UNIVERSITY FOR DEVELOPMENT STUDIES

PROSPECTS AND CHALLENGES OF THE NATIONAL HEALTH INSURANCE SCHEME IN TOLON DISTRICT OF GHANA

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BY

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DECLARATIONS

I Aniah Elizabeth hereby declare without any reservation whatsoever that this dissertation is my own research work, conducted under the supervision of Dr. Shamsu-Deen Ziblim. I also declare that this dissertation has not been presented in part or in full to any other institution for examination. I remain solely responsible for any discrepancies observed in this work.

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Supervisor's Declaration

I Dr.Shamsu-Deen Ziblim hereby declare that the preparation and presentation of the dissertation was supervised in accordance with the guide line on supervision of dissertation laid down by University for Development Studies (UDS)

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ABSTRACT

The National Health Insurance Scheme (NHIS) provides affordable health care services for the residents of Ghana, of which Tolon District is not an exception although the system is faced with challenges of untimely securing of drugs and poor attention to patients. The NHIS was introduced in 2005 to replace the "cash and carry'' system which made the health system very difficult to access in Ghana especially in the Tolon District. The study examined the challenges and prospects of the NHIS in the Tolon District. The study relied on both primary and secondary sources of data through desk studies. Primary data was obtained through interview schedule and interview guide. The study revealed that about 83 percent of the study respondents are subscribers to the scheme whilst 70 percent claim they have their family members also registered to the scheme. The study identified challenges such as inadequate medical doctors, inadequate drugs provision, poor state of hospital facilities, inability of the scheme to cater for certain basic drugs among others were pertinent in impeding the success of the scheme in the Tolon District. The study therefore recommended among others things that management should be vigilant and expose any provider who would try to defraud the scheme, create a national consultative forum to dialogue to cover increased of chronic diseases and supply of their drugs and educate the people of Tolon on the consequences of seeking medical treatment from multiple health posts. Finally, government should increase budget allocation for health infrastructural development to absorb the pressure from the increasing health centre attendance due to the introduction of the NHIS. Also, there should be timely release of funds by government to pay service providers to enable them keep the scheme sustainable.

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LIST OF ACRONYMS

CBHIS	Community-Based Health Insurance Schemes
CHPS	Community Health Planning Services
CPC	Claims Processing Centre
CTM	Common Targeting Mechanism
DMHIS	District Mutual Health Insurance Schemes
FR	First Republic
GDRGs	Ghana Diagnostic Related Groupings
GLICO	Gemini Life Insurance Company
GMHIS	Goldfields Mutual Health Insurance Scheme
GMI	Ghana's Ministry of Health
GSS	Ghana Statistical Service
ID	Identity Card
LEAP	Livelihood Empowerment Against Poverty
LI	Legislative Instrument
MDGs	Millennium Development Goals
MHIS	Metcare Health Insurance Scheme
MHO	Mutual Health Organizations
MIC	Metropolitan Insurance Company
MIS	Middle-Income Status
MOH	Ministry Of Health
NHI	National Health Insurance

NHIA	The National Health Insurance Authority
NHIL	National Health Insurance Levy
NHIR	National Health Insurance Regulations
NHISA	National Health Insurance Scheme Act
NHS	National Health Service
PCHIS	Private Commercial Health Insurance Schemes
PI	Provident Insurance
PMHIS	Private Mutual Health Insurance Schemes
PNDC	Provisional National Defense Council
SHI	Social Health Insurance
SSNIT	Social Security and National Insurance Trust
SW	Social Welfare
UHC	Universal Health Coverage
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Health care financing continues to top the list of debatable social issues around the world. Many developing countries especially, keep on exploring different ways of financing their health systems. This is due to the fact that their health systems are chronically under-funded. User fees were initially introduced at the point of service delivery in some of these countries in order to generate revenue for the running of their health systems. In some contexts, the introduction of user fees led to improvement in the quality of health care services. However, evidence suggests that user fees constitute a strong barrier to the utilization of health care services, as well as preventing adherence to long term treatment among poor and vulnerable groups. These problems led to yet another debate to look for other alternatives of health care financing (Dalinjong and Laar, 2012).

Prepayment and risk pooling through Social Health Insurance (SHI) and taxation are found to provide protection against some of the undesirable effects of user fees. The international community is therefore paying more attention to SHI as one of the promising financing mechanisms for providing coverage to populations against high health care service costs. SHI is seen as helping to pool health risks, prevent health related impoverishment and improvement in efficiency and quality of health care services. It also provides access to health care services for the poor and helps mobilize revenue for providers. Nonetheless, the implementation of SHI programmes are challenged in terms of high administrative cost, lack of managerial skills, problems of cost containment and ensuring national

coverage. Due to these, there are still few examples of SHI schemes operating at large scale in developing countries (Dalinjong and Laar, 2012).

The National Health Insurance Authority (NHIA) was established in Ghana under the National Health Insurance Act (Act 650) in 2003. In October 2012, a new law, Act 852 replaced Act 650 to consolidate the NHIS, remove administrative bottlenecks, introduce transparency, reduce opportunities for corruption and gaming of the system, and make for more effective governance of the scheme (NHIA, 2012).

Ghana is among the few African countries that promulgated a National Health Insurance (NHI) Law (Act 650) in 2003. Hitherto, the country had been providing free health care services for her citizens after independence in 1957. This was possible due to the small population size (about 8 million) at the time and a flourishing economy. However, the free health care services could not be sustained because of the economic crisis in the 1970s and early 1980s which adversely affected all sectors of the economy leading to budget cuts on social spending including health and education. Thus, little money was available for the health sector and this led to widespread shortages of essential medicines, supplies and equipment which adversely affected the quality of care in public health facilities (Dalinjong and Laar, 2012).

To forestall these problems, cost recovery or user fees, popularly called “cash and carry” was introduced in the late 1980s in all government facilities. Patients were made to pay for the full cost of medication and care. The argument for the user fees was to generate revenue and to discourage frivolous use of health care services. However, the user fees policy affected the utilization of health care services by Ghanaians. The poor especially, were undertaking self-medication and also reporting

late to health facilities for treatment. This prompted the need to look for other alternatives of health care financing, which led to the introduction of some Community-based Health Insurance Schemes (CBHIS) in the early 1990s. As at 2003, such CBHIS covered only about 1 percent of the country's population (19 million), leaving many Ghanaians uncovered against high health care service costs (Dalinjong and Laar, 2012).

In order to promote universal coverage and equity health care, the government of Ghana adopted the National Health Insurance Scheme (NHIS) in 2003, which was fully implemented in 2005. The NHIS aimed to assure equitable and universal access for all residents of Ghana to an acceptable quality package of essential health care services without payment being required at the point of use. The ultimate goal of the NHIS was the provision of universal health insurance coverage for all Ghanaians, irrespective of their socio-economic background. The NHIS is based on District Mutual Health Insurance Schemes (DMHIS), which operates in all districts of the country. The NHIS covers both the formal and informal sectors of the economy (Adinkra, 2014). According to McIntyre *et* al. (2003) the implementation of the NHIS draws experience from the operations of the CBHIS. As at June 2009, about 67 percent of the Ghanaian population had subscribed to the NHIS. (Adinkra, 2014).

According to Jehu-Appiah *et* al. (2011) he NHIS is financed through the following means: a national health insurance levy of 2.5 percent on certain good and services, 2.5 percent monthly payroll deduction being part of the contribution to the Social Security and National Insurance Trust (SSNIT) for formal sector workers, government budgetary allocation and donor funding. They further stated that the formal sector workers (SSNIT) still have to pay a registration fee to a DMHIS to be able to access health care services. While the informal sector members pay a yearly premium to the NHIS.

However, the core poor, pregnant women, pensioners, people above the age of 70 and those below 18 years are exempted from premium payment. There is no other cost sharing or co-payments with the NHIS, except the premium paid.

According to Dalinjong and Laar (2012) the benefit package of the NHIS consists of 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. About 95 percent of the diseases in Ghana are covered under the NHIS. However, some services classified to be unnecessary or very expensive are on the exclusion list. Among these are; cosmetic surgery, drugs not listed on the NHIS drugs list (including antiretroviral drugs), assisted reproduction, organ transplantation, and private inpatient accommodation (Dalinjong and Laar, 2012)

Fee for service type of provider payment mechanism was used for paying health care providers initially. But this was replaced with the Ghana Diagnostic Related Groupings (GDRGs) in April, 2008. The reason for the replacement was that the fee for each service was found to be low and hence unattractive, especially for the private providers to participate. Health care providers are advised to participate in the provision of health care through NHIS, in order to reduce congestions and delays for clients when they seek health care services (Dalinjong and Laar, 2012).

With the fee for service, providers were also required to submit detailed information on all services and charges for claims submissions. This involves a lot of paperwork which providers were not happy with. Hence the GDRGs were introduced to help remedy some of these issues. The tariff covers the full cost of the estimated direct consumables for direct patient care, anaesthesia and other investigations. The GDRGs also captures about 80 percent of the estimated overhead cost for public

health facilities, comprising of building and equipment maintenance, housekeeping and utilities (Dalinjong and Laar, 2012).

It is expected that the new tariff would generate adequate revenue from the NHIS for providers to cover a significant portion of their cost of operation. Since 2012, the NHIS has been experimenting with capitation in the Ashanti Region of Ghana, to test its feasibility for scaling up, alongside the GDRGs (NHIA, 2012; Dalinjong and Laar, 2012).

Since the inception of the NHIS, many studies have been carried out on the willingness and acceptability of the NHIS, the determinants of enrolment into the NHIS, and the health seeking behaviour of insured clients (Dalinjong and Laar, 2012). For instance, a study by Asenso-Okyere *et al*. (2009), found more than 90 percent of the respondents agreeing to enrol in the NHIS and about 63.6 percent willing to pay a monthly premium of $3.03. On determinants of enrolment into the NHIS, it was also reported by Jehu-Appiah et. al. (2011) that individuals from poorer households were less likely to enrol compared with those from rich households. However, there is limited knowledge on the influence of the NHIS on the behaviour of health care providers. Health care providers form an important segment of health care delivery. Their (providers) behaviour plays a significant role in determining whether the goals of a health system can be achieved (Dalinjong and Laar, 2012).

1.2 Problem statement

The efficiency and sustainability of the NHIS depend on the tripartite stakeholders (the scheme, service providers and subscribers). The scheme is expected to ensure quick and timely disbursement

of funds to the providers. On the part of the service providers, they must ensure quality service delivery to subscribers while the latter is expected to facilitate payment of premiums where appropriate.

The responsibilities of the scheme and the service providers are spelt out succinctly in Section 37(7) of the National Health Insurance Regulations, 2004 (L.I 1809) as follows: "A claim for payment of health care services rendered under a scheme licensed under this Act shall be filed within sixty calendar days from the date of the discharge of the patient or rendering of the service .On the other hand, section 38 (1) of the L.I 1809 states "A claim for payment of health care service rendered which is submitted to the scheme shall, unless there is any legal impediment, be paid by the scheme within four weeks after receipt of the claim from the health care facility. It has been observed that, whilst health care facilities do honour section 37 (7) of L.1 1809, the scheme has not been able to comply with section 38(1) of the L.1 1809. This raises concerns about the efficiency of the scheme. Therefore, sometimes claims submitted by the health care providers hit a snag (AG, 2012).

If the scheme owes some providers, the obvious and unanswered question is whether the scheme is sustainable enough to serve the needs of subscribers. It is against this backdrop, this study, therefore, sought to examine the challenges and prospects that confront the scheme from the perspective of service providers and subscribers in the Tolon District of Northern Ghana.

1.3 Main Objective

The research seeks to examine the challenges and prospects of the National Health Insurance Scheme in the Tolon District.

1.3.1 Specific Objectives

1. To examine the challenges involved in accessing the National Health Insurance Scheme in the Tolon District
2. To assess the prospects of the National Health Insurance Scheme in the Tolon District of Northern Region
3. To explore the implications of the National Health Insurance Scheme for continuous affordable health care access for the people.

1.4 Research Questions

1. What are the challenges confronting clients in accessing the National Health Insurance scheme in the Tolon District?
2. What are the prospects of the National Health Insurance scheme in the Tolon District?
3. What are the implications of the National Health Insurance Scheme in the context of the continuous affordable health care access for the people?

1.5 Significance of the Study

1. The empirical data of the study will be useful to policy makers who may require information on prospects and challenges of the National Health Insurance Scheme in Ghana. The study may also provide a sense of direction for donors and non-governmental organizations who may cooperate with the health sector towards achieving the health objective of the Millennium Development Goals (MDGs)
2. Hospitals and clinics in the Tolon District may use the findings of this research to improve and expand their health care activities.
3. The study may identify challenges hindering the operation of the scheme and chart appropriate mechanism to ensure a sustainable health care delivery in the Tolon District
4. The findings of the study would contribute some information to the existing body of data on health care delivery and the National Health Insurance Scheme and provide a sense of direction for the improvement of the scheme in government's attempt to run the scheme satisfactorily.

