured fell sick in 2008. It was evident that only about 2% were ill and visited the facilities once. All other fell ill and visited the facilities on two or more occasions Metro Health Directorate, Tamale (MHD, 2009).

Information from the Metro. Health Directorate, Tamale (MHD) indicates that the average health bill of the non-insured was soaring high comparatively through the previous years, both for OPD and IPD patients. It was evident that the highest cost was incurred in the drug stores/pharmacy shops followed by the hospitals. Further analysis of comparing these average health bills indicated that the non-insured spent more than 4 to 6 times the cost incurred at the facilities than the official premium collected by the scheme.

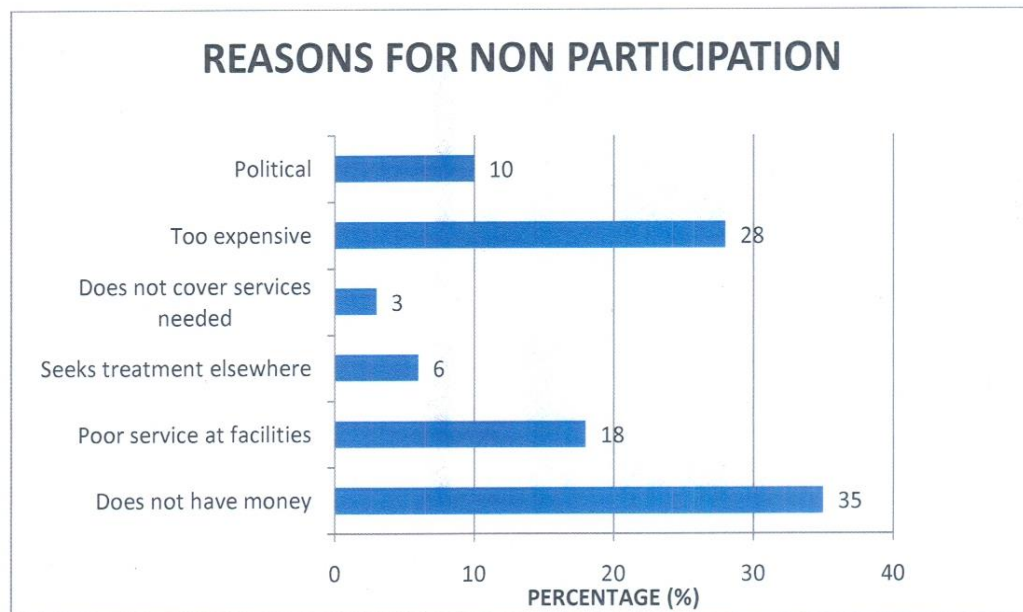




4.2.2 Main Reasons for Not Joining the Scheme

In the quest of the study to find out some of the reasons why a segment of the population is still not enrolled to the scheme and to enhance premium collection from the informal sector, the following reasons were given. The most predominant reason was that they do not have money (35%), followed by the claim that the premium was high for them (28%). About 6% of the non-insured sought treatment elsewhere due to religious beliefs and doctrines, whilst about 10% stated politics as the reason for not being enrolled. This is because the 10% saw the scheme as the brain child of their political opponent and thus saw no importance in joining it. 18% of the respondents assigned poor service rendering to the insured as their reason for not joining while 3% indicated that facilities do not cover services needed. Figure 4.8 below captures these views.

