UNIVERSITY OF CAPE COAST

PERCEPTION OF THE NON-INSURED PERSONS ON THE NATIONAL HEALTH INSURANCE SCHEME: A CASE STUDY OF THE JIRAPA DISTRICT.

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BY

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DISSERTATION SUBMITTED TO THE INSTITUTE FOR DEVELOPMENT STUDIES OF THE FACULTY OF SOCIAL SCIENCES, UNIVERSITY OF CAPE COAST IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF ARTS DEGREE IN HUMAN RESOURCE MANAGEMENT

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DECLARATION

CANDIDATE'S DECLARATION

I hereby declare that this dissertation is the result of my own original research and that no part of this has been presented for another degree in this university or elsewhere.

Candidate's Signature…… Date……..

Name……..

SUPERVISOR'S DECLARATION

I hereby declare that the preparation and presentation of the dissertation were supervised in accordance with the guidelines on supervision of dissertation laid down by University of Cape Coast.

Supervisor's Signature…… Date…….

Name…….

ABSTRACT

Some literature of health insurance indicate that it is a private or public system of protection against the losses owing to medical expenses, or a method of providing for members of a defined group or community with protection against the cost of medical care. The national health insurance scheme has been identified as the more humane, efficient and sustainable means of financing healthcare in low-income countries, especially where a large percentage of the population are in the informal sector.

Perceptions of the non-insured members have been examined after five years of implementation of the scheme and 232 respondents were interviewed in five selected area councils in the Jirapa district. Systematic sampling technique was used to determine the sampling units. Data was collected using interview schedule and analysed with statistical package for service solution (SPSS) programme.

The results indicated that the youth, whose ages ranged between 18 and 45 years and who were mainly the males were not insured. The study also showed that, due to poverty, most subscribers could not renew their membership or register at all with the scheme. It is recommended that payment of the current premium be made flexible on installment basis and any increase on the premium might eliminate a lot of people since they would not be able to afford. More so, the study showed that there were inadequate doctors, nurses and drugs at the various health facilities which could compromise the quality of health care services and thus contributed to the low membership registration and renewal rate.

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DEDICATION

This work is dedicated to my lovely wife; Bernice Bomba-Ire, our son, Melynn Bomba-Ire, daughter, Morsina Bomb-Ire and in memory of my late father.

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CHAPTER ONE

INTRODUCTION

Background to the study

In the 1960's in the United States, the term health insurance was principally associated with medical insurance because its primary aim was to protect vulnerable groups from unbearably high medical bills. Similarly, in Korea and Taiwan, their respective universal health insurance systems implemented in 1988 and 1995 respectively were designed to provide equal access to medical care and thus shield individuals and families from financial risks caused by a long-term hospitalization or technically specialized medical treatment (Son, 2002). In the Netherlands however, health care is funded mainly from compulsory contributions by employers and employees into a social insurance sickness funds and voluntary contributions to private insurance companies, both of which in turn pay providers. In this case, virtually the entire population enjoys access to the needed health care and is shielded from the risk of incurring expenditures that would otherwise be too high to impoverish some individuals or families (Kutzin, 2000).

It is significant to note also that there has been an increasing emergence of community-based health insurance during the past couple of years in Thailand (Jutting, 2004). Indeed, Thailand's Health Care Programme offers an illustrative example of how a state programme can foster the growth of private risk-sharing.

Since its initiation as a pilot programme in 1991, the government promoted voluntary risks sharing, schemes attracting 28.2 per cent of the Thai population (WHO, 2004). However, the government has been depending on public subsidies, a situation that must not persist in the long run as future regulations need to be put in place to ensure financial sustainability and also meet certain performance standards.

In 1980s and 1990s many countries implemented health sector reforms which included the introduction or consolidation of cost-recovery mechanisms, in particular out-of-pocket fees, paid at the time of illness, which had the unintended effect of decreasing access to health care by the poor. Since the mid-1990s, the increasing incidence and prevalence of human immuno-deficiency virus/acquired immuno-deficiency syndrome (HIV/AIDS), Tuberculosis (TB), and other communicable diseases in low-income countries have contributed to the widening of the gap between the need for, and the utilization of health services among poor individuals. However, in low-income countries, majority of the population remains uncovered against the risk of illness (World Bank, 1994).

The unprecedented waves of democratization and development of civic society that Africa has witnessed since the late 1980s and the weaknesses of the various health financing mechanisms particularly the widespread unpopularity of the ‘cash and carry’ system, especially its negative consequences on the poor led governments to commission various studies into alternatives, principally insurance based ones. These conditions also made it possible for autonomous, grass root response to the problems people face, including health care access and

service quality. A recent initiative of this type has been the emergence of and fairly rapid growth of Mutual Health Organizations, which attempt to improve their members' access to quality health care by mobilizing the individual contributions and resources of those members who may be individuals or families (Atim, 1998).

Ghana as an African country went through series of challenges in financing health care immediately after independence. There was no direct out-of-pocket payment at the point of consumption of health care in public health facilities immediately after independence. Financing of health in the public sector was therefore entirely through tax revenue. The sustainability of this form of financing became questionable as the economy began to show signs of decline in the 1970s following competing demands on the same financial source. The general tax revenue did not allow for a percentage earmarked for health (Ministry of Health, 2004).

This situation continued until 1985 when the Government was compelled under International Monetary Fund (IMF) conditionalities and Structural Adjustment Programme (SAP) prescriptions to introduce user fees for all medical conditions except certain specified communicable diseases and selected vulnerable groups such as the under-fives, elderly and antenatal services for pregnant women. However the exemption policy was poorly implemented due to poorly defined guidelines and mechanisms to adequately identify eligible beneficiaries and to prevent possible financial leakages culminating into drastic fall in standard of health care provision in the ensuing years. There was acute

shortage of essential drugs in all public health facilities and hence the introduction of user fees in public health facilities. However the user fees resulted in the first observed decline in utilization rates in public facilities across the country (Ministry of Health, 2004).

In spite of this, the government went ahead to institute full cost recovery for drugs as a way of generating revenue to address the shortage of drugs. The payment mechanism put in place was termed `Cash and Carry`, and its implementation further compounded the utilization problem by creating a financial barrier to health care access especially for the poor (Ministry of Health, 2004).

Contributing to the debates surrounding the effects of user fees on service utilization, Nyonator and Kutzin (1999) observed that while the upper and middle income persons were better off under a user fee regime, the poor were all excluded from using health facilities by formal and informal charges (Nyonator & Kutzin 1999). Thus, the benefits of user fees have been challenged, particularly with respect to equity of access to health care (Gilson 1998; Creese 1991). This often results in delays in seeking health care, non-compliance to treatment, and consequently premature death especially amongst the poor.

It was against this background that the government of Ghana introduced National Health Insurance Scheme (NHIS) partly in response to the health care cost at the point of service delivery, which posed a financial barrier to health care access in the country. Indeed, it is estimated that out of 18 percent of the population who require health care at any given time, only 20 percent of them are

able to access it (Ministry of Health 2004a). In essence therefore, about 80 percent of people living in Ghana who need health care cannot afford to pay out-of-pocket at the point of service use.

Ultimately therefore, the enactment of the National Health Insurance Act (Act 650) in 2003 was basically a response to the adverse equity impact of user fees. Hence, the vision of government in instituting a national health insurance scheme in the country is to ensure equitable and universal access for all residents of Ghana to an acceptable quality package of essential health care. In sum, the policy objective is that, "within the next five years, every resident of Ghana shall belong to a health insurance scheme that adequately covers him or her against the need to pay out-of-pocket at the point of service use in order to obtain access to a defined package of acceptable quality of health services (Ministry of Health 2004a).