1.6 Organization of the Dissertation

This study was divided into five chapters. Chapter One consisted of the introduction and general background of the dissertation. Chapter Two comprised of literature review with particular relevance to the topic and the study area such as textbooks, journals, newsletters and maps. Chapter Three presented the methodology used in the data collection such as population size, sample frame and sample size and study area.

Chapter Four analysed and discussed the data collected from the field in relation to the National Health Insurance Scheme and how the scheme is alleviating financial constrains associated with access to health care delivery in the Tolon District. The last of the five chapters composed of summary, conclusion and recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter reviewed literature in the area of health care financing with particular reference to social health insurance by other researchers and scholars. It includes the history of health insurance policy and the current state of the National Health Insurance Scheme in Ghana. To this end, published and unpublished literatures were reviewed, lapses in some theories and concepts were identified and acknowledgement made.

2.1 The Health Insurance Policy: A View from Broader Context

Two major types of health insurance could be identified worldwide based on source of funding; these are private health insurance and public health insurance. In the private health insurance context, Saltman and Dubois (2004) defined the scheme as a mechanism for people to make financial contributions to protect themselves from potentially extreme financial costs of medical care if they

become severely ill and ensure that they have access to health care when they need it. Purely private enterprise health care systems are comparatively rare and where they exist, it is usually for a comparatively well-off sub population in a poor country with a poorer standard of health care for instance, private clinics for a small, wealthy expatriate population in an otherwise poor country.

On the other hand, public health insurance social security health care model is where workers and their families are insured by the State. There are two types of public health insurance. These are publicly funded health insurance scheme, where the residents of the country are insured by the State and social health insurance, where the whole population or most of the population are members of a sickness insurance company (Kashner *et al.*, 1998). The World Health Organisation defines social health insurance as "a financial protection mechanism, for health care through health risk sharing and fund pooling for a larger group of population."

The publicly funded health insurance is financed through taxation. When taxation is the primary means of financing health care, everyone receives the same level of coverage regardless of their ability to pay, their level of taxation, or risk factors. Most developed countries currently have partially or fully publicly funded health systems. Examples are United Kingdom's National Health Service (NHS), or the Medicare systems in Canada and in Australia (Kashner *et al*., 1998). Social health insurance (SHI) is financed through a government mandated social insurance programme based on the collection of funds contributed by individuals, employers, and sometimes government subsidies (Saltman and Dubois, 2004).

Social security health care model may exist under the social health insurance. This is when workers and their families are insured by the State. SHI systems are characterized by the presence of sickness

funds which usually receive a proportional contribution of their members' wages. With these insurance contributions, these funds are used to pay medical costs of their members to the extent that the services are included in the sometimes nationally defined benefit package. Affiliation to such funds is usually based on professional, geographic, religious/political and/or non-partisan criteria (Saltman and Dubois, 2004). Usually, there are user fees for several health care services to inhibit usage and to keep social health insurance affordable.

Otto von Bismarck has been credited as the first to make social health insurance mandatory on a national scale in Germany in 1889, but social health insurance was already common for many centuries in Europe (Wikipedia.com, 2015). Countries with SHI systems include Austria, Belgium, Germany, France, and Luxembourg. Generally, their per capita health expenditures are higher than in tax-based systems. The nature of health care financing systems varies widely across developed countries. With the exception of the United States and South Africa, all of the developed countries have implemented some kind of national health insurance system; that is, they have established programmes to ensure that the majority of their citizens have access to health care services with minimal cost sharing (Baker, 2011).

Some countries such as Germany and France require employers to offer and employees to purchase a health insurance plan with payroll taxes as the major source of funding for this. In other countries such as Canada, general tax revenues supply the major source of funding for their health insurance systems (WHO, 2008). Again in Canada health insurance scheme is administered by each province under the Canada Health Act which requires all people to have free access to basic health services.

Collectively, the public provincial health insurance systems in Canada are frequently referred to as Medicare. Private health insurance is allowed but the provincial governments allow it only for services that the public health plans do not cover; for example, semi-private or private rooms in hospitals and prescription drug plans. Canadians are free to use private insurance for elective medical services such as laser vision correction surgery, cosmetic surgery, and other non-basic medical procedures (Baker, 2011).

Still, the UK's National Health Service (NHS) is a publicly funded health care system that provides coverage to everyone normally resident in the UK. It is not strictly insurance system because first, there are no premiums collected, second, costs are not charged at the patient level and third, costs are not pre-paid from a pool. However, it does achieve the main aim of insurance which is to spread financial risk arising from ill-health. Private health care has continued to operate parallel to the NHS, paid for largely by private insurance but it is used by less than 8 percent of the population, and generally as a top up to NHS services (Xu *et al*., 2003).

The NHS provides the majority of health care in the UK including primary care, in-patient care, long-term health care, ophthalmology and dentistry. Recently the private sector has been increasingly used to increase NHS capacity despite a large proportion of the British public opposing such involvement. According to the WHO (2008), government funding covered 86 percent of overall health care expenditures in the UK as of 2004 with private expenditures covering the remaining 14 percent.

Generally, Huber *et al.* (2002) proposed models through which health insurance system could cover the poor and the rich. According to them, participatory model and the provider-driven or technocratic models are pertinent in health insurance administration. Participatory model is where communities organize themselves to establish a health insurance system. In a process of participatory bottom-up planning, priorities are defined and important decisions such as determining the benefit package are taken by the communities. The beneficiaries own and manage the system themselves and therefore are the financial risk bearers. A contract is signed between each individual and all the others. They collect the premiums to cover the types of care previously defined and provided by facilities contracted. The insurer and the care provider negotiate the terms of care. Schemes that are functioning properly may play a strong role in defending the interests of households they represent. They can negotiate for better quality such as better availability of essential drugs, or improved provider behaviour (Huber *et al*., 2002).

Another useful category is the provider-managed which are often initiated by a hospital that is concerned about securing a stable source of revenue in a context where many patients cannot pay the bills. The health care provider is the insurer and manager of the scheme and is therefore the financial risk bearer. No intermediary structure exists between the payer of the fund and the health care provider. Priorities like defining the benefit package are usually set in a process of top-down planning. The community plays only a negligible part in the process. In some examples, a genuine concern to raise people's access to care can be the driving factor. Some disadvantages of these models are that the community often perceives this technocratic top-down management approach unfavourable. Also, the non-involvement of the community may lead to a suspicious and distrustful clientele that is likely to show all features of moral hazard behaviour (Hubert *et al.,* 2002). Furthermore the little contact

with and knowledge of the grassroots membership does not allow for necessary adjustments like taking consumer interests more into account.

2.2 History of Health Financing in Ghana: Past Experience and Economic Implications

Over the years, the history of Ghana's health financing has undergone many changes (Owusu, 2010). Before Ghana gained independence, health financing was done mainly through out-of-pocket payments by patients. Under the leadership of its first president after independence, health care in public health facilities were financed entirely by the Ghana Health Service with revenue coming from the national coffers (GHS, 2009; Arhinful, 2003). Nguyen *et al.* (2011) reported that this practice of tax-based health financing system where payment for health services in the public sector was done by the government was a common practice among many pro-colonial African countries at that time.

Frimpong (2013) stated that this system allowed Ghanaians to seek medical care in any government health institution for free, be it a hospital, clinic, health centre or pharmacy. The advantage of this system was that it was progressive such that high income individuals paid higher taxes than low income people. It also provided service for everybody without any costs, so it protected the poor people from financial shocks. It did not involve user charges at point of service although private health facilities at that time charged user fees. The disadvantages were however very clear in that low quality medical services were provided and it was biased towards the urban populace and neglected the rural poor (Gobah and Liang 2010; Agyepong and Adjei, 2008).

Agyepong and Adjei (2008) reported that in the early 1970, tax revenue in Ghana coupled with a dwindling economy could no longer support a tax-based health financing system and this led to the introduction of payment of minimal out-of-pocket fees in the public health sector in 1972. The stagnation and eventual decline in economic growth affected the health sector so much that there was a decline in the quality of health care delivery in public health facilities. There were also widespread shortages of essential medicines, supplies and equipment.

In 1983, with an economy which was literally on the verge of bankruptcy, Ghana, the once shining star of Africa had no choice but to accede to the demands from the International Monitoring Fund (IMF) and the World Bank for market reforms which led to the introduction of a structural adjustment programme in that same year. The programme was about shifting the structure of incentives in the economy away from non-tradeable to tradeables. Central to this was the goal of getting prices right by withdrawing subsidies, liberalising the domestic and external trade regime, and pursuing a more appropriate exchange rate policy for example, currency devaluation (Asenso-Okyere *et. al.,* 1998; Agyepong, 1999).

The structural adjustment programme was very much concerned about balancing budgets and servicing both domestic and external public debt. To do this, there were budget cuts on social spending with education and health bearing the heaviest brunt. Slowly but surely, the government was forced to raise public sector user fees for health care significantly adjustment policies and this public user fee became popularly known as “Cash and Carry” or “Pay As-You-Go” in 1985 (Asenso-Okyere *et al.*, 1998; Agyepong and Adjei, 2008; Frimpong, 2013).

This system was a product of the structural adjustment programme which the IMF and the World Bank had prescribed and which, Ghana readily adopted. It involved the wholesale withdrawal of government subsidies on health delivery. Under the cash-and carry system, patients were asked to pay for full cost of medication and care. Due to economic crises and mismanagement, the government had to reduce spending on health and social affairs. Less money was available for health. The government was not able to finance the health system via general taxation (Mensah *et al*., 2010).

According to Agyepong and Adjei (2008), the purpose of the cash and carry was for government to recover at least 15 percent of recurrent expenditure for quality health care improvements. The Ministry of Health in its report in 2001, stated that this purpose was achieved which saw an improvement in the supply and availability of essential medicines. However, the cash and carry had its own shortfalls.

Osei-Akoto (2004) reiterates that there was the presumption that cost recovery would help reduce unnecessary visits by patients who would abuse the system because it was free. Evidence gathered thus far suggests that none of the above assumptions materialized. Since its introduction, cash-and carry appeared to have carried away health services from the people. The cash-and-carry system could best be described as stinking and dehumanizing because, patients who did not have the ability to pay for medical services were turned away from hospitals only to die at home. The disabled, poor and accident victims were being asked to pay on the spot before getting medical attention.

Also, the cash and carry system resulted in low-income earners postponing attendance to hospitals for treatment whenever they fall ill. Self-medication became popular whilst others also desperately resorted to traditional and faith healers although their services were not regulated by law (Arhinful-Tenkorang, 2001).

Adomah-Yeboah (2005) also pointed out that the Cash and Carry was a system which had no human face. There is empirical evidence that shows that with the introduction of user fees there was a decrease in service utilization especially among the poor who were domiciled in the rural areas. There isn't any strong evidence that significant amount of money were generated by the introduction of user fees which helped in improving health facilities. To make matters worse, cost recovery was introduced at a time when many people had been laid off from the public sector and income levels were extremely low. Many poor people were turned away from health centres for lack of funds.

Unfortunately, the poor were simply priced out of hospital care and a two-tier health care system came into operation with better facilities for those who could afford to pay. Once again, women and children bore the brunt of such harsh policies. The introduction of user fees further impoverished the majority of Ghanaians and it devastated their ability to sustain a livelihood for a long time. Some people especially the poor living below the poverty line had to borrow money, took out loans, sold their animals or furniture, dissolved their little savings, cut down on buying food and even stopped sending their children to school in order to pay for health care. The process of borrowing money from the extended family or neighbourhood delayed treatment and in many cases, caused deterioration of

the illness or even death. In other cases, people did not seek medical treatment because they could not afford it which often increased their morbidity and mortality (Adomah-Yeboah, 2005).

According to Agyepong (1999), the government is at liberty to intervene when there is a market failure therefore it was heart-warming when in 2004, the government rekindled the need for social equity to be a key part of health-care policy. The author further recommended that Ghana should strategize to attain the Millennium Development Goals and Middle-Income Status by 2015. The main goals of the health ministry should therefore be in three folds namely: increasing public access to health care, improving the quality and efficiency of health care delivery and lastly, improving and increasing programs of education on curative and preventive health care.

2.3 Health Insurance in Ghana; brief historical context

The Nkoranza Health Insurance Scheme is believed to be the first community health insurance (CHI) scheme in Ghana. It was started by the St. Theresa's Catholic Mission Hospital in 1992. It was very successful and stood the test of time (Agyepong and Adjei, 2008; Atim and Madjiguene, 2000).

In 1990, a unit was created in the Ministry of Health by government purposely to oversee the establishment of a national health insurance as an alternative to the cash and carry system. However, after nine years of consultancy and feasibilities studies carried out by the unit, the proposed pilot of the scheme which was supposed to take-off in the Eastern Region with organised groups such as cocoa farmers never materialised. No reasons or explanations were given for the failure.

However, research have shown that issues such as lack of leadership, direction, consensus on the part of the Ministry of Health and the failure to appreciate the challenges of implementing a centralised social health insurance scheme in a developing country like Ghana are partly to be blamed (Agyepong and Adjei, 2008; Arhinful, 2003; Atim *et al.*, 2001). Similarly, the Social Security and National Insurance Scheme (SSNIT) also made some efforts towards the establishment of another centralized health insurance scheme purported to be managed by an institution called Ghana Health Care Company however, this also never materialised although public expenditure was made on feasibility studies, personnel and software.