Figure 4.8: Non-insured Reasons for not Joining the Scheme



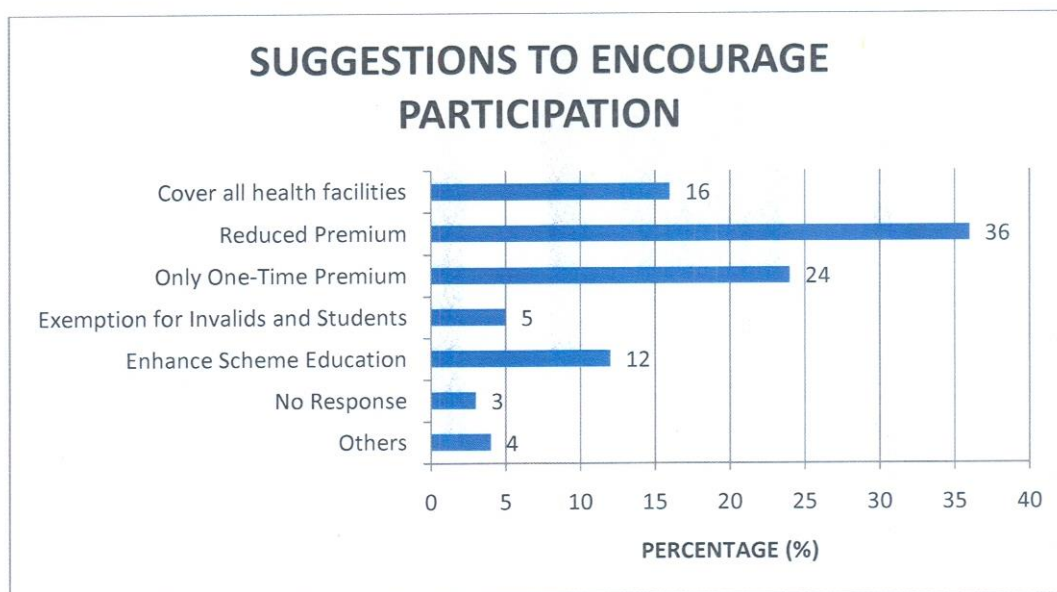
Source: Field Survey, August, 2010.



In an attempt to solicit the views of the non-insured as to how to encourage them to join the scheme they made the following suggestions:

It was an open secret that the non-insured wanted reduction in the premium (36%), desires a one-time payment of premium where a member would pay only once in his/her life time. They also suggested that all health facilities should be covered by the scheme (16%) whilst the Scheme's education should be enhanced (12%). About 7% also chose to either abstain or gave other suggestion such as the political connotation given to the scheme as depicted in Figure 4.9 below.

Figure 4.9: Suggested Ways to Encourage the Non-insured to Join



Source: Field Survey, August, 2010.

4.2.3 Balancing Premiums with Claims from the Health Facilities

In answering the research question "do the premiums collected commensurate the claims put in by the health facilities?" the total premium collected from 2005-2008

was taken and compared with the total cost of running the scheme for the same period to ascertain how sustainable the scheme is.

A perfunctory view of table 4.6 indicates that TMMHIS is running at a loss. Though, it is a mutual nonprofit making insurance scheme, it is important that its cost does not go far above its premium. This evidently indicates that there is some inefficiency that need to be addressed. Table 4.6 shows the raw figures for claims and administrative expenses of the scheme.

Table 4.6: Income and Cost of TMMHIS from 2005 to 2008 (GH¢)

Year	Premium	Claims	Administrative Cost	Total Cost
2005	165,437.85	90,611.1	10,067.9	100,679
2006	176,909.1	106,044.33	15,253.14	121,297.47
2007	445,705.37	582,113	51,449.46	(633,562.46)
2008	1,743,658	1,904,895.21	60,195.87	(1,965,091.08)
TOTAL	2,531,710.32	2,683,663.64	136,966.37	(2,820,630.01)

Source: TMMHIS, August, 2010.

From the above table, it is deduced that generally membership has been on the increase except from 2008 where a downward trend is noticed. Regarding NHIS, utilization correlates with increasing membership, however, whereas increasing utilization . could be an indicator of satisfaction with health care services, it has cost implication for schemes and perhaps overall financial sustainability. The fall out of