Currently, there are two main types of health insurance schemes that have been permitted under the Act to operate in Ghana; District Mutual Health Insurance Scheme and Private Health Insurance Scheme which may be commercial or mutual (National Health Insurance Act 2003). Among these, the government of Ghana has chosen to support the development of the District Mutual Health Insurance Schemes as part of the strategies for delivering its pro-poor policy on access to health care by the underprivileged segments of society. Thus, from the onset, the policy is committed to achieving universal coverage with gradual extension, using a combined approach of social health insurance and community-based prepayment mechanisms to cover both the formal and informal

sector workers. Nevertheless, the key challenges for pursuing universal coverage include the fact that the informal sector constitutes 70 percent of the population, of which 40 percent are estimated to be poor (Ministry of Health 2004a). In addition, the willingness to contribute substantial general tax revenue to the health sector is a major challenge.

However, the policy enjoys a strong political will, and has received significant commitment from both government and the Ministry of Finance. This is understandable against the background that the launching of health insurance scheme on a national scale as an alternative, rather than a complimentary scheme to the much-criticized `Cash and Carry`, was partly in fulfillment of election promise (NPP Manifesto, 2000).

In terms of premium levels and benefits package, it is anticipated that every person living in Ghana will contribute in accordance with the principle of ability to pay, in order to enjoy a package of health services covering over 95 percent of diseases afflicting Ghanaians. Therefore there will be differential contribution levels as a way of incorporating a cross-subsidization mechanism into the contribution levels, thus making the rich pay more than the less privileged. Hence, whilst employees in the formal sector will be covered by taking 2.5 percent of their Social Security and National Insurance Trust (SSNIT) Fund, those in the informal sector who are very poor are expected to contribute a minimum of seven cedis twenty pesewas per adult per annum while adults who are poor will pay GH¢18 per adult for middle income and GH¢48 per adult for the rich and the very rich (National Health Insurance Act, 2003).

The National Health Insurance Fund will be used to pay the premiums on behalf of the indigent, aged and children under 18 years. In this context, the indigent refers to the core poor, who are considered unemployed and receive no consistent financial support from any identifiable sources (National Health Insurance Act 2003). These premiums are however subject to review by the various schemes subject to approval by the National Health Insurance Authority.

Therefore the National Health Scheme is funded through the following sources:

- The health insurance levy of 2.5 percent sales tax on all goods and services except essential items such as drugs on the Essential Drugs List, mosquito net, goods for the disable, water, education, salt, agricultural, and aquatic food products in its raw state produced in Ghana, live animals and fishing equipment among others.
- 2.5 percent of the Social Security and National Insurance Trust Fund
- Government funds
- Premiums from informal sector contributors
- Investment income, grants and donations.

The National Health Insurance Fund will be used in the following ways;

- Fully subsidized for indigents
- Reinsurance
- Risk equalization and
- Provide general subsidies to district-wide schemes.

The Act also provides for a quite comprehensive benefit package which includes both out-patient and in-patient care. There is however a provision for an exclusion list which includes appliances and prostheses, cosmetic surgery, anti-retroviral drugs, fertility treatment, dialysis for chronic renal failure, organ transplants, drugs which are not within the National Health Insurance Essential Drug List (NHIEDL) and VIP wards (National Health Insurance Act, 2003).

Statement of the problem

The NHIS became fully operational in 2005 and since then over 11 million people (representing 55 percent of the country's population) had registered with the 145 district mutual insurance schemes that are operational as at the first quarter of 2008. This percentage exceeds the 30-40 percent coverage that was set as the target for the period (www.nhis.gov.gh).

However, the Second Quarter Regional Performance Report of the schemes in the Upper West Region for 2008 indicated that 392,726 people resident in the Region enrolled with the scheme representing 60 percent coverage. A further analysis of the report indicated that Jirapa-Lambussie District-Wide Mutual Health Insurance Scheme (JLDWMHIS) had enrolled a total of 73,522 representing 66.35 percent of the district population covered as against the expected national target of 70 percent to be achieved by the end of 2008 (Alagpulinsa and Zury, 2008).

Lambussie is quite far away from the scheme's administrative office located in Jirapa coupled with the fact that the district hospital serving the two districts is also located in the Jirapa town and thus limits access to membership

registration and quality healthcare services of the people there than their counterparts in Jirapa district. It is therefore expected that residents in the Jirapa district would enroll with the scheme more than those in Lambussie. However, the 2008 half-year performance report of the Scheme presented by the Board Chairman at the Annual General Assembly Meeting clearly indicated that majority of the current membership of the scheme with respect to the district populations were those from the Lambussie-Karni district. For instance, out of a total district population of 37,382 of the Lambussie-Karni district, 30,282 subscribers joined the scheme representing 81 percent while in the case of Jirapa 52,266 subscribed out of the population of 72,652 representing 72 percent of the district population (August, 2008).

Again, the enrollment data of the Scheme report reveals a very worrying picture with regard to active membership of the Scheme as only 54 percent of those whose cards expired renewed their membership. Indeed, the national health insurance policy framework for Ghana states categorically that “it is compulsory for every person living in Ghana to belong to a health insurance scheme type” (Ministry of Health, 2004).

However, factors such as the nature of the insurance policy, inability of the scheme staff and agents to adequately reach potential subscribers in the communities, lack of satisfaction with the health care services provided to the already insured could affect the operation of the scheme. As such it is possible that these may have an effect on the perception of the non-insured clients in the Jirapa district in particular and the schemes ability to sign on new members or

retain old members. Indeed, the JLDWMHIS could be considered to be recording moderate successes in its coverage due to increasing efforts by the management staff, agents and other stakeholders of the Scheme through the intensification of public education activities, outreach services, and special programmes, a number of challenges remained to be examined in order to enhance the sustainability of the scheme. The research therefore seeks to examine the perception of the non-insured members of the scheme on its operations.

Objectives of the study

General objective:

The general objective of the study is to examine the perception of non-insured clients on the National Health Insurance Scheme.

Specific objectives

The specific objectives of the study include:

- To ascertain the perception of the non-insured clients on the level of premiums.
- To examine the impeding aspects of the health insurance policy.
- To determine how the non-insured clients perceive the quality of medical treatment offered to insured clients by service providers.
- To assess the efficiency of the scheme's management staff.
- To make recommendations for implementation by the appropriate authorities.

Research questions

- How affordable are the premiums to residents of the district?
- What aspects of the health insurance policy hinder enrollment?
- How does non-insured client perceive the quality of medical treatment offered to the insured clients under the Scheme?
- How efficient is the scheme's management staff?

Scope of the study

The scope of the study is limited to assessing the perception of non-insured clients on the National Health Insurance Scheme in the Jirapa District in the Upper West Region. It will examine their opinions on ability to pay premiums, impeding aspects of the insurance policy, the quality of medical care provided by service providers and the efficiency of scheme management.

Justification for the study

It is a popular believe in the health insurance theory and practice that, when clients assessments are used in concert with other effectiveness and efficiency measures, more comprehensive organizational strategy options for policies aimed at improvement can be arrived at. Given that the scheme is still new in the entire country and Jirapa district in particular the assessment of clients' perception would unveil not only the impeding factors to enrolment but also provide an alternative framework for the implementation of the programme as very little or no research is done in this aspect of the scheme in the District.