Arhin (1995) also indicated that another feasibility study was carried out in 1993 in the Dangme West District. The study was funded by UNICEF with strong backing from the Ministry of Health. The purpose was for the establishment of a community health insurance for the non-formal sector. The outcome of the study was very promising therefore a pilot district – wide community health insurance was planned. The Ministry of Health was tasked to finance the designing of the scheme whilst the European Union would finance the monitoring and evaluation.

However, following the retirement of the Director of Medical Services of Ministry of Health, the ministry lost interest in the project hence the financial support for the scheme design ended abruptly. The EU, after the initial instalments of their grant decided not to renew the agreement for financial support for the scheme. In spite of these setbacks, the district assembly and the communities in the district managed to complete the designing of the scheme. Funds from organisations such as United Nations Development Plan (UNDP), Danish International Development Assistance (DANIDA), and the World Health Organisation (WHO) were used to kick-start the scheme. Registration of

beneficiaries began in October 2000. Financial support to sustain the scheme was provided by the Ghana Health Service and the Ministry of Health (Agyepong and Adjei, 2008; DWHIS, 2003:2002).

After the success in implementation of the community health insurance in the Dangme West District, many other CHI schemes known as Mutual Health Organisations (MHO) sprung up. Most of these CHI schemes were sponsored by faith-based institutions with foreign development partners such as DANIDA and United State Agency for International Development (USAID). The district health directors and assemblies also offered their support to the development of these MHO's (Agyepong and Adjei, 2008).

2.4 The National Health Insurance Scheme (NHIS)

In 2003, the National Health Insurance Scheme bill (Act 650) was passed into law by the parliament of Ghana and in 2004 the scheme was established. Owusu (2010) stated that the passing of the bill into law by parliament provided the platform for the establishment of mutual health insurance schemes at the district level in Ghana. The aim of the scheme was to remove cost as a barrier to health care delivery at the point of need.

The NHIS was introduced to liberate Ghanaians especially the indigents from the burden of the cash and carry system. Boni (2011) also added that the NHIS was specifically designed to provide affordable health care to the poor and vulnerable in society with adults required to contribute minimal annual payment as compared to the amount charged for the service provided them by health intuitions.

Apart from providing Ghanaians with a much improved humane financial arrangement to enable the poor access health care service without out-of-pocket payments at the point of service delivery, the scheme was also to ensure the improvement in the quality of health care delivery for all Ghanaians (Owusu-Sekyere and Chiaraah, 2014).

In 2005, the scheme registered about 1.3 million active members representing about 6 percent of the entire population. By the end of 2013, active membership stood at about 10.2 million representing 38 percent of Ghana's current population (NHIA, 2013). Today, the NHIS has grown to become a major instrument for financing health care delivery in Ghana. The scheme accounts for over 85 percent of the revenue base of public and quasi-public health facilities. The scheme is also credited with improvements in the health-seeking behaviour of many people in the country (Mensah *et al*., 2010).

2.4.1 Funding of the National Health Insurance Scheme

The NHIS is basically financed from the National Health Insurance Fund (NHIF). The National Health Insurance Levy (NHIL) of 2.5 percent tax on selected goods and services goes to the NHIF. Formal sector workers contribute 2.5 percent of each person's 18.5 percent contributions to the Social Security and National Insurance Trust (SSNIT) to NHIF. Government budget allocations and premiums from informal sector workers are the other fund generating sources towards the running of the scheme. Other funding sources include funds allocated to the scheme by parliament, returns on the investments made by the National Health Insurance Council (NHIC), grants, donations, gifts and voluntary contributions made to the NHIF (NHIA, 2013).

The NHIF is required to expend its funds through the following means;

1. Pay for the health care costs of members of the National Health Insurance Scheme.
2. Pay for approved administrative expenses in relation to the running of the National Health Insurance Scheme.
3. Facilitate the provision of or access to health care services and
4. Invest in any other facilitating programmes to promote access to health services as may be determined by the Minister of Health in consultation with the Board of NHIA.

The National Health Insurance Authority (NHIA) reported that by 31st December, 2013, the Authority earned a total revenue of GH¢904.30 million and incurred total expenditure of GH¢1,001.10 million resulting in a net operating deficit of GH¢96.80 million. The NHIA added that claims cost for the period was GH¢785.64 million, representing 78.48 percent of the total expenditure.

2.5 Management of the National Health Insurance Scheme by the NHIA

The National Health Insurance Authority is mandated by law to secure the implementation of the NHIS. The NHIA is also responsible for the registration, licensing and regulation of health insurance schemes in the country. It is also required to grant credentials to health care providers and monitor their performance for efficient and quality service delivery. The NHIA also manages the NHIF and devise mechanisms to ensure that indigents are adequately catered for under the NHIS (NHIA, 2013).

The governing body of the NHIA is a board consisting of a Chairperson, the Chief Executive and other members drawn from various stakeholder organisations. The board is appointed by the President of Ghana. The responsibility of the board is to ensure proper and effective performance of the

functions of the Authority. The management executive is made up of the Chief Executive and the deputies. There are other technical directors and deputy directors in various departments. Management of the NHIS is decentralised to the regional and district levels to ensure accountability and transparency (NHIA, 2013).

2.6 Operations of the National Health Insurance Scheme

2.6.1 Membership Management

According to the NHIA (2013), the total active membership for the scheme increased from 8, 885,757 in 2012 to 10,145,196 in 2013 (Table 2.1). As at December 2013, 38 percent of Ghana's population were active subscribers to the NHIS. There was a significant increase in the number of renewals done in 2013 as compared to the previous year.

Table 2.1: Comparison of new registration and renewal by NHIS subscribers across the country

Year	New	Renewal	Total	Percent of National Population
2012	3,249,667	5,636,090	8,885,757	35
2013	3,444,570	6,700,626	10,145,195	38
Change	6 %	19 %	14 %	3

Source: NHIA, 2013.

On regional basis, Ashanti Region recorded the highest number (Table 2.2) of active members in 2013 whilst the Upper West Region registered the least. Northern Region recorded a significant

number (391,728) of new subscribers to the scheme in 2013 with 488, 789 card-bearers renewing their membership to the scheme.

Table 2.2: Regional representation of active membership of the NHIS as at 2013

Region	New	Renewal	Active Membership	Percent of Total
Ashanti	472,903	1,242,485	1,715,388	17
Brong Ahafo	405, 088	984,752	1, 353,840	13
Central	382,595	484, 341	866, 936	9
Eastern	337,097	773,024	1,110,121	11
Greater Accra	565, 281	714,976	1,280,257	13
Northern	391,728	488,789	880,517	9
Upper East	166,538	476,740	643,278	6
Upper West	99,620	322,797	422,417	4
Volta	326,243	584,326	910,569	9
Western	297, 477	664,396	961,873	9
Total	**3,444,570**	**6,700,626**	**10,145,196**	**100**

Source: NHIA, 2013.

2.6.2 Categories of National Health Insurance Scheme Subscribers

According to the NHIA (2013), new categories of membership have been added to the previous membership categories. The security services have been included, namely; the Ghana police, the military and other security organisations (Table 2.3). The largest percentage of active NHIS members are children under 18 years and this is followed by workers in the informal sector.

Table 2.1: Categories of membership of NHIS as at December 2013 in Ghana

Category	Percent contribution
SSNIT Contributors	3.6
SSNIT Pensioners	0.2
Informal Sector	33.6
Below 18 years	46.5
Indigents	12.1
Military	0.2
Security Services	0.003
Police Service	0.1
Total	100.0

Source: NHIA, 2013.

2.6.3 The National Health Insurance Scheme and Maternity Care

In July 2008, the Free Maternity Care program was introduced into the NHIS. This was to contribute to Ghana's efforts in meeting its Millennium Development Goals (MDGs) 4 and 5. This allows pregnant women to receive free maternal care under the scheme (Table 2.4).

Table 2.2: Nationwide registration under free maternal care from 2009 to 2013

Year	Registration
2009	383,216
2010	504,609
2011	485,460
2012	754,658
2013	774,009
Total	**2,901,952**

Source: NHIA, 2013.

2.6.4 The National Health Insurance Scheme and Indigents

One of the goals of the NHIS was to make health care affordable and accessible by the poor and vulnerable in society. As part of efforts to meeting this goal, the NHIA deployed various strategies to identify indigents for free registration to the scheme. The focus of the 2011-2014 Medium Term Strategic Plan of the NHIA was to get more indigents covered by the scheme (NHIA, 2013).

The Legislative Instrument (LI 1809) defines an indigent as someone who does not have any identifiable source of income, unemployed and does not have any place to live. This definition by the LI makes it very difficult to identify persons who are poor and vulnerable for exemption from paying premiums (NHIA, 2013).

The NHIA reported in 2013 that although 23, 238 indigents were enrolled unto the scheme in 2005, the definition of the indigents by the LI still made it difficult for the scheme to identify and enrol them. This compelled the Authority to collaborate with existing organisations who are offering pro-poor interventions in Ghana to assist the NHIS in identifying and covering such people.

In 2011, the NHIA together with the Social Welfare began to enrol beneficiaries of the Livelihood Empowerment Against Poverty (LEAP) unto the scheme. In June 2013, collaboration between the department of social welfare and the NHIA extended the coverage of indigents in the NHIS to pro-poor interventions in Ghana. The idea to enrol beneficiaries of pro-poor interventions in Ghana by the NHIA resulted in the registration of over one million poor and vulnerable people in 2013. The scheme unprecedentedly enrolled about 1.5 million poor and vulnerable people unto the scheme for

free in 2014 (myjoyonline.com, 2014). There has been a significant improvement (Table 2.5) in the enrolment of the indigents since 2009 and this shows how the scheme is expanding.

Table: 2. 3: Nationwide enrolment of indigents from 2009 to 2013

Year	Enrolment	Percent change
2009	138,870	-
2010	117,295	- 16
2011	342, 127	192
2012	393,453	15
2013	1,231,305	213

Source: NHIA, 2013.

To make the identification of indigents easy for enrolment unto the scheme in 2013, the NHIA used the following proxies to identify them for enrolment until the Common Targeting Mechanism (CTM) tool for targeting and enrolling indigents is completed. Criteria used by the NHIA to identify indigents include the following;

1. Beneficiaries of the Livelihood Empowerment Against Poverty (LEAP).
2. Children in orphanages across the country.
3. Children who are blind, deaf and dump in special schools and in the community.

4. Mentally retarded and mentally ill patients within mental homes and in the community who can be reached.

5. Persons currently receiving financial support from recognized institutions such as the District Assemblies and NGOs due to extreme poverty.

6. Mothers with twins and triplets within the communities and are begging to feed them.

7. People Living with HIV/AIDS who are poor and do not have any source of income.

8. Persons being treated for Tuberculosis on Daily Observation Treatment (DOTs) and do not have any source of income.

9. Prisoners who are reported poor by the Prison Officers.

10. Children who are receiving free school uniforms.

11. Children benefiting from the School Feeding Programme.

2.6.5 Enrolment and Payment of premiums

Owusu-Sekyere and Chiaraah (2010) reported that enrolment to the NHIS is legally mandatory however lack of reliable information on the informal sector and the fact that the scheme is a social policy has made enrolment by citizens a voluntary act. Currently, apart from the contributors from the formal sector whose contributions are deducted at source, that is SSNIT contributors, all other persons under the scheme are virtually voluntary subscribers.

Contributions in the form of payment of premiums vary across the membership of the scheme due to the underlying principle of the NHIS to make health care affordable to all, especially the poor in society. Initially, premium contributions for the informal sector workers ranged from a minimum of

GH¢7.2 to a maximum of GH¢48 depending on the individual's income and it is subject to renewal every 13 months (Gobah and Liang, 2010; Boni, 2010). However, according to the NHIA (2013) there was a challenge with this arrangement due to the fluctuation in income earned among the informal sector workers. Hence a flat-rate was introduced to address this challenge although it is obvious that lower income earners in the informal sector will not be favoured by this arrangement. However, every Ghanaian pays 2.5 percent NHIS levy on all goods and services as contribution to the scheme.

The scheme exempts children under 18 years, adults 70 years and above, indigents, pregnant women and formal sector workers who are SSNIT contributors from paying annual premiums (NHIA, 2013). Gobah and Liang (2010) reported that as at 2010, the exempt group constituted about 70.6 percent of the total subscribers to the scheme with children less than 18 years constituting 49.44 percent and adults over 70 years constituting 6.67 percent.

2.6.6 Benefit package of National Health Insurance Scheme

The NHIS covers 95 percent of the most common disease burden in Ghana. The benefit package includes general out-patient care, oral health, eye care, comprehensive delivery care, diagnostic tests, generic medicines and emergency care. Disease conditions that require highly specialised care such as organ transplants, dialysis for chronic renal failure and services already provided by government vertical programs such as family planning, HIV/AIDS and immunization are not covered by the scheme (Gobah and Liang, 2010; Jehu-Appiah *et al*., 2011).