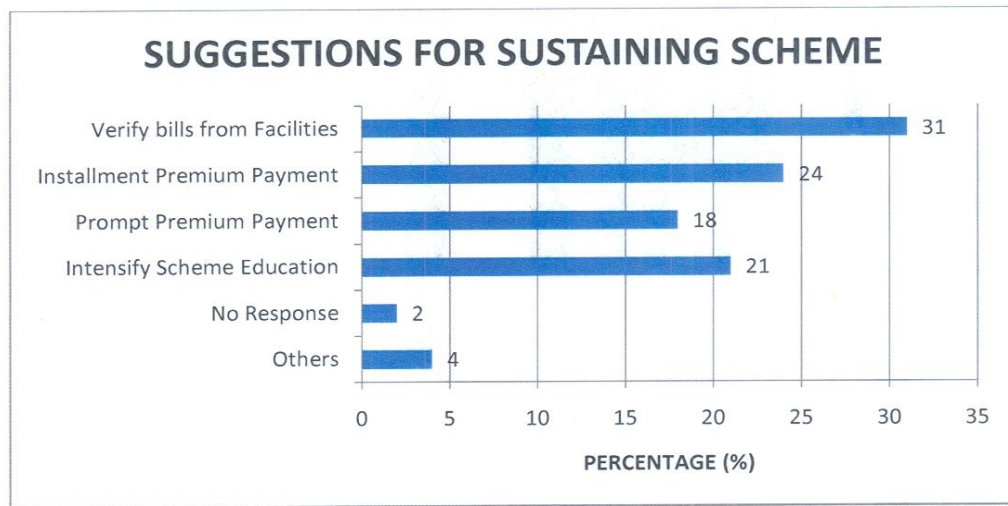




the above implies the scheme is not sustainable and that prudent measures like intensification of membership retention and practicing of graduated premiums charges should be employed to remedy the situation. While in 'normal' insurance system, increased membership brings increased income from premium, in the case of NHIS, the income is largely de-coupled. This means that the more successful the NHIS (in terms of coverage), the greater the risk of financial difficulties.

The imbalances in income and cost noticed in table 4.6 could also be attributed to the fact that drug costs are currently billed separately on top of the fixed DRG payment per episode and it is reported by the NHIA that the number of drugs per prescription have increased from 4.5 in 2004 to 6 now with some more expensive drugs being particularly favoured by some doctors (NHIA, 2010). In addition to the increase in members, there has been an increase in utilization of services by members which is the expected result of any reduction in financial barriers to care. While this is a positive development, it is also something to be monitored carefully, in terms of the implications for cash flows and ultimately sustainability. In this wise, insured respondents were asked to suggest ways of making the scheme sustainable, and the result is as depicted in figure 4.10 below.

Figure 4.10: Suggestions for the Sustainability of the Scheme by the Insured.



Source: Field Survey, *August, 2010*.



In the survey as much as 31 % suspected health facilities that they visit as inflating their bills of claims to the scheme. 21 % saw the need to intensify the scheme's educational drive through which members could be encouraged to make prompt payment (18%). Again, respondents suggested that management should encourage premium payment on installment basis (24%). About 2% however did not offer any response.



Case Studies:

Case One (1)

Hudu: Can you kindly introduce yourself and tell me your view about the National Health Insurance Scheme?

Answer: I am Victoria Yeledour, the former Claim Officer for Tamale Metro Mutual Health Insurance Scheme and currently a Monitoring and Evaluation Officer in charge of claims at the Regional Office of the National Health Insurance Authority, Northern Region, Tamale. I think National Health Insurance Scheme serves a lot of good. In the first place, for the first time in the history of Ghana, there is a body (NHIS) that can question the conduct of health workers. This body has the mandate to determine through accreditation of providers which providers should provide service to residents in Ghana. Before now, no one cared so quality was not assured. Infact, there was no value for money. Secondly, the scheme has improved financial accessibility to quality health care. This the scheme has done through the elimination of the financial barrier that was in place previously. However, most people still think the financial barrier is not completely eliminated because some people can still not afford the premium to register with the NHIS. But come to think of it, the NHIS registers very poor people (indigents) free of charge, it registers pregnant women, people who are seventy years and above and children who are below eighteen years free of charge so, what were these people expecting? Better still, the premium is graduated That is the richer you are the higher you pay.

Hudu: In your opinion, what are some of the challenges of the NHIS?

Answer: All what we need to do is to strictly enforce the provisions of the scheme. One thing the scheme has not adequately catered for is geographically accessibility.



My experience shows that even people with NHIS ID cards still spend so much on transportation to get to facilities to receive quality health service. ·

Hudu: *Taking the premium and the cost into consideration, do you think the scheme is sustainable?*

Answer: *I think with the current amount we pay as premium as compared to claims being submitted by facilities, the claims far out weights the premium and if nothing effective is done about it, the scheme is likely to face serious financial challenges.*

Hudu: *What is your recommendation to ensure sustainability?*

Answer: *I think apart from the fact that the premium needs increment for some category of people in such a way that the people in poorer communities pay less while their counterparts in richer communities pay more, the gate keeper system should be enforced. Even with the current premium, if the gate keeper system is enforced and managed well, schemes will be sustainable. I say this because it will reduce claims drastically. When I talk of gate keeper system, I mean clients educated well and encouraged to as much as possible to visit appropriate primary health care units as their first point of call. And this can be by all stakeholders. So all in all, in my opinion, if all players in the implementation process play their parts well, the scheme will be sustainable. That is, if providers desist from submitting fraudulent claims and all systems working effectively in the scheme, the scheme will not find itself in financial crises.*

Field Survey, August, 2010.