Ultimately therefore, findings of the study would lead to increasing knowledge of the researcher in the research area, and adding data to the already

existing literature on the National Health Insurance Scheme. It will also provide data and basis for further studies.

Operational definitions

- Insured client- Any person that has the valid policy with the Scheme (Valid identity card)
- Premium- Amount of money paid by or on behalf of a member to scheme in order to a member.
- Indigent- the poorest of the poor in society
- Health Insurance- A risk-sharing mechanism where resources are pooled into a common pool to take care of health care cost of many people.
- Benefit package- The available out-patients, in-patients and drugs under the National Health Insurance Scheme.

Organization of the study

The study has been divided into five chapters; Introduction, Literature Review, Methodology, Data Analysis and Presentation and Findings/Conclusions/Recommendations. The first chapter is the introduction which tackles issues such as the background to the study, the statement of the problem, significance of the study, objectives, research questions and finally the organization of the study.

The second chapter captures literature review which highlights existing and relevant literature on the research topic as well as the theoretical framework of the study. Literature is reviewed on: premium levels with respect to the ability

to pay, the insurance policy, quality of health care services provided and finally the efficiency of the scheme staff.

The third chapter also captures methodology which focuses on the study design, study area, study population, sampling design, sample size, data collection instruments, data sources, and data analysis procedures.

Chapter four deals with data analysis and presentation of findings, while the last chapter deals with summary of results, drawing conclusions and making recommendations for future improvement of the research area.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter focuses on the review of relevant literature of the study. It is conducted in the following areas: theories in insurance, ability to pay premiums, nature of the health insurance policy, quality of healthcare services provided efficiency of the scheme staff and conceptual framework to illustrate the interplay of the relevant variables. This review informs the researcher of the level to which studies have already been conducted in the study area. In addition, it is to indicate the gap between what has been studied and what is yet to be explored in the field of study thereby avoiding duplications but contributing to knowledge. The review equips the researcher with adequate knowledge on the appropriate methodology and statistical tools to use in the study.

Theories

There are several theories guiding the operation of health insurance globally but two theories would be discussed in this work; theory of the demand for insurance and theory of the insurance decision with standard gamble specification.

Theory of demand for insurance postulated by Bernoulli in 1738 states that an individual derives different levels of satisfaction or utility from different

levels of income (or wealth) and that in general, an individual's utility increases with the income, but at a decreasing rate. He derives the condition under which the utility level is achieved after paying the insurance premium to exceed the expected utility level from the remaining uninsured. The theory assumes that people purchase insurance because they want to maximize expected utility. It is however difficult to measure consumer satisfaction and expected outcomes as health insurance depends on the future and thus the above theory is not suitable for the research.

Theory of insurance decision with standard gamble specification: modeled by Friedman and Savage (cited by Nyman, 2002) states that, a small certain loss (insurance premium) is preferred to a large, but actuarially equivalent, uncertain loss. It means that purchasing insurance is choosing certainty in preference to uncertainty (Friedman & Savage, 1948,). Based on the principles and concepts that established the Jirapa-Lambussie scheme, Friedman and Savage's theory can best explain it as subscribers are expected to register so that when they are sick the insurance scheme will pay whatever bills that would be involved. This research work is therefore pinged on the theory of insurance decision with the standard gamble specification

According to Arrow (1963) and Zeckhauser (1970) (cited by Manning & Marquis, 1996) social choices about health insurance involve a trade-off between the gains from risk reduction and the deadweight losses from the incentive to purchase more health care when insured. The economic purpose of insurance is to reduce financial uncertainty or risk. All other things being equal, individuals are

generally willing to pay more than an actuarially fair amount to reduce the risk of a large financial loss caused by the possible future occurrence of illness and the resultant medical care expense. The greater the aversion to risk, the more health insurance will reduce the risk faced by the consumer.

According to Pauly, 2004, another important empirical implication of the theory of insurance is that if premiums are actuarially fair, the theory says that all risk averse people should buy insurance whose benefits just equal the amount of loss. Thus if insurance is subsidized sufficiently to reduce its explicit premiums to the actuarially fair level or lower, there should in theory be 100 percent take up and 100 percent coverage. In reality however, this may not happen because consumers are poorly informed about the value of insurance, because they believe that their expected expenses are lower than those on which the premium is based, or because moral hazard makes the premium much higher than expected expenses without insurance.

As mentioned by Manning and Marquis (1996), relying on the economic proposition that choices about consumption of health services depend on the same variables and parameters as do choices about insurance. The only major difference between the demand for health insurance and the demand for health services is that the choice of insurance is made before uncertainties are resolved, while choice about consumption tends to be made after major uncertainties are resolved. For example, a person buys health insurance to protect against the financial consequence of a possible future illness, but the purchase of health care

services occurs after the illness occurs; this simple example ignores any residual uncertainty about the damage's extent (Manning and Marquis, 1996).

Ability to pay insurance premiums

Insurance premiums are the monies paid to the insurance scheme in order to be a member and which largely determines the benefit package. Thus the income level of the populace is crucial to the number of members of any insurance scheme.

However, health insurance is seen as a method of providing members of a defined group or community with protection against the cost of medical care (Bennett, 2004). To ensure financial sustainability and self-sufficiency in financing health care without relying on out-of-pocket payments at the point of service use, national health insurance schemes have been identified as more humane, efficient and sustainable means of financing health care in low-income countries. This is common especially where a large percentage of the population is self-employed in the informal sector because both the rich and the poor will contribute towards affordable health care for everyone (Bennett, 2004). In this context therefore, the ability to pay premium in order to access health care as and when needed could be equated to user fees charged by health care facilities and thus out-of-pocket payment at the point service use. In the insurance arena, unfortunately, the informal sector that has to make this contribution into the common pool is mostly faced with the ability to pay. However, the National Health Insurance Act that governs the operations of the Jirapa-Lambussie District-Wide Mutual Health Insurance Scheme allows individuals especially in the

informal sector to contribute their premiums according to ability to pay which is based on income levels and therefore quite flexible (NHI ACT, 650).

When payment for healthcare started in the mid 1980s, the World Bank, alongside United States Assisted International Development (USAID) and United Nations International Conference of Educational Fund (UNICEF) were the leading international development agencies promoting the adoption of user fees for health care in the public health sector of developing countries (World Bank, 1987). Nonetheless, the World Bank recognized later that fees could limit access to health services by the poor, and therefore most of its policy papers prescribed that fees should be accompanied by appropriate systems of waivers (Griffin, 1992). In spite of their theoretical appeal, the viability of waivers and exemptions is an empirical question. Hitherto, in the early 1990s the World Bank had de-emphasized user fees in the context of health financing and instead begun to promote risk sharing (Dror & Preker, 2002). The phenomenon of paying for services at the point of services consumed necessitated the introduction of the national health insurance scheme but the ability of the populace to raise the premium in the low economic environment remains a key issue to be answered.