2.6.7 NHIS Service Providers and Payment of claims

The NHIA is mandated to give accreditation to qualified health facilities, both public and private to provide services under the NHIS across the country. From 2010 to 2012, a total of 3,943 health facilities applied for accreditation and 3, 822 representing 96.9 percent qualified to be accredited. Another 45 facilities were granted provisional accreditation while 121 (0.03 percent) facilities failed to meet the minimum requirements to be accredited. On regional basis, Ashanti Region has the highest number of accredited NHIS service providers followed by the Eastern Region while the Upper West Region recorded the lowest number of accredited facilities (Table 2.6).

Table 2.4: Regional representation of NHIS service providers as at 2013

Region	Number of accredited facilities	Percent
Ashanti	619	16.2
Brong Ahafo	376	9.8
Central	334	8.7
Eastern	514	13.5

Greater Accra	440	11.5
Northern	352	9.2
Upper East	211	5.5
Upper West	195	5.1
Volta	321	8.3
Western	460	12.0
Total	**3822**	**100.0**

Source: NHIA, 2013.

Accredited NHIS service providers include Chemical Shops, CHP zones, Clinics, Dental Clinics, Diagnostic Centres, Eye Clinics, Health Centres, Laboratories, Maternal Homes, Pharmacies, Physiotherapy, Polyclinics, Primary, Secondary and Tertiary Hospitals and Ultrasound. So far, out of these facilities, CHPS zones have received the highest number of accreditation with 1, 197 which accounts for 31.3 percent of NHIS service providers. Currently, government facilities account for 2,075 representing 54.3 percent of accredited facilities followed by 1,511 private facilities representing 39.5 percent with the rest being mission and quasi-government facilities (NHIA, 2013). Payment of claims to NHIS service providers is done at the district level by the District Mutual Health Insurance Schemes (DMHIS). Payment is done base on the Ghana Diagnostic Related Groupings (G-DRGs) and the drug tariff list. The NHIA is continually searching for means to improve on the way claims are paid to service providers to ensure cost containment, cost control escalation by sharing risk between schemes, providers and subscribers and for efficient use of health resource (Gobah and Liang, 2010 and NHIA, 2013). The introduction of the capitation payment system in the Ashanti

Region in 2012, Claims Processing Centres (CPC) in Tamale, Kumasi and Cape Coast and the piloting of Electronic claim methodology are all efforts being made by the NHIA to ensure transparency and boost efficiency in claims processing and payments.

2.6 Public perception on the National Health Insurance Scheme in Ghana

Sarpong *et al.* (2008) mentioned that Ghana is one of the few countries in Africa to successfully establish a nationwide health insurance scheme which is still in operation. In addition, Sodzi-Tettey et. al. (2012) revealed that Ghana's NHIS is a standard of study for many African countries.

However Owusu (2010) cited affordability to health care services and the removal of out-of-pocket payments at the point of health care delivery services as some of the positive perceptions recorded in favour of the scheme. In the opposite of the divide, inaccessibility to health facilities in some areas, delay in the release of membership cards, inability of the scheme to cover some essential drugs, long waiting time before one is attended to, were some of the negative perceptions raised by scheme members (Owusu, 2010; Gobah and Liang, 2010).

The introduction of the NHIS has increased the utilisation of health care services in the country as compared to the cash and carry era (Boni, 2010). However, this increment in the utilisation of health care services has increased the workload of health workers without any corresponding provision of incentives for them. Also, some scheme members have complained that the quality of services given to them is normally different from non-members of the scheme who pay cash at the point of health service delivery. Meanwhile the perceived over-utilisation of health care services by some members

of the scheme, the absent of incentives to make up for the increase in workload and the delay in the payment of claims to the health facilities by the NHIS were cited as some of the reasons some health workers put up poor behaviours towards scheme members (Witter and Garshong, 2009; Dalinjong and Laar, 2012).

From the point of view of non-members of the scheme, Dalinjong and Laar (2012) posited that although certain procedures in accessing health care are still the same since the introduction of the scheme, low quality of health care delivery, low quality of drugs, long waiting time at health facilities, increase in the cost of health care services for non-subscribers and the absent of essential drugs from the list of drugs covered by the scheme are some of the negative perceptions associated with the introduction of the scheme.

The introduction of free maternity care for pregnant women into the scheme have also increased the rate at which expectant mothers visit health facilities as compared to the days under the cash and carry system. Expectant mothers are now more likely to deliver in health facilities and also more likely to attend pre-natal and post-natal care regularly without any financial barriers (Mensah *et al.*, 2010).

Generally, it is widely accepted by both subscribers and non-subscribers that the NHIS has made a positive impact on health care delivery service in the country and majority of subscribers are happy with its introduction (Owusu, 2010; Dalinjong and Laar, 2012; Gobah and Liang, 2010).The NHIS is currently viewed as one of the best social intervention programmes introduced to Ghanaians and it is

unique in the sense that its sustainability does not depend on donor funding (Owusu-Sekyere and Chiaraah, 2014).

2.7 Challenges associated with the National Health Insurance Scheme

Although the NHIS is widely embraced by Ghanaians, the scheme is still bedevilled with some bottle-necks that have to be removed to improve on the performance of the scheme (Boni, 2010; myjoyonline.com, 2014).

2.7.1 Management and payment of claims to health service providers

One of the major challenges facing the NHIS is the management and payment of claims to health service providers which is usually done through the District Mutual Health Insurance Schemes (Auditor General, 2012 and NHIA, 2013).

In 2012, the Auditor-General reported the following as the key challenges confronting the scheme in claims management and payments;

1. Irregularities in the processing and payments of claims at the District Mutual Health Insurance Schemes (DMHIS).
2. Delay in the payment of claims to health service providers under scheme by the DMHIS.

The irregularities in the processing of claims create the enabling environment for fraudulent activities to occur in the payments of claims to service providers. Also, the manual way of processing claims is a major contributing factor in the delay in payment of claims to service providers (Auditor General, 2012). Dalinjong and Laar (2012) also established that the delay in the payment of claims to the

service providers hinder the smooth operations of these health facilities in the area of drug and non-drug procurements.

According to Dalinjong and Laar (2010), the delay in claims payments has a trickling effect on subscribers to the scheme in the following ways:

1. Service providers are compelled to turn their attention to non-subscribers who are ready to pay cash for services. This causes non-subscribers to the scheme to spend less time in seeking health care as compared to scheme subscribers.
2. Service providers are also compelled to issue prescription forms to subscribers to the scheme to buy drugs out of the facilities.

Reimbursement of funds to service providers constitute about 80 percent of the operational funds of these service providers hence the delay in payment of claims is key a challenge which the NHIA is putting measures in place to overcome (NHIA, 2013).

2.7.2 Quality of health care delivery by health service providers

Adogla (2013) reported that the success of the NHIS does not depend solely on the NHIA but also the health service providers contracted to the scheme. The author revealed the following as some of the challenges subscribers to the scheme face at the premises of some of these service providers;

1. Charging of illegal fees and exploiting of patients.
2. Unprofessional behaviours such as verbal abuse and undue delays.
3. Referral of clients to some private medical health facilities that are not contracted to the scheme.

4. Sale of drugs to clients with the excuse that these drugs are not covered by the scheme.
5. Use of unqualified staff by some private health facilities.

These unethical practices have made some Ghanaian slows confidence in the scheme. Hence if not curbed will go a long way to defeat the purpose of the scheme (Adogla, 2013).

2.7.3 Abuse of health care services

Darlinjong and Laar (2012) reported that service providers claim the introduction of the NHIS has given some subscribers the leverage to frequent health facilities at the slightest ailment which increases the workload of the health workers. The author revealed that some subscribers go as far as attempting to collect drugs for their friends and relatives who are not subscribers to the scheme. Some subscribers were also accused of not completing the treatment course given to them by one service provider before jumping to another service provider to begin another treatment course (NHIA, 2012).

2.7.4 Enrolment and coverage of the scheme

Ten years after its inception, questions have been asked about the pace of enrolment and general coverage of the NHIS. Although enrolment to the scheme is legally binding to every citizen, statistics have shown that as at 2013, less than half of Ghana's population can be considered as active subscribers to the scheme (Owusu-Sekyere and Chiaraah, 2014). Previous subscribers have refused to renew their cards due to delay in processing the insurance identification (ID) cards after registration, the yearly renewal of the ID cards and the high premium payments for registration. Some insurance agents have been accused deliberately causing the delay in the processing of the ID cards

so they can charge unauthorised fees from subscribers (Darlinjon and Laar, 2012; Owusu-Sekyere and Chiaraah, 2014).

Boni (2010) also reported that in some deprived areas people have refused to enrol because of ignorance about the purpose of the scheme. In addition, there has been lower enrolment from impoverished areas as compared to the urban and perceived rich areas which defeats the purpose of the scheme of making health care affordable to the poor. Also, the high illiteracy rate especially in the rural areas has an effect on enrolment since there is a high probability of an educated person to enrol than the uneducated likewise high income earners are more likely to enrol than low income earners (Jehu-Appiah *et al.,* 2011 ; Gobah and Liang, 2010; Owusu-Sekyere and Chiaraah, 2014).

2.8 Prospects of the National Health Insurance Scheme

Despite the aforementioned challenges of the scheme, its relevance is still widely felt in some circles. This is reflected in the fact that the scheme has provided coverage for vulnerable groups like mothers, children, the poor and the aged (Gobah and Liang 2010). Many countries in Africa have proposed to understudy Ghana's health insurance policy. Recently, after a visit to understudy Ghana's health insurance, officials of the Federal Ministry of Health gave glowing accounts of the globally acclaimed health insurance scheme. After twelve years of dynamic implementation , it is only a step in a right direction that the NHIA is rolling out activities and opening up conversations to take stock, recognize achievements and challenges and chart new paths forward (Sodzi-Tettey *et.al,* 2012).

The introduction of three (3) new Claims Processing Centres (CPCs) in Tamale, Kumasi and Cape Coast and the piloting of the electronic claims project are some of the strategies the NHIA has rolled

out recently to improve on claims management and payments to improve on the scheme. The unprecedented registration of about 1.5 million indigents to the scheme in 2014 signifies efforts being made by the NHIA to ensure that the poor and vulnerable in society are covered per the objective of the scheme. Another mechanism to ensure efficient performance of the scheme is the introduction of the "gatekeeper" system as a cost control measure. This system ensures that a visit to the secondary and tertiary health facilities by subscribers to scheme is by referral from a primary health facility in order to minimise unnecessary cost (NHIS, 2010).

There is also the political will from government to improve the scheme by expanding coverage to people with mental health, physical disability, prostate cancer and family planning services. (Gobah and Liang, 2010). In addition, the National Health Insurance Act (Act 650) was repealed and replaced by a new law (Act 852) with the objective of enabling the scheme attain a universal health insurance coverage for persons resident in Ghana and non-residents visiting Ghana.

Hence a number of initiatives have been put in place over the years to simultaneously address sustainability challenges and Universal Health Coverage (UHC) goals. These were driven by a re-engineering program that was accelerated in 2009, drawing on lessons from previous experiences, with the view to re positioning the scheme for efficiency and effectiveness (Mensah *et al*., 2010).

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter is devoted to the methodology for the study. Specific areas of discussion include; the study design, study area map, research approach, methods and tools of the research. The choice of the suitable research methodology was guided by the theoretical underpinning of the nature of the research problem; the study goal and objectives; the type of data needed thus, secondary and primary; how data would be analysed; interpreted and presented; the scope of the study; and the purpose of the study. Apart from these, the other factor that informed the choice of the methodology is the nature of respondents.

3.1 Research Design

Based on the objectives of the research, appropriate methodology was developed to collect data to satisfy the objectives of the research. The study design was mainly qualitative in nature. This method allowed the researcher to use non-probability sampling techniques like purposive sampling and the results were presented in the form of percentages, frequencies and narratives.