Case two (2)

Hudu: Can you kindly introduce yourself and tell me your view about the National Health Insurance Scheme?

Answer: Ehhh! What is it about? Are you sure I will not be heard on radio? These days you may not know what can put you into trouble because people read politics into everything. Anyway, that was just by the way, My name is Patience Kpabia, the proprietor of Multipavum Pharmacy. I was among the first set of providers who embraced health insurance. In fact, health insurance in my opinion is the best thing that ever happened to health delivery system in Ghana but if it is not managed well, it may fail. In one way or the other, the scheme is keeping us on our toes because every provider providing service to health insurance clients is aware that if they do not do the right thing their claims may either be rejected completely or huge sums of money deducted from their claims. In fact, sometimes the deductions they make from our claims is so huge that it can contribute to collapsing shops. But for me it is alright because the right things be done. Looking round, all pharmacy shops are putting their places in good shape and form so as to remain accredited One good thing the scheme has done for me is that the shelf life of medicines has considerably reduced and payment for medicines dispensed assured Though payment delays but we are sure that no matter what, it would be done.

Hudu: Taking the premium and the cost into consideration, do you think the scheme is sustainable?

Answer: I think something should be done about the premium if not the scheme may suffer in future. Secondly, the politicization of the scheme is discouraging both providers from providing service and potential clients from enrolling onto the scheme.



Thirdly, the prices of medicines in the medicines list should be reviewed upward if not, it demotivates providers from serving medicines to policy holders or better still, it creates room for some providers to serve drugs yet take the balance in price from clients and for me, this does not help the scheme. For instance, assuming a drug is GH¢15.00 in the market and the health insurance list quotes that same drug at GH¢10.25, whenever a client comes with a prescription containing that drug, a provider may be tempted to serve the client with the drug yet take a cash of GH¢4. 7 5 being the difference between market price and the health insurance price from him/her.

Hudu: *What is your recommendation to ensure sustainability?*

Answer: I think the scheme should improve their communication with providers. That is if they vet claims and finds any discrepancies, they should first of all communicate to us to give us room to respond Most of the Claims Officers are not clinicians so its not everything about medicines that they will understand hence I expect them to always seek explanation for some of the things they come across during vetting instead of just slapping the deductions on us. This behavior is too unilateral and some providers feel indicted when this happens. I even know two pharmacy shops that have stop serving health insurance client because of the low prices of medicines in the health insurance medicines list and the no listening behavior of the managers. So for me these are some of the things you need to work on to make the scheme sustainable.

Field Survey, August, 2010.

From the above case, it is clear some service providers actually embraced the NHIS at its inception. The case further portrays the NHIS serves as a check to the providers and this goes further to ensure quality. However, the providers are not happy with

some of the policies and practices of the NHIS as shown in the above case yet no forum is given them to air their views on issues that affect them rather a vacuum is created and every player in the scheme lives in an island of his/her own and do whatever pleases them. This is a serious threat to the financial sustainability of the NHIS and something be done to improved communication and collaborated between stakeholders.



CHAPTER FIVE

5.0 SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary

It is evident that the TMMHIS has a number of health providers made up of drug stores, pharmacies, clinics, health posts and hospitals. Among these the prominent ones are the Teaching Hospital (referral facility), Regional Hospital, the West End Hospital and SDA Hospital. Undeniably the scheme has played a significant role in mobilizing financial resources for these providers as well as improving financial access of its members to quality healthcare. Currently, the system of payment to the providers, Ghana Diagnostic Related Grouping (G-DRG) is burdening to the scheme whilst most favourable to the providers due to its in-built incentives.

The views of the insured and the non-insured (community) are very important for the development and sustainability of the scheme. The analysis showed that both are comparable in many social characteristics, which is, household size, age, education, number of spouses, religion, ethnicity and occupation. It was established that on the basis of household wealth assessment, the insured are relatively well-off compared to the non-insured. Invariably, the two groups have almost the same socio-economic characteristics.