Nevertheless, one of the most important necessary conditions for demand for voluntary health insurance is known to be present in many developing countries where there exists a relatively high level of unpredictable out-of-pocket payments for medical services. It suggests that such insurance would be widespread in the sense of covering a large fraction of total medical care spending though it does not guarantee that the spending will be adequate by some

normative definition. This also immediately rules out one commonly mentioned explanation for the absence of voluntary medical insurance that, consumers in general cannot afford the insurance. Affordability is sometimes called unfavorable economic and social conditions and does not have a precise economic meaning in any case and therefore, for some consumers, insurance is affordable precisely because the alternative to insurance is payment out-of-pocket which is voluntarily made. If the high out-of-pocket payments are affordable and they must be if consumers are willing to make them, then insurance in principle is even more affordable. Of course, this argument also allows for the possibility that, even those who would not have had sufficient income to make voluntary out-of-pocket payments would demand insurance. A household unwilling to pay a high but rare out of pocket expense may still be willing to pay the lower annual premium to cover that expense.

Arhin-Tenkorang (2001) notes that health insurance is a mechanism for spreading the risks of incurring health care costs over a group of individuals or households. This is dependent on risk sharing and subsequent cross-subsidization of health care expenditure among the participants. An arrangement designed to provide risk sharing for illness related events, and which is accessible to households in a health insurance scheme regardless of the orthodoxy of its operational modalities. Nevertheless, Arhin-Tenkorang has indicated that some studies have reported that low-income households are initially reluctant to join insurance schemes because they do not readily accept the idea of ‘paying’ for services they might not use.

Similarly, in traditional rural societies, individuals usually expect a return from any contribution they make. The informal risk-pooling arrangements are commonly based on balanced reciprocity, which is the standard for fairness. Any "gift" must be returned at some future time (Platteau, 1997). Health insurance is however different as it implies that the members who will benefit within the near future remain unknown at the time of contribution. For the scheme in Jirapa, an individual who contributes to the scheme but does not fall sick will never benefit and the contribution is non-refundable.

Contributing to the debates surrounding the effects of user fees on service utilization, Nyonator and Kutzin (1999) have also observed that while the upper and middle income persons were better off under a user fee regime because they had access to health care that they perceived to be of good quality because of the fee system, the poor were all excluded from using health facilities by formal and informal charges (Nyonator & Kutzin 1999). According to Gilson 1998 (cited by Basadi et al, 2007), the benefits of user fees have been challenged, particularly with respect to equity of access to healthcare. This accordingly often results in delays in seeking health care, non-compliance to treatment, and consequently premature death especially amongst the poor.

On the contrary, payment of premium to be a member of the Jirapa-Lambussie scheme is according to categories where only the informal sector workers pay cash at the point of registration while the formal sector workers pay through deductions from their monthly SSNIT contributions at source. However, the premiums of children, aged and indigents are paid by the government as

subsidies to the scheme. The government pays subsidy from the insurance fund to the schemes that register such people. Invariably, their registration is free and they may abuse the utilization of the health care service.

Nevertheless detractors of user fees for health services state that fees do more harm than good. They argue that in many cases where fees are imposed, the extra revenue drawn represents only a small and irrelevant share of total revenue (WHO Study Group, 1993); yet at the same time the fees have a substantially detrimental effect on the demand by the poorest (Gilson & Russell,1994). Rather than deterring spurious demand, fees would inhibit appropriate demand, thus keeping use of preventive and curative services below a social optimum, particularly among the poorest members of society (Abel Smith, 1993).

While there is evidence that specific fee structures may improve health care demand patterns –for example higher consultation fees in public hospitals for those bypassing lower-level facilities, existing demands are at a relatively lower cost (Dercon & Ruttens, 1998). Accepting the argument that people are drawn by higher rather than lower (or no) prices for the same service would be questioning the fact that, in general, consumption of goods drops as their price rises. However, the insurance scheme operates on gate-keeper system where a sick insured patient must attend a primary healthcare facility and go through the referral system to a higher facility (NHI ACT, 650).

As a result of the need for patients to pay for health care services, the Ministry of Health of Cambodia in 1996 introduced the National Charter on Health Financing (NCHF) which sought to formalize cost recovery in the form of

user fees around the country: to reduce unofficial charges and household out-of-pocket expenditures; to improve quality of care through increased and timely availability of medical supplies; and to motivate staff through performance-related payments funded by fees (National Charter on Health Financing in the Kingdom of Cambodia, 1996). In essence therefore, the introduction of health insurance in any country helps not only in making health care accessible and affordable to the citizenry especially, in public health facilities but also prevents financial leakages and illegal charges and therefore the situation in Ghana is not different. Diagnostic-Related-Grouping (DRG) billing system that eliminates itemized billing is instituted in the Jirapa district to avoid illegal charges at the facility level (NHI Tariff and Benefits Package, 2008).

The insurance policy

This is the policy framework that governs the operation of the insurance scheme and every formal scheme has a policy that regulates its operations.

Gertler, Locay and Sanderson (1987) used empirical results from their analysis of health care demand in Peru to suggest that the adoption of a flat consultation user fee in Ministry of Health facilities could promote inequality in access to healthcare. Accordingly, demand by the poor drop significantly in response to a price increase and a simultaneous improvement in quality, while demand by the poor could fall with the flat fee policy and that of the non-poor could go up. These authors recommended the adoption of a system of sliding fees on the basis of ability to pay. Further, it has been shown that fees are not the only costs faced by potential users of health services. For example, in Cambodia

transportation and food costs associated with the use of hospital services could greatly exceed the fees charged by the provider (Hardeman, 2001). Thus, while fee exemptions may improve equity in access, to be effective in some cases they must be accompanied by supplementary subsidies to defray additional and significant non-fee costs associated with consumption.

In Morocco for example the poor can obtain indigence certificates through their local governments, thereby becoming entitled to free health care in government health facilities. The process for the awarding of such certificates, however, is subject to abuse, and thus subsidies appear to be poorly targeted. It is estimated that the richest quintile captures 40 percent of Ministry of Health spending while the poorest 40 percent receives less than 20 percent of Ministry of Health resources (World Bank, 2001b). When there is a leakage there is a case for improving the efficacy of targeting, as this will help to reach the poor with the subsidy and thus exempt them from the fees.

In Community Based Insurance (CBI), owners are individuals and households whose degree of asset diversification is still far lower. As a result, the low income level of CBI enrollees may force most CBI schemes to stick to narrowly defined products in spite of a basic need for diversification (Musau, 1999). For example, the Mburahati Health Trust Fund in Tanzania only offers a limited benefit package of outpatient care, along with a cost reimbursement of 10 percent for treatment in public hospitals. Chronic diseases, Human Immuno-deficiency Virus/Acquired Immune Deficiency Syndrome, and tuberculosis are not covered (Musau, 1999).

On the other hand however, an unregulated private insurer has the option to specify its offer along three dimensions (Zweifel & Breyer, 1997). Firstly, it can decide to cover only certain types of services and leave out others, for instance, to include inpatient and exclude outpatient care like the community health fund in Tanzania (Musau, 1999). Secondly, it can differentiate its offer by covering or excluding services offered by certain provider categories, for instance including only physicians registered with a public agency and excluding those who are not. Thirdly, it may determine the amount of the benefits paid in case of sickness. On the contrary, the national health insurance scheme operated in Ghana includes both inpatients and outpatients services but only excludes certain services (NHIA, 650).