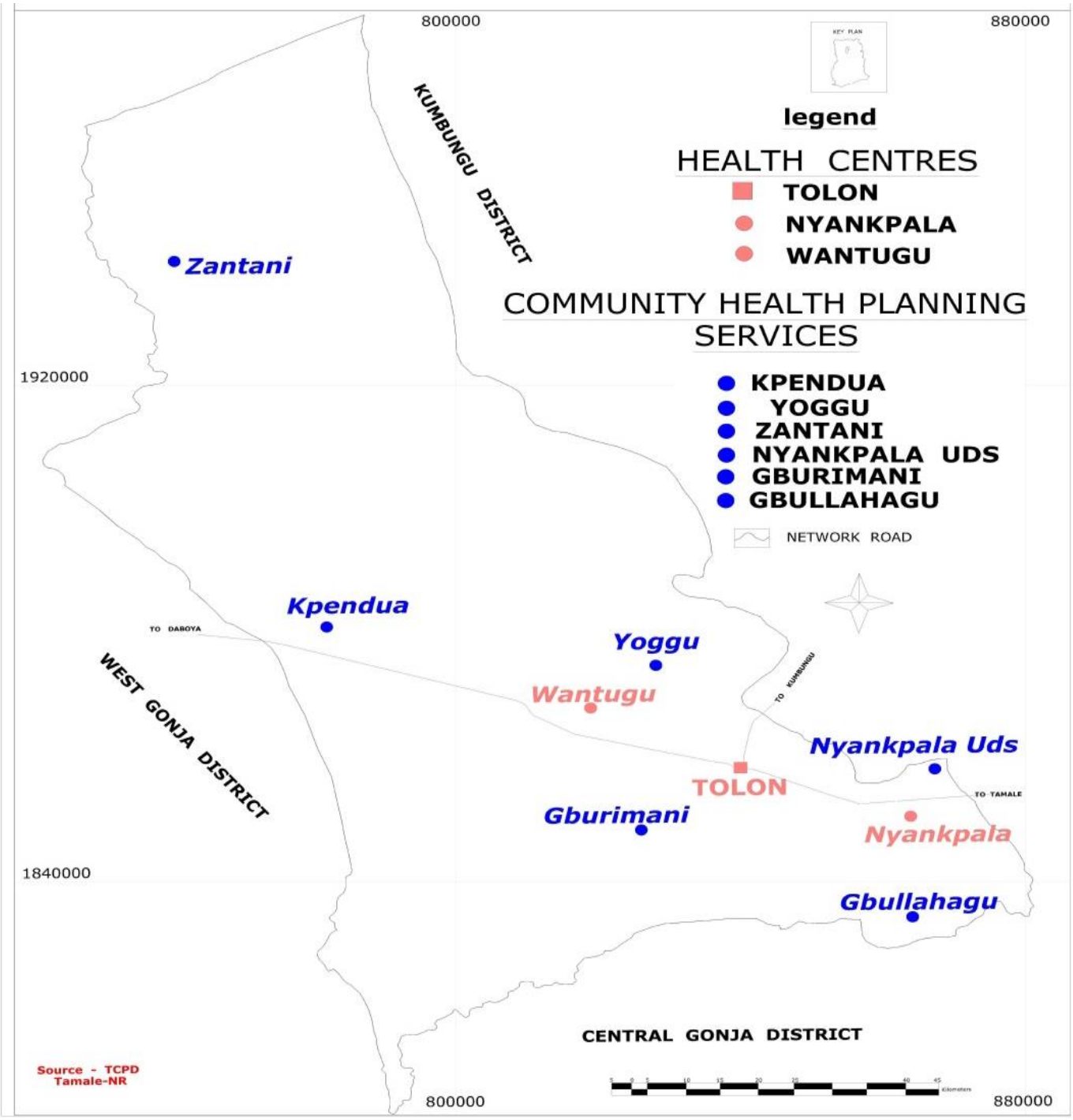
3.2 Study Area

The study area comprises of the physical environment and the demographic features of the Tolon District in the Northern Region. These include location, climate, vegetation, population, water and sanitation, health facilities among others.

3.2.1 Location

The study was carried out in three communities in the Tolon District (Figure 3.1) of the Northern Region. The district (formerly Tolon-Kumbungu District) was carved out of the then Western Dagomba district in 1998. The district was separated from Kumbungu and inaugurated as a district on 28th June 2012 (Ghanadistricts.com, 2015). Tolon District lies between latitude 9° 15' and 10° 02' North and Longitudes 0° 53' and 1° 25' West. It shares boundaries to the North with Kumbungu district, North Gonja to the West, Central Gonja to the South and Sagnarigu Districts to the East. The district is among twenty-six (26) districts in the Northern Region with Tolon as its administrative capital (GSS, 2014).

Figure 3. 1: A sketch map of the Tolon District



Source; Regional Town and Country Planning, Tamale.

3.2.2 Climate

Tolon District like any other district in the Northern Region receives a unimodal rainfall in a year which starts in April and become intense in July-August. The amount of rainfall sharply reduces and comes to a complete halt from October – November. The mean annual rainfall ranges between 950 mm – 1,200 mm. The dry season, characterised by the Harmattan, starts from November to March with day temperatures ranging from 33^{o}C to 40 ^{o}C while average night temperatures range from 20 ^{o}C to 26 ^{o}C. The area is prone to occasional storm which depending on its intensity and frequency causes soil erosion (GSS, 2014). The seasonal weather changes are accompanied with diseases such as malaria, pneumonia, cerebrospinal meningitis among others. These diseases are very relevant to the National Health Insurance Scheme.

3.2.3 Vegetation

Tolon District is characterised with grassland interspersed with guinea savannah woodland. Drought resistant trees such as Neem, Dawadawa, Shea, Cashew, Mango, Acassia, Mahogany and Baobab are very common in the district. The Shea tree has gained international recognition as an economic tree for the people in the district due to its economic value. The seasonal picking, processing and marketing of the Shea nuts serve as income generating avenue for the people in the district especially the women (Ghanadistricts.com, 2015). The income generated from these economic activities help in premium payment (Ghanadistricts.com, 2015; GSS, 2014).

3.2.4 Population

The total population of the Tolon District stands at 72, 990. Male and Female figures are 36,360 and 36,630 respectively. About 88.4 percent of the population are predominantly rural settlers whilst 11.6 percent reside in the urban areas of the district. Fifty-three percent (53%) of the male population are 19 years or below whilst 34.8 percent fall within 20 - 49 years. The majority (56.2%) of the female population are 19 years or below whilst 32 percent fall within 20 – 49 years (GSS, 2014).

3.2.5 Education and Literacy Rate

The district has been zoned into five (5) educational circuits namely; Nyankpala, Tolon, Tali, Kasulyili and Lungbunga. According to the GSS (2014), the Tolon District can boast of 68 Kindergartens, 69 Primary Schools, 19 Junior High Schools and 3 Senior High Schools (1 public and 2 private) and a University. In spite of all these statistics, the district has one of the lowest literacy rates in the Northern Region with about 73.8 percent of the population known to be illiterates in any language compared to a Regional percentage of 62.5 percent.

3.2.6 Water and Sanitation

Piped water is the most common source of drinking water for urban dwellers in the district. About 1.7 percent of households have access to piped water in their homes and about 10.8% have access to public tap. Only about 35 – 40 percent of the rural population of the district have access to safe drinking water during the rainy and dry seasons respectively. Also, about 60 – 70 percent of the population in the district do have access to safe drinking water within 500 m. The main water sources especially in the dry season for the rural settlers are wells, dugouts, and dams. Other sources include

streams, rivers and rainwater during the rainy season. The water situation coupled with poor sanitation has very serious implications for the health of the people in the district. About 88 percent of the population in Tolon district do not have toilet facilities hence practice the 'free range system. Less than 3 percent use the flush toilet whilst about 4 percent and 6 percent resort to public toilets and traditional pit toilets respectively.

3.2.7 Economic Status

The Tolon District is predominantly a farming district with about 75 percent of its labour force being peasant farmers. Farming occurs in both rural and urban areas in the district and is mostly done with rudimentary tools like cutlass and hoe. Only a few farmers are able to afford the services of a tractor during land preparation. Crop production is heavily dependent on rainfall therefore yearly crop output is affected. The common crops grown in the district are Maize, Rice, Groundnut, Millet, Sorghum, Yam, Cassava and vegetables such as Tomato, Pepper. Tobacco and cotton are also occasionally grown in the district. Fishing is also a common activity in communities located along the White Volta Basin. The GSS (2014) reported that less than 2 percent of the inhabitants engage in other economic activities such as petty trading.

According to GSS (2014), the standard of living in the Tolon district is very low as compared to the national average. The average income per month for a household is about GH¢20.20. The District is considered as one of the poorest districts in Northern Region because majority of the inhabitants are peasant/subsistent farmers. Their output is not enough for them to put some out for sale in the market. This and many other hardships in the district has contributed significantly to the seasonal migration

of the youth to the south in such of greener pastures only to end up as Kayayee ; which has become a national canker.

3.2.8 Health facilities

The district has 159 communities based on Community Based Surveillance (CBS) concept. It has three (3) main sub – districts namely, the Tolon, Nyankpala and Cheseggu and Wantugu sub-districts respectively. Access to health facilities in the Tolon District is 54.2 percent compared to 35 percent and 57.6 percent for the region and nation respectively. There are five health facilities under the Tolon sub-district, namely; Tolon Health Centre, Kpendua CHPS Zone, Tolon R.C.H Clinic, Gburimani CHPS and Yoggu CHPS Zone. The Nyankpala sub-district covers the Nyankpala Health Centre and the Gbulahegu Clinic with the Lingbunga Clinic, Kasulyili CHPS and Zantani CHPS zones falling under the Cheseggu and Wantugu sub-district (GSS, 2010).

3.3 Sampling Procedure

Respondents selected for this study were NHIS subscribers who accessed the insurance scheme and the service providers of scheme. These respondents were selected from three prominent Health centres located in three communities in the Tolon District namely; Nyankpala, Tolon and Wantugu. In order to ascertain quality information needed for analysis, the interviewer tracked respondents at the Out Patient Department (OPD) of the health facilities for the purpose of interviewing them. The objective here was to authenticate the data to reflect accurate answers for addressing appropriately the research questions.

3.4 Sample Size

According to GSS (2014) the Tolon District has a population of 72,990 and about 80 percent of them are card-bearing members of the National Health Insurance Scheme. A sample size of 200 card-bearers was purposively selected for the study. This sample size was chosen because it is deemed representative enough to cover the views of the 80 percent card-bearing members of the NHIS in the District. Also, the data collection tool used demands that a sizeable sample size must be chosen to ensure quality response from the respondents. This is supported by a study by Farooq (2013) which indicates that interview schedule is best suited for small sample sizes. In addition, 5 stakeholder officials such as scheme managers and health service providers in the District were also interviewed for the study (Table 3.1).

Table 3.1: Sample distribution of sample size of Card-bearing members

Name of Community/Health posts	No. of members
Tolon	92
Nyankpala	65
Wantugu	43
Total	**200**

Source: Field survey, 2014.

3.5 Sampling Methods

In conducting this study, purposive sampling method was employed to select NHIS card-bearers and after which a simple random sampling technique was employed to select the respondents. The respondents were assigned with numbers (1-3) and any respondent with the number three (3) was picked for interview.

3.6 Sources of Data

3.6.1 Primary Data

The study was conducted with the following tools/ survey instruments interview schedule, interview guide and observation guide. Data collection methods such as personal observation, and interviews were employed in the study. Primary data was collected in June, 2014.

3.6.2 Interview Schedule

Farooq (2013) defines interview schedule as a set of questions along with their answers asked and filled in by the interviewer in a face-to-face meeting with the interviewee. The same author stated further that employing interview schedule in qualitative research leads to more and accurate information from respondents irrespective of their educational background. In addition interview schedule removes the possibility of being bias on the part of the interviewer and provides the room for difficult situations to be studied.

In this study, open ended questions were asked in order to explicitly solicit information regarding prospects and challenges of health insurance in the Tolon District. The interview schedule was

divided into three sections: section (A) dealt with demographic characteristics of respondents, section (B) consisted of prospects of National Health Insurance Scheme and section (C) consisted of challenges of National Health Insurance Scheme in the Tolon District.

3.6.3 Interview Guide

Twumasi (2001) defined interview as any person-to-person interaction between two or more individuals with a specific purpose in mind. Interviews are classified into unstructured and structured. Interview guide was developed to guide the interview process. The rationale for using this approach was to enable collective engagement of individual respondents within which questions were formulated and asked spontaneously as the interview progressed. This approach also allowed the respondents to freely express their opinion. This therefore supports Twumasi (2001) view that a good interview is one in which the interviewee takes over the control of the interview situation and talk freely.

3.6.4 Observation

Personal observations were made to assess how patients were handled by health workers and the state of the physical structures of the health facilities, laboratory facilities. To this end, observation guide was prepared to guide the observation process.

3.7 Secondary Data

The study also made use of secondary data across a wide spectrum of scholarly materials. This involved internet search of journals, text books, newsletters and annual reports that have data with

direct relevance to challenges and prospects of the Ghana's National Health Insurance Scheme, with particular reference to the Tolon District of Northern Region. Gathering and reviewing secondary information provided clues for avoiding objectives and research questions of other researches within this study which would have been accidentally replicated.

3.8 Data Analysis

The study deployed mainly qualitative approach of data analysis. Statistical Package for Social Sciences now modified to read Statistical Product and Service Solutions (SPSS) version 16.0 was used for the analysis and the results were expressed in tables, graphs, figures and narratives. The qualitative analysis enabled the researcher to describe the phenomenon and to make interpretations and quotations of direct speeches of respondents. The use of qualitative method enabled filling in information gaps that would have otherwise been missing.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.0 Introduction

This chapter presents results and discussions of the study. In all a total of 200 subscribers were interviewed. This chapter specifically throws light on the demographic characteristics of respondents such as marital, educational status and occupation and also their general views on the challenges and prospects of the NHIS.

4.1 Sex distribution of respondents

Out of the 200 respondents interviewed (Figure 4.1), 180 were females representing 90 percent whiles 20 of them representing 10 percent were males. The dominance of females among the respondents could be attributed to their biological make up since they are potential expectant mothers and the availability of free maternal care under the scheme is enough to encourage them to enrol to the scheme. This assertion is supported by Mensah *et al*., (2010).