Whilst the inability of the non-insured was attributed to not having money (35%) and the premium being high (28%), the insured joined the scheme with the view of sharing health-related risks in a way to improving access to health care. Other concerns of the non-insured were that services provided by the health facilities were of low quality and political reasons (10%) for not patronizing the scheme. According to the statistics the non-insured forms about 19.2% of the population of the





Metropolis, that leaves an overwhelming 80.8% insured persons who saw the current premium as meaningful whether agreeably or otherwise (since most of them are compulsory contributors bounded by the laws of the land).

Both the insured and the non-insured agreed that the scheme should enhance its educational drive through radio and TV announcements, community dramas and durbars. About 24% of the non-insured suggested one-time life premium payment and the inclusion of more or all health facilities in the scheme's coverage. The insured suggested the encouragement for prompt payment of premiums either in full or on installment basis. Both groups by implication accepted that TMMHIS has made health care provision in Tamale Metropolis easy and accessible. It is evident according to the study that the average health bill of the non-insured is relatively higher than that of the insured. In all cases it is suggested that the scheme should endeavour to increase its coverage to capture the non-insured.

Finally, the study revealed that the operational cost and the claims together outweigh the premium inflows and this situation is not healthy enough for the sustenance of the scheme.

5.2 Conclusion

As explained by Ndiaye (2006), Mutual health insurance is a system driven by such principles as democratic governance, autonomy and freedom, personal development, not-for-profit approach, solidarity, equity, cross subsidization and responsible management. By sharing health-related risks, the system improves access to health care for beneficiaries who contribute to it. Members pay a contribution which entitles them to a package of services at partner health facilities. So is the case of the Tamale



Metro. Mutual Health Insurance Scheme (TMMHIS), which renders such services to its members in the Tamale Metropolitan area.

It is important that the scheme is preserved and sustained to continue to rescue people from the obnoxious threats and adverse effects of both 'user fee' and the 'cash-and-carry systems of previous years. It is statistically evident that health insurance is a better and reliable alternative of financing health since it spreads the risk of incurring health care costs over a group of subscribers, (Aikins, 2005).

For effective and realistic collection and payment of premium, enhanced education through Radio/TV announcements and effective collaboration with the religious bodies in activities such as one-on-one talks, dramas and durbars would go a long way to help capture the non-insured, help all to appreciate the need to make prompt premium payment in order to sustain the scheme, management should accept and encourage payment of premium on installment basis so that non salary workers and the perceived poor would be in the position to joining the scheme and honour their financial obligations without any recognizable burden.

Matching the premiums collected with cost (claims and operational cost) indicates that the financial sustainability of schemes appear weak, reinforcing growing and heavy dependency on re-insurance from NHIA. Thus as a matter of urgency, the operational cost of the scheme should be reviewed drastically in order to help sustain the scheme.

To address the inefficiencies it is important to control utilization, practice effective gate keeper system, consider the feasibility of introducing co-payment, introduce and practice monitoring and control mechanisms for claims and fraud management, intensify membership retention and practice graduated premium charges. It is



reiterated that an electronic configuration of the whole system would help minimize fraud if not eliminating it. As already stated the medicines list currently being used be reviewed regularly.

To conclude, TMMHIS is promoted as a solution to many health system problems. Like other MHOs, TMMHIS can provide additional avenues of resource mobilization and financial protection against devastating health-care expenditures, increase financial access to care, promote equity through risk-pooling as well as strengthen community solidarity and demand for quality care. At a minimum, MHOs should contribute to increased use of effective and needed health services and serve as a proxy for improved health (PHRplus, 2004).

5.3 Recommendations

Since, it is important for the scheme to have an absolute coverage over the area of jurisdiction; it is recommended that Radio/TV announcements and effective collaboration with the religious bodies in activities such as one-on-one talks, dramas and durbars would go a long way to help capture the non-insured.

Equally, the district assemblies should be used to disseminate information on the National Health Insurance Scheme.

In addition, it is recommended that the Scheme accepts and encourages installment payment of premium so that non salary workers and the perceived poor would be in the position to join the scheme and honour their financial obligations without any decipherable burden.

To address the concerns of the respondents, it is important that services provided by health facilities be put under thorough clinical audit to ensure value for money and



prevent cheating by some selfish individuals on the scheme. Better still; an electronic configuration of the whole system would help to minimize fraud if not eliminating it.

Further, it is recommended that medicines' list presently used be reviewed periodically to reflect the essential medicines' list and current market prices in order to avoid discrepancies in the accounting systems.