The social type of health insurance scheme operated in the Jirapa District is state owned but insists that its citizens should belong to one of the insurance schemes in the country. The government generally sponsors national health insurance scheme and membership is usually compulsory for specified segment(s) of the population. In this wise, the government may decree that all members of the population be insured or restrict its requirement to low-income or high-risk groups, essentially those who might be unwilling or unable to finance what is thought to be an 'appropriate' level of health care (Creese & Bennett, 1997; Atim, 1998; Bennett & Gilson, 2001). Generally, social insurance is aimed at providing accessible, equitable and affordable health care to all its populace but more particularly the poorest segment of society. Based on the aforementioned, all residents of the Jirapa District are required by the National Health Insurance Act

(Act 650) to enroll with the scheme within five years. However, membership to the scheme is currently voluntary as citizens can join or not as and when they want. All communities in the district have registration agents and community health insurance committees who register interested clients and also sensitize members on the concepts of the scheme. Registration of members is also done in the scheme's office, designated places in the various communities and at homes.

In order to avoid adverse selection, the policy requires that both parents are registered before their children below 18 years can benefit freely from the scheme. In addition, subscribers who are 70 years and/or above and indigents are expected to enroll with the scheme without paying premium, while two-and-half percent of SSNIT contributions of all formal sector workers are deducted automatically at the end of each month (L I, 1809).

The validity of membership is one year and must be renewed before expiry. This arrangement is to ensure that every person living in Ghana is a member of the scheme and contributes in accordance with the principle of ability to pay, in order to enjoy the minimum benefit package of health care services covering over 95 percent of diseases afflicting Ghanaians. The government collects national Health Insurance Levies on selected commodities and services which are used to pay for bills of the exempt categories to ensure that every person living in Ghana has equitable access to quality health care (NHI Act, 650). It is therefore estimated that 100 percent of the entire people resident in Ghana should enroll with the scheme taking cognizance of its enormous benefits over the "cash and carry system".

According to Price and Mays, 1985 (cited by Hurd & McGarry, 1996), social insurance schemes do not encourage adverse selection as that can collapse the system if only sick or old people are allowed to enroll. Apparently, adverse selection is sufficiently widespread that it can be detected empirically, and several papers have provided evidence of selection in the non-elderly population (Price & Mays, 1985; Marquis & Phelps, 1987). In this regard, Wolfe and Goddeeris (1991) found that those with large past expenditures were significantly more likely to hold private supplemental insurance; yet, those whose health was poor were not more likely to hold private insurance than those in good health. Similarly, Eggers and Prihoda (1982) also found that when Medicare recipients were given a choice of enrolling in a Health Management Organization or continuing with a fee-for-service program, the healthier elderly chose the Health Management Organization while the less healthy remained with a fee-for service plan, providing some evidence of adverse selection. Therefore, any selection would have to be by unobserved tastes for service use, but those tastes are not related to health status.

Schieber (1997) reported that though there were strong arguments in favour of universal coverage for health insurance which could be brought about by mandatory membership, this type of health insurance was not feasible in an environment where most people were self-employed or informal sector workers.

With regards to synchronizing contribution collection with income earning period by mutual health organizations, Bennett et al (1998) reported that, majority of them in Africa appear to have achieved synchronization of the collection of

contributions with the income earning periods of the target population. They further mentioned that, mutual health organizations (MHOs) based in rural communities, for example, Ghana and Senegal were collecting monthly premiums, while others were collecting four years automatic deductions spread over just the first three months.

According to Hoff and Stiglitz (1993), moral hazard may be even less of a problem in Community Based Insurance Schemes which usually consist of small risk pools. First, asymmetric information is less pronounced in a small community, where each member of the pool can easily monitor the behaviour of the others. Therefore, any overuse of an extended benefit package would be quickly detected. Furthermore, the sanctions meted out by the community can be enormous constituting a very effective device to enforce discipline among the insured. The experience of community-based credit schemes is instructive in this regard. Failure to pay back a credit may be sanctioned by whipping and indeed expulsion from the community (Hoff & Stiglitz, 1993). Ultimately therefore, Community Based Insurance schemes should be less hampered than private insurers by moral hazard considerations when deciding about an expansion of their benefit package.

Ultimately, the enactment of the National Health Insurance Act (Act 650) in 2003 in Ghana was a response to the adverse equity impact of user fees. Hence, the vision of government in instituting a national health insurance scheme in the country was to assure equitable and universal access for all residents of Ghana to an acceptable quality of essential health care. In sum, the policy

objective is that by 2005 every resident of Ghana should belong to a health insurance scheme that adequately covers him or her against the need to pay out-of-pocket at the point of service use. This was to ensure that they had access to a defined package of acceptable quality of health services (Ministry of Health, 2004a).

Quality of healthcare services

The type of healthcare services covered by an insurance scheme, professional competence of staff, availability of essential drugs and logistics including infrastructure is important in determining the quality of healthcare services provided to clients (Pauly, 2004).

According to Birdsall, 1983 and Nickson, 1990 as cited by Bitran and Giedion, 2003, proponents of user fees for health care had argued that fee revenue could make public spending more efficient: by improving the availability of complementary inputs such as medicines, user fees helped put to better use the otherwise underutilized government-financed health workers and infrastructure. In addition, by financing medicines and other supplies, fees could make it possible for government health providers to improve the quality of care (Bitran and Giedion, 2003).

Similarly, Akin (1986), another supporter of user-fees as cited by Bitran and Giedion, (2003) also noted that even where government-provided health services were nominally free of charge, in practice not only quality was low but there were hidden payments and additional user costs (such as long waiting and private purchases of medicines) that resulted in low or unmet demand. As a

consequence, low fees for low-quality public services constituted a less desirable policy than some fees for better quality care. However, the Jirapa scheme was established as a pro-poor policy and therefore, not all subscribers paid the premium and yet quality health care was expected to improve. Health care providers were therefore expected to comply with the patients' charter, standard treatment protocols and contractual agreement signed with the scheme to ensure that good quality of health care services were provided to insured clients.

Similarly, evidence from the Dominican Republic and El Salvador indicates that nominally free, low quality government health services face low demand (Bitran, 1989). At the same time, even the poorest pay substantial fees for better or more accessible private care, showing thereby that, even the poor often prefer to make some user fee payments rather than consume low quality, free services. Some also believed that fees convey a signal of higher service value that boosts demand above that achieved when the same services were offered free of charge. According to Birdsall, 1986, fees promoted a sense of ownership of the services received, thus empowering consumers to demand greater quality and higher provider accountability as cited by Bitran and Giedion, 2003. It was clear from this analysis that health insurance should not be nominally free but individuals must be made to contribute a certain commitment fee so as to avoid abuse and also ensure maximum utilization of services. Although the Jirapa scheme membership was free for some members, quality of healthcare provided by accredited facilities was in accordance with the Ghana standard treatment protocols. The quality of healthcare was therefore expected to be high.

Implementation of an insurance scheme generally required health providers to institute certain measures to be able to conform to the new ways of working with clients, for example, billing procedures, payment methods, service quality issues etc. (Atim, 2000). Sheppard (1996) also recommended that decentralization especially with providers' involvement could be important within community –based Health Insurance Schemes. For example, in Bokoro in the Democratic Republic of Congo, each health sector participating in the community health insurance scheme, exercised some control over its profit as a 25 percent share was allocated for its immediate use. They also noted that while nurses welcomed the commission of 3 percent of the premium income they collected, they also seemed to appreciate being part of a well –functioning system that allowed them to use the locally –available resources to provide health care to their population.

Hitherto, Gilson (1997), in her review of the experience with user fees in the health sector in Africa, noted that if fees were associated with quality of improvements, as in community financing schemes of the Bamako Initiative type, this offsets their negative impact on utilization, and the introduction of fees plus quality improvements may even generate utilization increases among the poorest. Conversely poverty itself induces illness as medical care is out of reach.