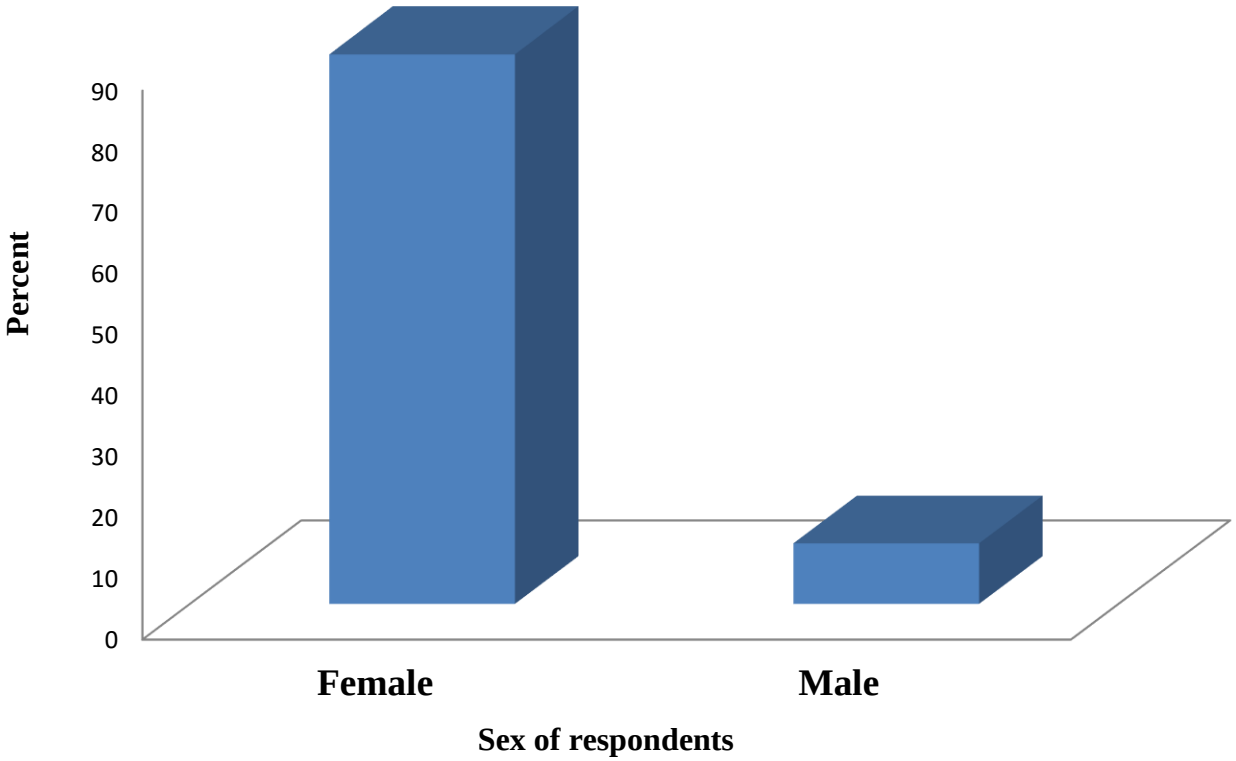


Figure 4.1: Sex of respondents

Source: Field Survey, 2014.

However this finding contradicts the findings of Gobah and Liang (2010) that men are more likely to enrol unto the scheme than women. Another reason for the high enrolment by women could be attributed to the vulnerability of women living in deprived areas and also the role women play in house-keeping and taking care of the sick in the Tolon District.

4.2 Age of Respondents

The majority (83 %) of the respondents fell within the reproductive age range of 18 – 49 whilst 12 percent are within the ages of 50 – 59 (Table 4.1). This means about 95 % of respondents form part of the active work force population hence they are deemed capable of affording premiums so far as they earn enough from their occupation.

Table 4. 1: Age group of respondents

Age range (Years)	Number of respondents	Percent
18 – 49	166	83
50 – 59	24	12
60+	10	5
Total	**200**	**100**

Source: Field survey, 2014.

This finding collaborates that of Owusu-Sekyere and Chiaraah (2014) which claims that income earners are more likely to enrol to the scheme than the unemployed. Five percent of the respondents fall outside the workforce class.

4.3 Occupation of Respondents

The survey revealed that 63 percent of the respondents engage in farming (Figure 4.2) as their major occupation followed by petty trading with 15 percent. Twelve percent work in the formal sector whilst 10 percent are unemployed. This confirms the findings of the Ghana Statistical Service (2014) that

the major occupation of inhabitants of the Tolon District is farming. These findings also confirm the NHIA (2013) report that the majority of Ghana's work force population are employed in the informal sector which requires them to pay premiums from their earnings. It was also revealed that 90 percent of the respondents are engaged in one economic activity or the other which makes it highly possible for them to afford to enrol unto the scheme as revealed by Jehu-Appiah *et al.*, (2011) and Owusu-Sekyere and Chiaraah (2014).

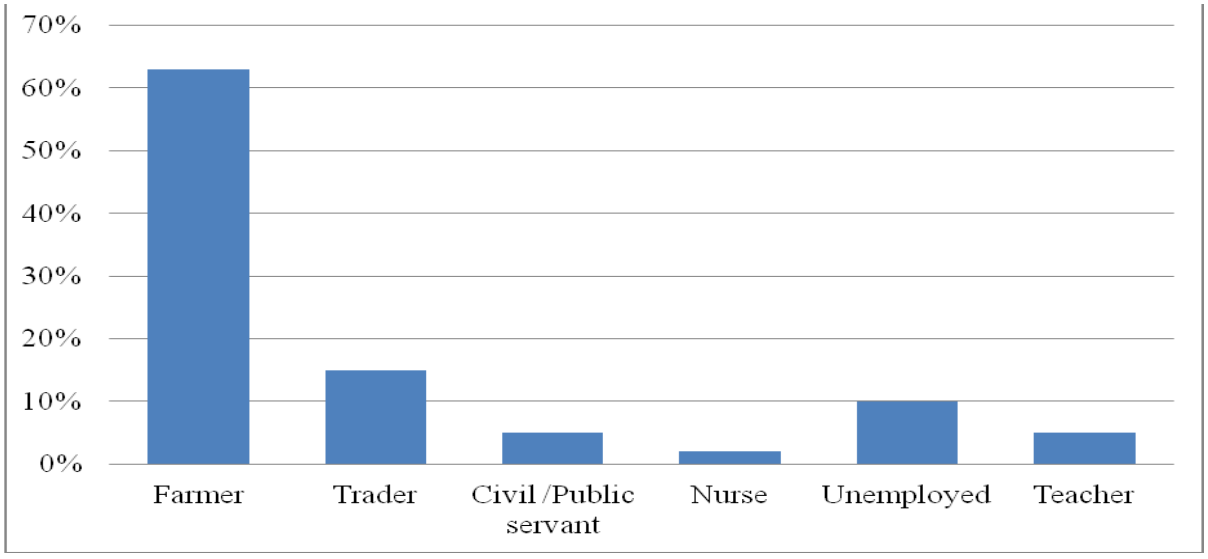


Figure 4. 2: Occupation of respondents

Source: Field survey, 2014.

4.4 Marital Status of Respondents

The majority (65%) of respondents were married (Figure 4.3) whilst 10 percent were widowed with 20 percent being single. Owusu- Sekyere and Chiaraah (2010) established that people who are

married are more likely to join the scheme. This could be attributed to potential parenthood since there is free maternal care under the scheme also majority of married couples are gainfully employed hence they can afford to pay premiums to enrol.

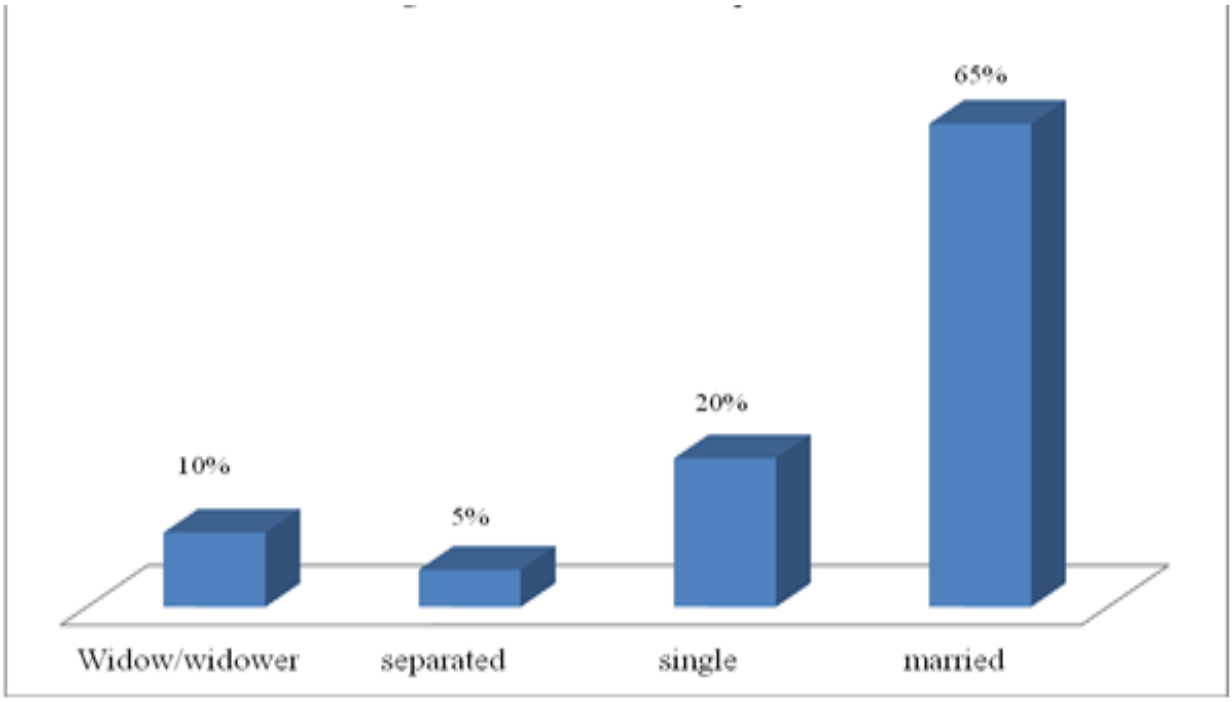


Figure 4. 3: Marital Status of Respondents

Source: Field survey, 2014.

4.5 Educational Background of Respondents

Fifty percent of respondents interviewed have never had any form of formal education whilst 14 percent have had a form of tertiary education (Table 4.2). According to reviewed literature literacy influences a person's choice to enrol unto the scheme. Literate people are more likely to enrol to the scheme as compared to those who have not received any formal education. Those who are literate are able to know the purpose of the scheme hence they do not need to be sensitised before they enrol. In addtion, literates are less likely to abuse the scheme (Jehu-Appiah *et al*., 2011; Gobah and Liang, 2010; Boni, 2010).

Table 4.2: Educational background of respondents

Level of education	**No. of respondents**	**Percent**
No formal education	100	50
Basic education	50	25
Senior high/middle school	22	11
Tertiary	28	14
Total	**200**	**100**

Source: Field survey, 2014.

4.6 Access to Health Care in the Tolon District

A hundred and seventy-five of the respondents representing 87 percent (Figure 4.4) claim they are able to access health facilities anytime they are sick with the NHIS cards. The NHIS is widely accepted by Ghanaians because it has been able to replace the dreaded cash and carry system (Gobah and Liang, 2010; and Boni, 2010). However, 13 percent of the respondents claim they do not get access to health care.

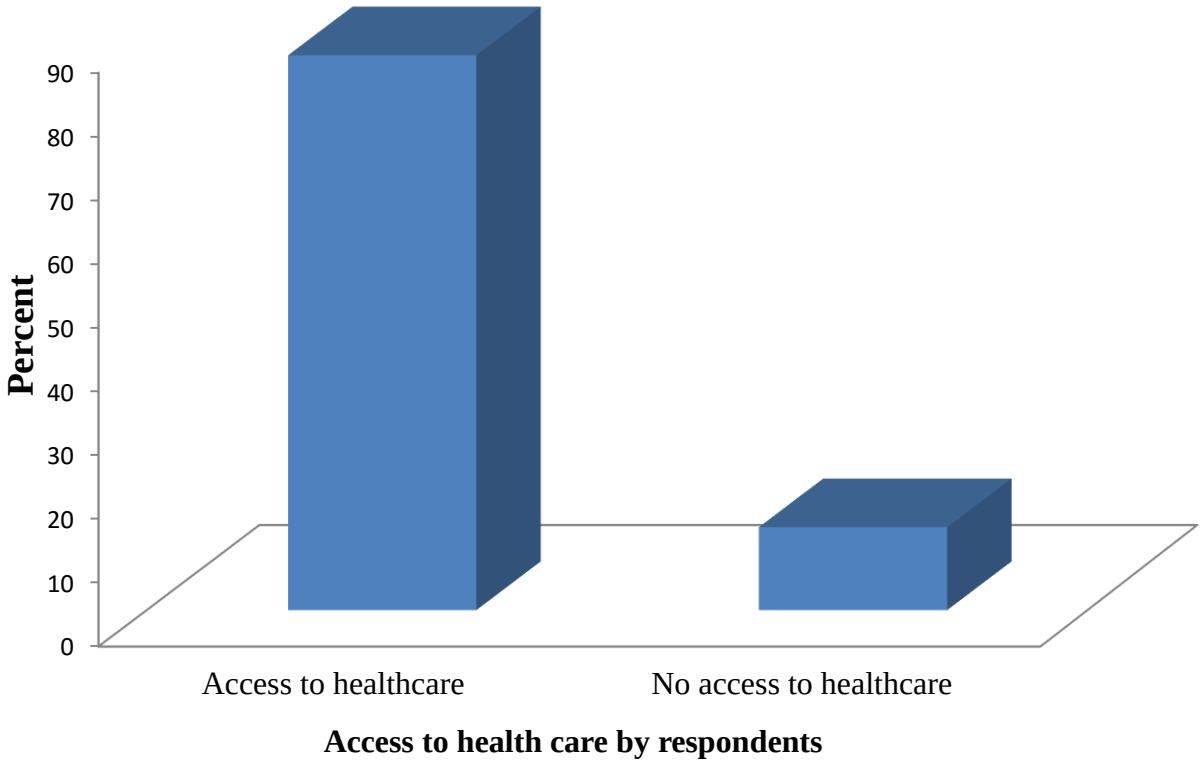


Figure 4. 4 Access to health care

Source: Field work, 2014.