It is also recommended that the operational cost of the scheme be reduced drastically in order to help sustain the scheme. Operational cost, such as fuel, utilities, repairs, allowances, maintenance, publicity and education, printing and stationery should be consciously managed to reduce the financial obligation on the scheme.

The periodic subsidy from the central fund (NHIA) should be increased and made regular to help alleviate the continuous indebtedness of the scheme to its health providers.

To address the inefficiencies, it is recommended that systems be put in place to control utilization through the practice effective gate keeper system and also consider the feasibility of introducing co-payment.

Finally, it is recommended that issues relating to health should not be politicized and positions to the National Health Insurance Scheme should be based on merit and not political affiliation.



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APPENDIX 'A'

UNIVERSITY FOR DEVELOPMENT STUDIES

FACULTY OF PLANNING

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a) Scheme Questionnaire

1) Region:..... 2) District:.....

2) Full name of Scheme:.....

Annual premium and enrolment statistics from 2005-2009

b) Annual Premiums:

Year	Registration	Renewals	New Premium
2005			
2006			
2007			
2008			
2009			

c) Annual enrolment:

Year	Informal sector	SSNIT contributors	SSNIT pensioners	Under 18	Over 70	Indigent
2005						
2006						
2007						
2008						
2009						

d) Provide information on the scheme's staff in the table below:

Name	Position	Gross salary	No. of years worked
1			
2			
3			
4			

e) Other operational cost

2005 items/activities	Amount (GH¢)
Community mobilization	
Office rentals	
Staff accommodation	
Electricity	
Stationery	
Others	



f) External support for the scheme.

Other sources of income for the scheme apart from the premiums of the members.

Name of individual/organization or activity	Amount realized (GH¢)	Year

g) Benefit package

Please list the benefit and the type of premium of scheme.

Benefit package	Type of premium paid (GH¢)

Has your benefit package changed over the period from 2005 to 2009?

Yes ☐ No ☐

If Yes, what did you add or remove from the benefit package?

Additions:

a.

b.

Removals:

a.

b.

Utilization of the scheme (2005-2009)

Category

2005	No. of policy holders who benefited
Informal sector	
SSNIT contributors	
SSNIT pensioners	
Under 18	
Over 70	
Indigent	

Category

2006	No. of policy holders who benefited
Informal sector	
SSNIT contributors	
SSNIT pensioners	
Under 18	
Over 70	
Indigent	

UDS LIBRARY



Category

2007	No. of policy holders who benefited
Informal sector	
SSNIT contributors	
SSNIT pensioners	
Under 18	
Over 70	
Indigent	

Category

2008	No. of policy holders who benefited
Informal sector	
SSNIT contributors	
SSNIT pensioners	
Under 18	
Over 70	
Indigent	

Category

2009	No. of policy holders who benefited
Informal sector	
SSNIT contributors	
SSNIT pensioners	
Under 18	
Over 70	
Indigent	

Please provide information on the total amount paid on behalf of members per year:

Year	Amount (GH¢)
2005	
2006	
2007	
2008	
2009	

Do you experience frequent use of the scheme as a form of abuse by some members?

☐

Yes

☐

No

If Yes, what do you think should be done to stop this frequent use?

.....

.....

.....

Issues of Subsidies

Does your scheme have any reserved set aside? ☐ Yes ☐ No

For what purpose is this money being used?

- a.
- b.
- c.



If No, what would you do when the scheme run bankrupt?

- a.
- b.
- c.

Providers' payment system

What mode of payment do you use to settle health bills with your health providers?

- a) daily vetting and payment
- b) weekly and payment
- c) monthly vetting and payment
- d) others (specify).....

How do you assess the payment arrangements you have with the health provider(s)?

- a) Excellent
- b) Very Good
- c) Good
- d) Satisfactory
- e) Poor
- f) Others specify:

Effectiveness of the Scheme

What are the benefits of having this health insurance?

- a. Easy financial access/affordability of health care.....
- b. Improved utilization of modern health care.....



- c. Improved revenue to health facilities.....
- d. Unity among community members.....
- e. Other (specify).....

Sustainability

How do you rate the financial stability of your scheme?

- a. Very stable
- b. Stable
- c. Unstable
- d. Very unstable

If Unstable or Very unstable, please state the problem(s)

- i.
- ii.
- iii.