Client Assessment conducted by Dean (1999) showed that health care and health insurance organizations were more comprehensive than assessment of medical care. It encompassed medical, social, cognitive and emotional components (Dean, 1999). Similarly, according to Linder-Pelz`s, in client

satisfaction theory, client satisfaction with health care as an attitude, was based on the summation of the very subjective assessments of the dimensions of the care experienced (Linder-Plez, 1982). These dimensions could include interactions with health insurance operators and agents, health care providers, the ease of access, the burden of costs and environmental issues such as cleanliness of the health facility.

However, Jessie and Shiela (2001) stated that understanding how clients evaluate their health care and how their health insurance scheme was managed was critical to the development of sound initiatives aimed at increasing health insurance coverage and health care delivery improvement ultimately. However, research with clients of mental health services suggested that they could effectively discriminate between services that were different in quality (Lebour, 1983; Sheppard, 1993). It was, however, important to recognise that evidence of positive client satisfaction was not, in itself, sufficient to establish the effectiveness or accessibility of treatment. Clients with no basis for comparison may be satisfied with services that were ineffective as determined by more objective outcome evaluations. On the other hand, clients may be displeased with services that achieved the objective of reducing their financial burden.

Many satisfaction surveys of clients of health and social services had shown high levels of satisfaction partly because they had used insensitive measures (Ruggeri, 1994). Similarly, the client survey report by Basadi et al (2007) indicated that subscribers of the Jirapa-Lambussie scheme had adequate knowledge and were generally satisfied with the minimum benefit package

offered by the scheme considering the minimum premium of seven Ghana cedis, twenty pesewas (GH¢7.20) although some basic drugs in the national health insurance drugs list were absent.

Efficiency of the insurance scheme staff

As a result of the increasing emphasis on cost containment and competition amongst the public and private care providers as well as the complex interactions between health insurance scheme, clients and health care providers, it become more important than ever for health insurance schemes and managers to have an accurate representation of clients` perception of care and the operations of health insurance scheme (Jesie & Shiela, 2001). Most studies that have been conducted on community financing scheme have dwelt on their effectiveness and have recommended government involvement in the schemes operations.

According to Caroline Quijasta (2006), Zimbabwe health insurance premiums increased by 7.7 percent - two times the rate of inflation. The annual premium for an employer health plan covering a family of four averaged nearly $11,500. The annual premium for single coverage averaged over $4,200. Experts agreed that the health care system was riddled with inefficiencies, excessive administrative expenses, inflated prices, poor management, inappropriate care, waste and fraud. These problems significantly increased the cost of medical care and health insurance for employers and workers and thus affected the security of families.

However, Musau (1999) notes that Community Based Insurance disposed of minimum administrative capacity meaning that their capability of monitoring

the behaviour of health care providers was very limited. Therefore, they might ran an even greater risk of purchasing services of lower quality when benefit package was extended. This forced them to concentrate their package on those possibly few services where purchasing was little affected by corruption. A public health insurer in principle was affected by corruption in the same way as a private one in that, it could offer only fewer services or lower-quality services for the amount of payroll tax or general tax received. This meant that the benefit package was not as comprehensive as it could be. However, the list of benefits cannot easily be purged on those items which suppliers provided (Musau, 1999).

Governments lacked the administrative and management capacity needed to establish and run social security schemes (Jutting, 1999). The average African government often did not have sufficient popular credibility for the organization and management of a nation-wide social insurance system (Criel, 2000). Insurers and providers needed sufficient managerial skills, which were often not available. Insuring public and private sector employees had often led to greater inequity. It benefited an already privileged population, increasing their access to both private and public sources of care.

In a situation where government health facilities remained heavily subsidized, consumption of their services by the insured implies double subsidy. While Mutual Health Organizations had the potential to influence efficiency in the health sector, majority of schemes did not use the spectrum of available design tools and mechanisms such as mandatory reference, co-payments, deductibles, ceilings on benefit cover, strict checking of members' identity, or an essential and

generic drugs policy (Atim, 1998). Many schemes suffered from poor design. Financial and managerial performance was weak to moderate. According to MAE (2000), a condition of improved efficiency was that free preventive and health promotion services were included in the package (cited by Gotz et al-www.gtz.de/health-insurancesept.2009). However, resource mobilization capacities were often modest and limited by the low amount of the insurance premium, low premium and cost recovery, low coverage rates and weak marketing capacity.

Often managers of MHOs lacked technical competence and schemes do not function efficiently. Some schemes took up quality issues when negotiating contracts with providers. The study by Atim (1998) found that few insurance schemes neither checked provider prescriptions nor monitored the quality of care delivered to their members. For MHO managers, it was difficult to enforce the stipulated quality aspects when providers were not fulfilling their contractual requirements. But schemes needed to initiate dialogue between users and providers of health services (Criel, 1999).

Conceptual framework

The mode of operation of the national health Insurance system

The main aim of the National Health Insurance Scheme is spreading the risks of incurring the healthcare cost of an individual over a group of subscribers. Prior to its implementation, access to healthcare had been hindered by ability to pay and thus the scheme was introduced to minimize or eliminate the financial barriers to access health care services at the time of illness. The scheme operated

under two main institutional frameworks; National Health Insurance Act (Act 650) and Legislation Instrument, 1809 with three main stakeholders; District Mutual Health Insurance Scheme/National Health Insurance Authority (NHIA), Subscribers and Service Providers as shown in figure 1 and 2 below.

The scheme registers subscribers, collects premiums from subscribers, receives funds from NHIA, issues ID cards to subscribers, administers claims and pays for the services offered to insured clients by providers. The schemes were funded and regulated by the National Health Insurance Authority and the two were therefore considered as one stakeholder.

On the other hand, subscribers register with the scheme, pay premiums and processing fees, issued with ID cards to access health care at accredited health facilities.

The final stakeholder of the scheme was the Service Provider, who authenticates insured clients' membership, provide treatments to clients, process claims and submit to the scheme for payment. In short, the Scheme collected premiums from subscribers, purchased healthcare services from providers for subscribers to benefit at the time of illness.

Therefore, all the three stakeholders were equally important and hence any break at any point in the process described above would disrupt the entire cycle of activities. That is if Service Providers did not provide satisfactory health care to insured clients, those who had not yet registered with the scheme would not do so any more and thus enrolment would be low. Similarly, those who had already registered but their cards expired would not renew the membership if card bearers

did not have access to health facilities with adequate health professionals to treat them when they were sick. Finally, the conduct of the scheme staff also had a very significant influence on membership registration and renewal as people would still have to pay for their health care cost if identity cards were not produced for subscribers and therefore joining the scheme would not be necessary. The mode operation of the scheme is shown by the institutional frame works in Figure 1 and 2.