4.7 Coverage of the Scheme on Family Members

Ninety-five percent of the respondents (Figure 4.5) indicated that their families were insured by the scheme. With five percent claiming that not everyone in their families were insured. The 5 percent who said not all of their family members were insured further explained that they were not financially sound to pay premiums for members of their families including monthly renewals. It was further revealed that they were also not married and that could be a factor for the enrolment as were also not married and that could be a factor for enrolment as Owusu-Sekyere and Chiaraah (2010) indicated that people who are married are more likely to enrol to the scheme together with their families.

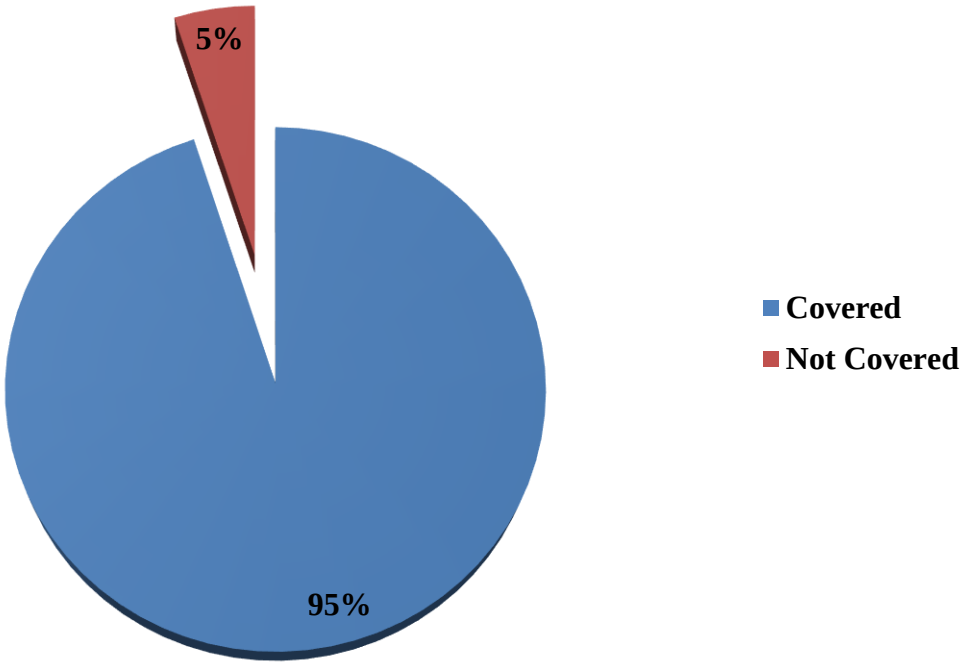


Figure 4. 5: Coverage of the NHIS among family members of respondents

Source: Field survey, 2014.

The majority of the respondents appreciated the implementation of the NHIS as reported by Gobah and Liang (2010) that the scheme is widely appreciated because it has provided coverage to people living in vulnerable and deprived communities. The high number of coverage upholds the purpose of the scheme since Tolon District is considered by the Ghana Statastiscal Service (2014) as one of the poorest districts in Northern Region.

4.8 The Quality of Service Delivered to Members

Out of the total number of 200 respondents (Table 4.3), 17.5 percent claim services rendered to them by health service providers under the scheme were poor therefore not satisfactory. They cited long waiting hours at the health facilities, long procedure in retrieving scheme cards, over-crowding at some of the facilities and poor doctor-to-patient ratio as some of the negative attributes of the scheme. These findings are similar to the findings of Adogla (2013) and Darlinjon and Laar (2012) as some of the common concerns raised about the scheme.

Table 4. 3: Quality of service delivery

Rating	No. of respondents	Percent
Poor	35	17.5
Excellent	25	13.5
Very good	35	17.5
Good	105	53.5
Total	**200**	**100**

Source: Field survey, 2014.

However, there was a general claim by a majority (82.5%) of the respondent that the introduction of the scheme has helped since no out-of-pocket payments are done at health centres any longer despite the long hours spent at the health facilities due to the increment in the number of health care seekers since the scheme came into operation. There has been an increase in the number of health facility users nationwide since the introduction of the NHIS (Mensah *et al.,* 2010).

4.9 Affordable health care under the NHIS

Out of 200 respondents (Figure 4.6), 90 percent of them said the NHIS is affordable since they have been able to insure themselves and their family members too. They added that the exemption of payment of premiums by children below 18 years made it possible to enrol all their children unto the scheme. The underlying principle of the NHIS was to make health care affordable and accessible to Ghanaians especially the poor and vulnerable (NHIA, 2013) hence the purpose of the scheme is not defeated in the Tolon District.

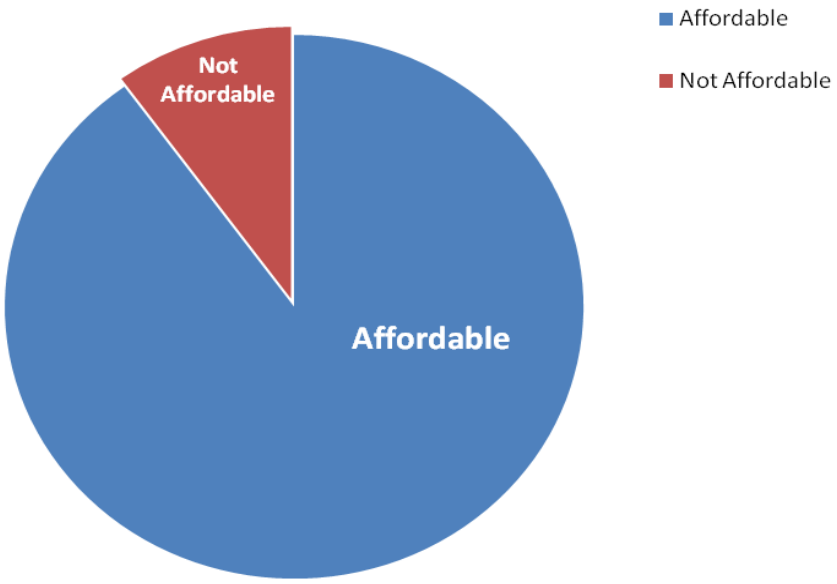


Figure 4. 6: Affordable health care under the NHIS

Source: Field survey, 2014.

However, 10 percent of the respondents claim they could not afford to pay premiums for themselves and other members of their families who were required to pay premiums before registration because of fluctuations in their earnings therefore some of their family members were not insured. The NHIA (2013) indicated that the payment of premiums by informal sector workers is a challenge due to the instability in their earnings.

4.10 Relevance of the National Health Insurance Scheme

The majority (90%) of the respondents indicated the relevance of the scheme (Table 4.4) and claimed the scheme should be continued since it gives the poor access to health care. They added that now the poor, aged and pregnant women can easily and readily access a health facility without thinking about money. This confirms the findings of Gobah and Liang (2010) which reported that the NHIS is very relevant in some circles because it provided coverage for vulnerable groups like mothers, children, the poor and the aged.

Although some of the respondents indicated some challenges with the scheme such as waiting for long hours at health facilities before being attended to by health workers, they still held the view that the introduction of the scheme has had a positive impact on accessibility and affordability of health care delivery in the eyes of the poor and vulnerable. This finding also upholds the purpose of the introduction of the scheme (NHIA, 2013). However, 10 percent of the respondents rated the scheme poorly claiming that people with the NHIS cards are usually treated poorly at health facilities as compared to their non-insured counterparts because they do not pay up-front. This concern was also raised by Adogla (2013).

Table 4. 4: Respondents perception on the relevance of the NHIS

Rating	No. of respondents	Percent
Excellent	90	45
Very good	40	20
Good	50	25
Poor	20	10
Total	**200**	**100**

Source: Field survey, 2014.

4.11 Views of nursing mothers on the NHIS

In most deprived rural communities, women and children are the most vulnerable since economic opportunities are limited therefore the introduction of the NHIS has brought great relief to women in such deprived areas especially nursing mothers. The majority (90%) of the respondents interviewed were women who were NHIS card bearers in the Tolon District. They claim that the scheme has made health care services affordable and accessible to them. The introduction of the free maternity care for pregnant women has also minimised the reliance on self-medication on the part of pregnant women and nursing mothers.

They added that most deliveries are done in the health centres now as compared to the cash and carry era where deliveries were done at home due to inability to afford hospital bills. Children who are below 18 years are also captured by the scheme for free which has lifted a heavy weight from the shoulders of the rural woman. The views of these women are in tune with the findings of Witter and Garshong (2009) who reported that the NHIS has significantly improved on the access to health facilities by pregnant women and nursing mothers which will help in minimising maternal or child mortality rate. Below is an excerpt of an in-depth interview with a women's group leader (Magazia);

> *The NHIS is very relevant, when my son fell sick, went on admission for three days, the bed was free, he was given six packets of drips (dextorite) free, and many drugs free except two drugs that I had to pay because they said it was not covered by NHIS. So it is very good, it helps the poor. I always encourage the women to register* (In-depth interview, 2014).

4.12 Prospects of the National Health Insurance Scheme in the Tolon district

Checks from some accredited health service providers in the district revealed a brighter future for the scheme. Accredited health facilities in the district have registered tremendous increase in hospital attendance as compared to the cash and carry era. The service providers also acknowledged the efforts the government and NHIA are making to make sure the scheme is improved and gets a wider coverage. They cited the introduction of new claims payments system which has minimised the delay in the reimbursement of funds to the service providers which shows how committed government and the NHIA are in ensuring smooth operation of the scheme. They also mentioned that efforts are being

made by both government and the NHIA to widen the coverage for the list of drugs and ailments currently under the scheme which is a step in the right direction.

The findings in the Tolon District about the prospects of the NHIS are not different from other districts. Government and NHIA are committed to ensuring the scheme is improved and sustained (Gobah and Liang, 2010).

4.13 Challenges with the NHIS in Tolon District

Access to primary health care is a key policy issue in Ghana, and is of particular importance in Districts like Tolon which is committed to promoting equitable access to primary health care as a strategy for addressing health inequity. Making sure that primary health care systems are equitable and accessible to all Ghanaians is an underlying principle of the NHIS.

4.13.1 Views from NHIS Subscribers

The NHIS has been widely accepted by people in the Tolon district; however the scheme is bedevilled with some challenges which need to be addressed to enhance the scheme (Table 4.5). Top on the list of challenges faced by subscribers is the inadequate laboratory facilities at the health facilities (Table 4.5). Twenty percent of the respondents claimed they were usually treated poorly treated by health workers whenever they access health facilities under the scheme. Also, another Thirty percent revealed that sometimes they are given prescriptions to buy some drugs which they think are very basic for the scheme to cover.

Table 4. 5: Challenges faced by NHIS subscribers in Tolon District

Challenges	**No. respondents**	**Percent**
Some drugs not covered by scheme	60	30
Poor treatment of patients by health workers	40	20
Inadequate laboratory facilities	80	40
Unprofessional behaviours of health workers	20	10
Total	**200**	**100**

Source: Field survey, 2014.

Ten percent cited unprofessional behaviour such verbal abuse, charging of illegal fees and the delay in processing documents on the part of health workers as some of the challenges encountered by the subscribers. Asana, an expectant mother who had subscribed to the scheme had this to say;

> *Hmm!! The problem I face is that you go and waste all your time only to be told that 'the drugs are not covered or the drugs are finished. Also some of the nurses do not treat us with respect. They insult us as if the services and drugs are coming from their pockets and not the Government. On the other hand, our counterparts*

who come with money for cash-and-carry services do not waste time in accessing health care (In-depth interview, 2014).

According to Adogla (2013) these findings are not only associated with NHIS subscribers in the Tolon District, it cuts across the country and such behaviours by the health workers towards scheme subscribers kills the confidence of Ghanaians in the scheme hence prevents some people from renewing their cards when they expire. Forty percent (40%) of the respondents claimed that the lack of laboratory facilities to make up for the increment in hospital attendance in some of the accredited health facilities causes undue delay to patients.