What are the two (2) most effective mobilization strategies that the scheme uses to mobilize resources and membership?

Resource

- a.
- b.
- c.





Members

- a.
- b.

What is the scheme's most effective education campaign?

.....

What do you consider as the 2 key strength of your scheme?

- a.
- b.

What do you consider as the 2 key weaknesses of your scheme?

- a.
- b.

Recommendations

Please provide 2 main recommendations on the following areas. That will help improve your scheme.

Mobilization of new members and retention of old members:

- a.
- b.

Financial management of the scheme.

- a.
- b.

Scheme viability and sustainability

- a.
- b.

Any other comment

- i.
- ii.
- iii.

Thank you



APPENDIX 'B'

UNIVERSITY FOR DEVELOPMENT STUDIES

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HEALTH PROVIDERS QUESTIONNAIRE

GENERAL:

1. Name of health provider

2. What sort of arrangement or agreement do you have with the TMMHIS?

- a) Memoranda of Understanding.....
- b) Signed agreement/Contract.....
- c) Unsigned agreement.....
- d) Others (specify).....

3. How long have you been servicing the scheme?

From

a)

2005.....2006.....2007.....2008.....2009.....



4. Who manages the affairs of the scheme in this facility?

- a) Administrator.....
- b) Accountant/Accounts officer.....
- c) Others (specify)

Payment system

5. What mode of payment does the scheme use to settle your bills?

- a. Daily vetting and Payment
- b. Weekly vetting and payment
- c. Monthly vetting and payment
- d. Others (specify).....

6. How do you assess this payment arrangement that you have with the scheme?

- a. Excellent
- b. Very Good
- c. Good
- d. Satisfactory
- e. Poor
- f. Others (specify)

7. If the answer to question 6 is POOR or OTHER, please provide what the problems are:

.....

.....

SUSTAINABILITY:

8. In your opinion, do you think the scheme is sustainable? Yes ☐ No ☐



If yes, what makes the scheme sustainable?

- a.
- b.

If No, what makes the scheme unsustainable?

- a.
- b.

List what you consider as the 2 main problems facing the scheme.

- a.
- b.

Health provider's Internally Generated Fund (IGF)

What is your total annual IGF from 2005-2009?

Year	Total IGF
2005	
2006	
2007	
2008	
2009	

What are the total Out-patient visits and In-patients for 2005-2008

Year	OPD	IPD
2005		
2006		
2007		
2008		
2009		

Effect of the scheme

What has been the positive influence of the scheme to your operations?

- a)
- b)
- c)

What has been the negative influence of the scheme operations?

- a.
- b.
- c.



Recommendations

What 2 main recommendations will you give for the improvement of the scheme's operations?

a.

b.

Any other comments?

i.

ii.

iii.

Thank you



APPENDIX 'C'

UNIVERSITY FOR DEVELOPMENT STUDIES

FACULTY OF PLANNING

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INSURED QUESTIONNAIRE

SECTION A. STUDY CHARACTERISTICS

1. Community:..... 2.District.....
3. Questionnaire No..... 4.Date:.....

SECTION B. Household and Respondents Characteristics

5. Sex: ☐ Male ☐ Female ☐
6. Age:
7. Educational level
8. Marital status:.....
9. Religion:.....
10. Ethnicity:.....



11. Main occupation:.....

12. Average monthly income.....

SECTION C. 9. Household wealth (Please tick where applicable)

House		Television	
Electricity		Telephone	
Pipe borne water		Mobile phone	
Flush toilet		Fridge	
Radio		freezer	

10a. Household wealth – durable assets

Bicycle		Luxurious car	
Motorbike		Commercial farm	
Private car		Poultry farm	
Commercial car		Livestock	

10b. What type of fuel do you use in cooking at home?.....

SECTION D. Membership with TMMHIS

11. For how long have you been a member of the scheme?.....years

12. Have you or any member of your household benefited by way of using the scheme?

(1) Yes ☐ (2) No ☐

13. If Yes, which years?

2005 ☐ 2006 ☐ 2007 ☐ 2008 ☐



14. In your opinion which group(s) of people in the community should be exempted from paying premiums, yet continue to enjoy the scheme's benefits?.....

15. In your opinion which group(s) should be made to pay only part of the premium and yet enjoy the full benefits of the scheme?.....

16. What is your main reason?

.....