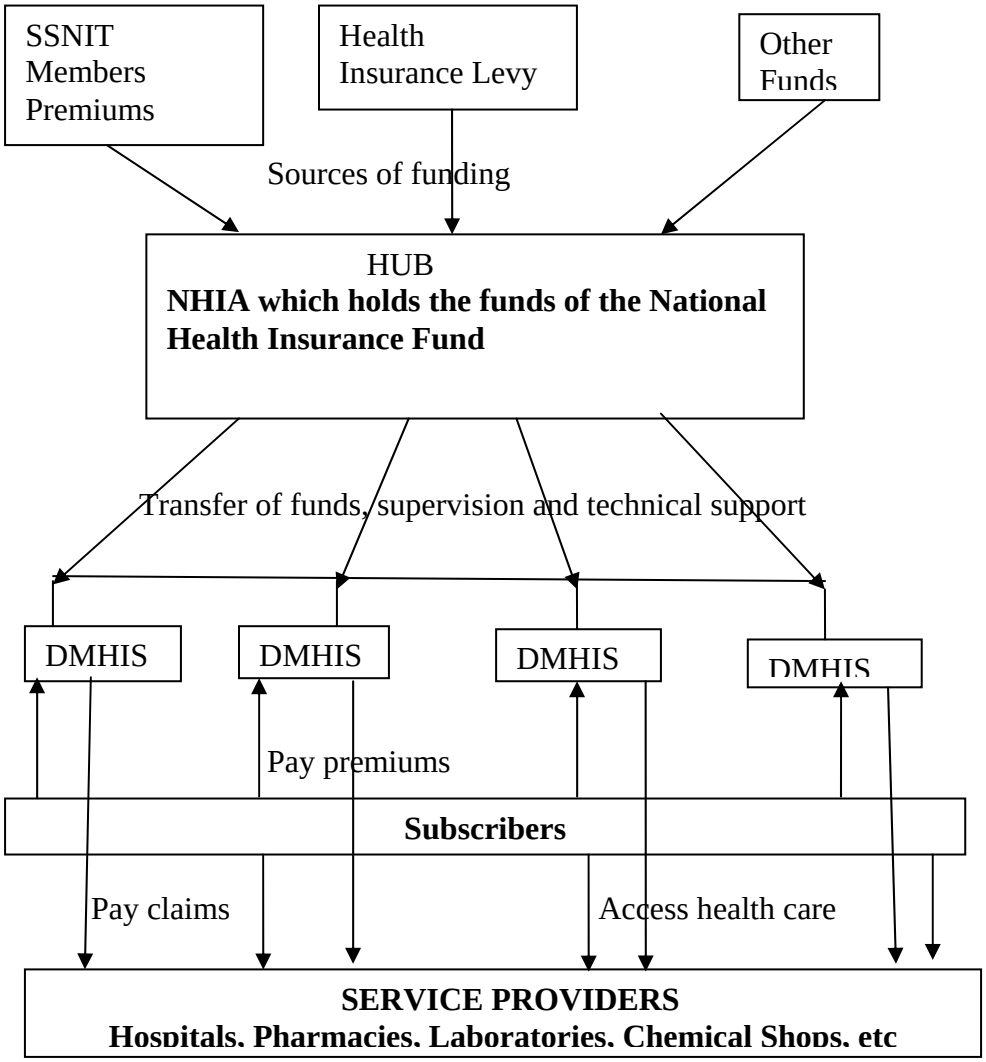

Figure 1: Existing institutional framework- National Health Insurance Act (Act 650)

Source: National Health Insurance Act (Act 650)

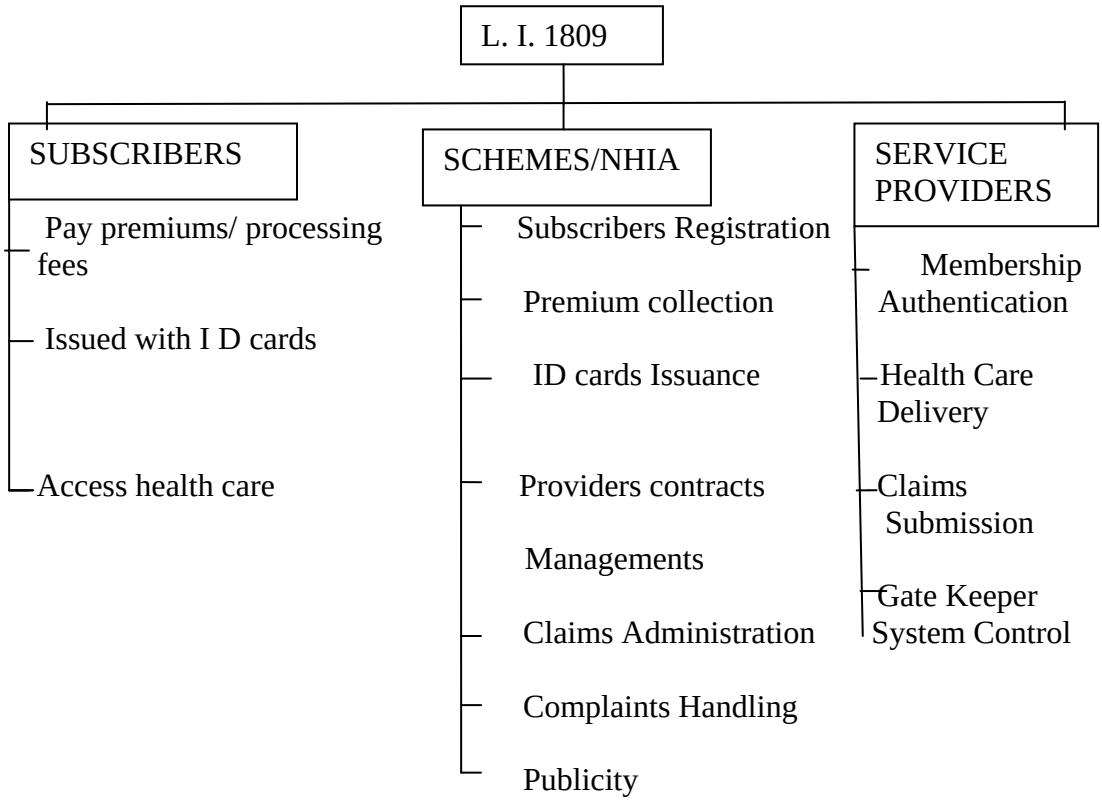

Figure 2: Existing institutional framework-national health insurance regulations, 2004 (l. I. 1809)

Source: Health Insurance Regulations, 2004 (L.I.1809)

CHAPTER THREE

METHODOLOGY

Introduction

This chapter gives a detailed explanation of the research methodology of the study. It presents the study area, research design, study population, sample and sampling techniques, sources of data, data collection instruments, reconnaissance visit and pre-test, administration of the data collection instruments, field work and related challenges, data analysis and presentation.

Study area

The study area focus principally on Jirapa district created from the Jirapa-Lambussie district in 2008. The Jirapa-Lambussie district was located in the North Western corner of the Upper West Region of Ghana. It was situated approximately between latitudes $10^0.25^{'}$ and 11^0 North and longitudes $20^0.25^{'}$ and $20^0.40^{'}$ West. It was the largest district in the region and covered a total land area of 1,667.6sq km. It was bounded to the North by Burkina Faso, to the west by Lawra District, to the East by Sissala West District and to the South by Nadowli District. The district capital, Jirapa was 62 km from the regional capital, Wa.

The Jirapa district had a total population of 72,652, projected from the 2000 population and housing census (Ghana Statistical Service, 2000). It had 183 communities dotted in the entire area. Most residents of the District were

Dagaabas with few other tribes forming the minority. There were varied religious bodies in the district with Christians denominating.

The spatial distribution of human settlement pattern reveals a dispersed type of population distribution due to land ownership. Jirapa town was the only town in the district with most of the communities being small and dispersed with population sizes ranging between 500 and 1000 people. The main economic activity in the district was agriculture with few people involved in petty trading/commerce. However, the farmers were predominantly peasants (small-scale) for domestic consumption.