4.13.2 Views from the Health Service Providers

Accredited health service providers both public and private indicated the challenges they face in the dispensation of their duties under the scheme. They claim that some NHIS subscribers abuse the scheme by frequenting the health facilities at the least opportunity. They added that 'shopping' of health facilities is rampant in the district. Some subscribers even attempt to use the scheme ID cards of others to access health care services.

They also indicated that although their facilities have recorded high attendance due to the introduction of the scheme, there has been no corresponding expansion to their facilities and this brings a lot of pressure to their facilities and also to the health workers too. They also bemoaned the inadequate number of Doctors in the district and sometimes the delay in the payment of claims as very challenging issues.

The Auditor-General (2012) cited delay in payment of claims and abuse of the scheme by some subscribers as some of the challenges affecting the smooth implementation of the scheme. The perceived abuse of the scheme which adds to the workload of the health workers compels some of them to behave unprofessionally towards subscribers (Whitter and Garshong, 2009; Dalinjong and Laar, 2012). Also the delay in reimbursement to these health facilities leaves them with no other option but to attend to non-subscribers who will pay up-front for services provided since the health facilities need the money to run their facilities (Dalinjong and Laar, 2012).

4.14 Suggested measures to overcome the challenges of NHIS

The provision of quality health care under the NHIS depends on all stakeholders; NHIA, health service providers and the subscribers. In this regard, measures to overcome challenges of NHIS are important to the success of the scheme.

Below are measures suggested by subscribers and service providers to enhance the performance of the scheme:

- Posting of more Doctors and other qualified health workers to the district.
- Increase the level of health facilities and upgrade others.
- The use of computers to store and retrieve data to minimise the delay in processing documents through the manual way.
- Wider drug coverage by the scheme.
- Regular supply of drugs to hospitals and payment of claims on time.

- Health workers who charge illegal fees must be punished by the appropriate authority such as the Ghana Health Service.
- Full implementation of the capitation policy by government to avoid patients from moving from one health facilitiy to another (facility shopping) with the same health complain which leads to waste of drugs.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5. 1 Summary of findings

This study was conducted to delve into prospects and challenges of the National Health Insurance Scheme (NHIS) at the Tolon District of Northern Region. In an attempt to order the results of the study in a scientific manner basic certain questions around prospects and challenges confronting clients in accessing the National Health Insurance scheme in the Tolon District became pertinent in the study. It was expected that the study would reveal empirical data that will be useful to Ghanaian policy makers who may explore further on the prospects and challenges of the National Health Insurance Scheme in the Tolon District or elsewhere. The study may also provide a sense of direction for Donor Agencies and Non-governmental Organizations who may be cooperating with the health sector towards achieving the health objective of the Millennium Development Goals (MDGs).

The study employed a qualitative approach of data collection. Purposive Sampling was used to select respondents for the study. Qualitative data was analysed through explanations, interpretations and direct speeches of respondents.

The findings of the study revealed that the people of Tolon District patronise the operation of NHIS as bedrock of health care delivery and making effort to chart out continued prospects for the scheme, though a few challenges were identified. The respondents, especially females within the ages of 20 to 49 representing 70 percent of the respondents are active NHIS subscribers as compared to any other age group.

The majority (78%) of the respondents who are insured under the NHIS are informal sector workers with 63 percent of them being farmers. They are dominated by women small holder farmers or subsistence farmers who by the laborious and fatigue nature of their practice regularly seek health care at the hospital. Notwithstanding the marital status of the respondents, up to 65 percent of them indicated that they and their entire family members access health care through NHIS at the Tolon District. Also the study revealed that majority of the people who access the health care have neither attained education to the level of Junior high school or not having formal education at all. Up to 50 percent of the respondents contacted indicated that they had not been to school at all.

Besides, over 80 percent of the respondents concurrently indicated some prospects for the scheme as they continuously access health care at the Tolon District for several years after they joined the NHIS. Again, 53 percent of the respondents indicated that they would rate the operation of the NHIS as '*good'* with 17 percent rating it '*very good'* as it continues to solve their health care needs in the

District. About 90 percent of the respondents attested that the scheme was affordable with yearly subscription of less than GH¢17.

The key challenges identified with the operation of the NHIS at the Tolon District included inadequate laboratory facilities, poor treatment of scheme subscribers, unprofessional behaviour on the part of some health workers, basic drugs not covered by the scheme, poor treatment handed out to NHIS card holders.

To address these challenges it was suggested by some of the stakeholders that, there is the need to strengthen collaboration among stakeholders for the purpose of providing better service for the scheme subscribers. It is also important that more education be given to service receivers in order to avoid or minimise the act of extortions that take place at some service provision centres.

5.2 Conclusions

Mutual health insurance scheme has become a major instrument in affordable and accessible quality health care for the people of Ghana. The scheme has made health care more accessible and affordable to both rich and the poor in both urban and rural communities. In the Tolon District, people who previously could not access health facilities can now receive medical attention early enough to avoid complications. In practice, health insurance scheme covers out-patient and in-patient cases, including accidents and investigations.

In the Tolon District, women who are considered vulnerable enjoy the scheme to the fullest with cases of maternity. In spite of all the challenges, the study established the optimism that the scheme has a future and would rise above its challenges to provide affordable and accessible, quality service

delivery. It could be said that the health insurance policy is a good one and it is worth pursuing and needs the support and cooperation of all the stakeholders.

5.3 Recommendations

In addressing the challenges and charting out vibrant prospects for the NHIS in the Tolon District, there is the need for both service providers and clients to adhere strictly to the roles and responsibilities defined by the NHI Act 650. On the basis of the findings and conclusions from the study, the following recommendations are made:

- Service providers should be honest in their submission of claims on subscribers without inflating the bills. They should not have a mind of milking the scheme to enrich themselves.
- The Universal Access to Health Care Campaigns, the general public and stakeholders in health must hold health care providers more accountable for the things that do tend to derail the efforts of the NHIA. Service providers should not forget that they have a contract with the NHIA, and the contract stipulates that, the NHIA pays the health providers to provide a certain range of service to clients, and for the Service providers to meet their part of the contract by proving services to clients in an efficient and professional manner.
- Polypharmacy (prescription of many drugs to a patient) as a result of multiple diagnoses should be avoided. Providers are entreated to adhere to the Standard Treatment Guideline of the Ghana Health Services.

- Collection of unauthorised money from subscribers at the point of service delivery by some health personnel make subscribers lose confidence in the scheme. Heads of various health facilities should be vigilant and whenever a case of such malpractice is reported to them, they should bring the perpetrator to book.

- Management of the scheme should educate the entire society of Tolon on the need for everybody to subscribe to the scheme. This could be achieved through the organisation of seminars and radio programmes for all stakeholders on the place or role and importance of the national health insurance scheme to the socio-economic development of the country

- Management of the NHIS should be vigilant and expose any provider who would try to defraud the scheme of funds, drugs and equipment. They should as well be disciplined by putting in place measures to check and minimise corrupt practices of the staff of the scheme.

- Government in collaboration with other stakeholders of the National Health Insurance Authority should organise a national consultative forum to dialogue on increase of chronic diseases and supply of their drugs. This would not credit the scheme but would also provide the population with assurance in accessing the scheme.
- All stakeholders in the health sector must uphold and maintain integrity, transparency and accountability in the relationships among them in order to achieve the aims and objectives for which the scheme was established.

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APPENDICES

APPENDIX A

INTERVIEW SCHEDULE FOR CARD-BEARERS OF NATIONAL HEALTH INSURANCE SCHEME

SECTION A.

DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

1. Sex: □Male □ Female

2. Age: .....

3. Occupation: □ Farmer

□ Trader

□ Unemployed

□ Civil/Public servant

□ Teacher

□Nurse

4. Marital Status: Single □

Married □

Divorced□

Separated □

5. Educational Background: □ No formal education / illiterate

□ Junior High School/Middle School

□ Senior High School/ Secondary School/ A Level□

□Diploma (Polytechnic/Teacher/Nursing Training)

□ University/ Professional Equivalent

□ Postgraduate Degree

SECTION B.

PROSPECTS OF NATIONAL HEALTH INSURANCE SCHEME

6. Do you access health care/ seek treatment from hospital with a health insurance card anytime you are sick? □Yes □ No

7. How long have you been accessing health insurance?

□1-5 □6-10 □11-15 □ 16-20 □ 21-25

8. Does your registration with the scheme cover all family members under your care?

□Yes □No

9. Do you find the scheme relevant in terms of health care provision?

□Yes □No

10. If you answer yes to question 9, please indicate list how you deem the scheme relevant?

a.....

b.....

c.....

11. Do you find the scheme affordable/ are you able to renew your membership with the scheme regularly?

□ Yes □ No

12. Do you think the scheme should continue to exist as health insurance policy?

□Yes □No

13. If you answer yes to question 14, how will you rate the scheme?

□ Excellent □ Good □Very good □Poor □ Extremely poor

SECTION C

CHALLENGES OF NATIONAL HEALTH INSURANCE SCHEME

14. Do you usually encounter any problems in the course of renewing /accessing your card?

□Yes □No

15. If you answer yes to question 14, please indicate the nature of the problems?
a.....

b.....

c.....

d.....

16. At the OPD, how will you rate the treatment you receive from the service providers?

□Poor □very poor □Good □Very good □Excellent

17. If you answer poor/very poor to question 16, please list the reasons for your claim

a.....

b.....

c.....

d.....

18. At the pharmacy/drug collection joint, how will you rate the treatment you receive from the service providers ?

□Poor □very poor □Good □Very good □Excellent

19. If you answer poor/very poor to question 17, please indicate your reasons for the claim.

a.....

b.....

c.....

d.....

20 Have you ever been told to pay for a medical service or drug that is not covered by the scheme?

□Yes □No

21. If you answer yes to question 20, please what will you suggest to accommodate this problem?

a.....

b.....

c.....

22. What is your perception or observation about the NHIS in the Tolon district?

a.....

b.....

c.....

d.....

APPENDIX B

INTERVIEW GUIDE FOR SERVICE PROVIDERS OF NATIONAL HEALTH INSURANCE SCHEME

DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

1. Sex: ☐ Male ☐ Female

2. Age:.....

3. Occupation: Civil/Public servant □Paramedic ☐

4. Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐

5. Educational Background: ☐ No formal education / illiterate

☐ Junior High School/Middle School

☐ Senior High School/ Secondary School/ A Level

☐ Diploma (Polytechnic/Teacher/Nursing Training)

☐ University/ Professional Equivalent

☐ Postgraduate Degree

6. Do the clients you serve appreciate /enjoy accessing the scheme?

☐ Yes ☐ No

7. If you indicate yes to question 6, please show how they express their appreciation

a.……

b.……

c.……

d……..

8. Do you think the Government can do more to improve on the scheme for effective health care delivery?

☐ Yes ☐ No

9. What do you think the Government can do to improve on the scheme?

a……

b……

c……

d…….

10. What challenges do you face with clients in providing services to them? Please list them

a……

b……

c……

11. How do you think the Government can intervene to improve on service provided for clients? Please list them

a……

b……

c……

APPENDIX C

INTERVIEW GUIDE FOR NATIONAL HEALTH INSURANCE SCHEME MANAGEMENT IN THE TOLON DISTRICT

1. How would you rate community awareness of the existence of the scheme?
a……

b……

2. What are some of the strategies that have been adopted to create more awareness of the existence of the scheme?

a.....

b.....

c.....

3. What are the significant achievements of the scheme in the district?

a.....

b.....

c.....

3. What measures have been put in place to ensure sustainability of the scheme?

a.....

b.....

4.What has been the District Assembly's contribution to the implementation of the NHIS?

a.....
b.....

6. What challenges do you face with clients in providing services to them?
a……

b…….....

APPENDIX D

INTERVIEW GUIDE FOR SERVICE PROVIDERS OF THE NATIONAL HEALTH INSURANCE SCHEME IN THE TOLON DISTRICT

PROSPECTS/CHALLENGES

1. How has the NHIS contributed in the health care delivery in the district?

a……..

b……..

2. Do the clients you serve appreciate /enjoy accessing the scheme, and how do they express their appreciation?

a…….....

b…….....

c……....

3. What do you think the Government can do to improve on the NHIS?

a…….....

b…….....

c…….....

4. What challenges do you face with clients in providing services to them?

a…….....

b…….....c..

.....……

5. What measures do you think stakeholders should be put in place to make the NHIS sustainable?

a…….....

b……

c.....

APPENDIX E

OBSERVATION GUIDE TO IDENTIFY THE PROSPECTS AND CHALLENGES OF THE NATIONAL HEALTH INSURANCE SCHEME IN THE TOLON DISTRICT

1. Describe the nature of roads from Tolon town to the Tolon health centre, Nyankpala clinic and Wantugu clinic.
2. Describe the nature of the buildings in each heath centre.
3. Is there any organizational structure?
4. How crowded is each outpatient department?
5. How crowded is the NHIS card renewal centre?
6. What is the behaviour of health workers towards clients?
7. Are there sufficient drugs for clients who visit the health centres?