.....

.....

.....

17. Which method of dissemination do you consider most effective for marketing health insurance in the metropolis?

- a. Radio/FM/TV announcements
- b. Religious bodies
- c. Community durbars
- d. Community dramas
- e. Others (Specify).....

SECTION E. Access to health care

18. How many times did you or any member of your household fall sick and sought health care last year (2009)?.....

19. Did you or any member of your household use the scheme last year (2009)?

20. If yes, did you or the member(s) of your household experience any problem when you went to the health providers(s)?

(1) Yes ☐ (2) No ☐

21. If yes to question 20, what was the problem(s)?

i.

ii.

iii.

22. Which of the health provider(s) of the scheme health facilities do you usually use?

.....

.....

23. Give reason(s) why you prefer that facility to others.

i.

ii.

iii.

SECTION F. Community perception

24. How would you rate the services of the TMMHIS?.....

1. Excellent

2. Very good

3. Good

4. Fair





5. Poor

6. Very poor

25. Give reason(s) for your answer

i.

ii.

iii.

26. Do you think TMMHIS has made health care better?

Yes ☐ No ☐

27. If yes, give reasons for your answer

i.

ii.

iii.

28. If No give reasons for your answer

i.

ii.

iii.



29. What do you think of the premium fee paid by new subscribers of the scheme?.....

- a. Very Low
- b. Low
- c. Very high
- d. High
- e. Others specify

30. What in your opinion should be the appropriate mode of premium payment to the scheme?

- 1. Onetime payment
- 2. Installment
- 3. Full payment at once
- 4. Other (specify).....

31. Give reasons for your answer in question 30

- i.
- ii.
- iii.

SECTION G. Community mobilization strategies

32. Do you have any suggestions on how to make the scheme sustainable?

- i.
- ii.
- iii.

APPENDIX 'D'

UNIVERSITY FOR DEVELOPMENT STUDIES

FACULTY OF PLANNING

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NON-INSURED QUESTIONNAIRE

SECTION A. STUDY CHARACTERISTICS

- 1) Community: 2) District:.....
3) Questionnaire No..... 4) Date:

SECTION B. Household and Respondents Characteristics

5) Sex: ☐ Male ☐ Female

6) Age:

7) Educational level:.....

8) Marital status:.....

9) Religion:.....

10) Ethnicity:.....

11) Main occupation:.....

12) Average monthly income.....



SECTION C. 9. Household wealth (Please tick where applicable)

House		Television	
Electricity		Telephone	
Pipe borne water		Mobile phone	
Flush toilet		Fridge	
Radio		freezer	

10a Household wealth – durable assets

Bicycle		Luxurious car	
Motorbike		Commercial farm	
Private car		Poultry farm	
Commercial car		Livestock	

10b. What type of fuel do you use in cooking at

home?.....

SECTION D. NON-MEMBERSHIP WITH TMMHIS

11. Have you heard of Tamale Mutual Health Insurance Scheme (TMMHIS)?

Yes ☐ No ☐

12. Are you a registered member? Yes ☐ No ☐

12. What would you say is your main reason for NOT joining the TMMHIS?

- a. Too expensive
- b. Political
- c. Does not have money
- d. Poor services at the facilities
- e. Seeks treatment elsewhere



f. Does not cover services needed

g. Others specify:

13. Which method(s) of dissemination do you consider most effective for marketing health insurance in the metropolis?

a. Radio/FM/TV announcements

b. Religious bodies

c. Community durbars

d. Community dramas

e. Others

(specify).....

SECTION E. Access to health care

14. How many times did you or any member of your household fall sick last year (2009)?.....

15. Where do you normally go for health care when you fall sick?

a) Tamale Teaching Hospital

b) Central Hospital

c) West Hospital

d) SDA Hospital

e) Clinics

f) Others specify:



16. What was the average health care cost when you last visited a health facility?

.....

17. Cost incurred

.....

18. Name of facility where this cost was

incurred.....

SECTION F. Community perception

19. Do you think TMMHIS has made health care better? Yes ☐ No ☐

20. If yes, give your reasons

i.

ii.

iii.

21. If No, give your reasons

i.

ii.

iii.



SECTION G. Community mobilization strategies

22. In your opinion what should the scheme do to encourage people to join?

i.

ii.

iii.

23. Any other comments

i.

ii.

iii.

Thank you

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