The district falls in the Guinea Savanna climatic Zone and experienced one season of rainfall and a long dry spell. However, the rainfall distribution varied from year to year sometimes with intermittent droughts and floods with most peak rains in September. Generally, the rainfall ranges between 900-1000mm per annum. The major and economic trees in the district were shea, dawadawa, baobab and neem species.

Research design

The study was cross-sectional involving a single contact with respondents who possessed the same characteristics. It also covered all categories of people such as children, adults and the aged. It best suited the study because it explored the perceptions of the people on the scheme at a point in time.

The study was also qualitative and quantitative in nature. It was qualitative nature because it provided opportunity for the respondents to express their views on the operations of the scheme. Thus descriptive and explanatory strategies were

implored to identify reasons why people living in the district did not register or failed to renew their membership with the scheme. It was also quantitative nature because it requested figures such as age and level of income of the respondents. It was retrospective in nature because it sought views from past events that related to benefits and challenges of the scheme.

Study population

The target population was made up of non-insured members of the Jirapa-Lambussie District-wide Mutual Health Insurance Scheme in the Jirapa district. This included members who registered with the scheme but did not renew and are therefore no longer members. It also included people living in the district but who never enrolled with the scheme since its inception.

This population included children, informal sector workers, social security and national insurance trust contributors, social security and national insurance trust pensioners, aged and indigents. Hence, the category of people selected for the study would represent all sectors of the population. Therefore, the findings would reflect the true perception of all people in the district about the scheme and the country at large.

Sample and sampling techniques

The Jirapa District was made up of eight area councils. Out of the eight area councils, the researcher selected five of them for the study. The five area councils were selected based on enrolment data of subscribers at the scheme office. Area councils with low enrolments were selected because the study was interested in finding out factors that caused low registration and membership. The

selected area councils were Tuggo, Sabuli, Duori, Tizza and Gbare (JL/DMHIS, 2008). Prior to the establishment of the scheme, data of all households was taken and database created. With this database, the list of both the never-insured and the insured but who failed to renew their membership was obtained.

According to Siegel (1997), one is free to choose any sample size from an identifiable group of individuals, and that there is no requirement that the sample size should be the same for each group but according to the population of the group. Guided by this assertion, the sample sizes of the various communities that constituted the target population were obtained based on the total non-insured individuals in each community selected.

The total population of the district was 72,522, out of which 52,266 people were registered members of the scheme (JL/DMHIS, 2008). However, the total membership of the non-insured in the five area councils was 598. According to Sarantakos (2005), a population of 598 can be adequately represented by a sample size of 232 people. Borg and Gall (1989) posited that for individuals in a defined population to have an equal probability and independent chances of being selected as members of a sample, systematic sampling could be employed to reach the desired sample units. However, stratified random sampling procedure was employed in selecting the sample size of 232. This procedure provided a fair representation of those who never registered with the scheme and those members who ever registered but did not renew their membership.

Table 1: Area Council populations and sample size

Area council	Population Did not renew	Population Never registered	Sample Did not renew	Sample Never Registered	Total Sample
Tuggo	41	51	16	20	36
Sabuli	113	32	43	12	55
Duori	133	21	50	9	59
Tizza	39	44	15	18	33
Gbare	106	18	41	8	49
Total	432	166	165	67	232

Source: field work, 2009

The sampling frame was in two groups. The first comprised those who never registered with the scheme and the second comprised those who registered but did not renew from each area council. With the sample sizes determined above, the units were drawn from each sampling frame by means of sampling (symbolized by q) that is equal to N/n, where N is the number of units in the target population and n is the number of units of the sample for each sample frame of each area council. A number was then randomly selected between one and the sampling fraction, q which served as the reference point. A count was made from this reference point and each time the sampling fraction, q was reached, the number corresponding to it was recorded until the sample was obtained. The sum of two sampling frames from each council was then computed and these constituted the final sample size as shown in Table 1 above.

Sources of data

The data for the study was obtained from both primary and secondary sources. Primary data was obtained through the use of interview schedule on non-insured members of the scheme in the district. However, secondary data was obtained from the scheme office in Jirapa, the Regional Office of National Health Insurance Authority-Wa and Jirapa District Assembly.

Data collection instruments

The main instrument used for collecting the primary data for the study was interview schedule. The interview schedule included both close-ended and open-ended items. The combination of these types of questions provided the respondents the opportunity to adequately express their opinions in the open-ended questions. There were also quality control questions to cross check the reliability of the answers provided by the respondents.

The items in the interview schedule included background information of respondents such as level of formal education, occupation, age, religious affiliation, nationality and sex. There were questions on ability-to-pay premium, nature of the insurance policy, quality of healthcare rendered to the insured and non-insured and the work efficiency of scheme staff. These areas were assessed using multiple choice questions and the Likert's scale in particular to facilitate easy response to the questions.

Reconnaissance visit and pre-test

Four field assistants were recruited and trained to help in the administration of the research instrument. The training was based on the data

collection instruments and ethics of research as majority of the community members were illiterates. The training was also based on effective translation of the interview schedule into the local language. The data collection instrument was pre-tested and errors detected were corrected before the actual exercise was carried out.

Administration of the data collection instruments

The field assistants recruited used 18 days to collect the data from the field. They arranged with the interviewees on the appropriate times to conduct the interviews. This enabled the respondents to be relaxed and composed during the questioning so that they could respond appropriately to the questions. For the illiterate respondents, the interview was conducted in the local.

Field work and related challenges

Some respondents initially did not want to respond and had to be persuaded after explaining the rationale of the study to them. It resulted in spending more than the stipulated time which added to cost. Others also said the questions were too many and wanted to stop along the line but were encouraged to complete the interview. Another major challenge was that some of the selected respondents had travelled and had to be replaced by different people.

Data analysis and presentation

The data was analyzed using Statistical Package for Service Solutions (SPSS) Version 16. The data was edited, coded and then entered into either the SPSS or excel programme and analyzed. The products were presented in charts,

percentages, frequencies, tables and graphs. The data systematically analyzed, interpreted and presented under the following relevant captions: background characteristics, ability to pay premium, the nature of the insurance policy, quality of healthcare services provided and efficiency of the scheme management staff.

Limitations

The study was designed to cover all the non-insured clients in the entire Jirapa district where the scheme operates but due to a number of constraints such as inadequate funds to acquire enough logistics, inadequate requisite human resource and inadequate time on the part of the researcher, the study was only conducted in five area councils in the district.

Interview schedule was the main instruments for the data collection. However, given enough time, observation and focus group discussions could also be employed to elicit more information from the respondents. Nevertheless, the interview schedule was selected because it provided opportunity for the researcher to ask probing questions in order to elicit more information from the respondents who may otherwise not understood the questions. It also had an additional advantage since the respondents were free to express their opinions by way of questioning the researcher on issues pertaining to the study.

Stratified random sampling technique was used to determine the sample size since the perceptions of two groups from the target population (those who never registered and those who did not renew their membership after expiry) were needed for the interview. It ensured that fair representations of the two groups were selected to constitute the sample. The sample size was two hundred and

thirty two (232) non-insured clients comprising the above since the inception of the scheme. This sample enabled the researcher to understand why people were not enrolling with the scheme or did not renew their membership.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

This chapter deals with the data analysis and presentation of respondents perceptions about the National Health Insurance Scheme in the Jirapa District.

Background characteristics of respondents

Specific background characteristics of the respondents, which were considered relevant to the study included: sex, age, tribe, nationality, religious affiliation, level of education, and occupation of the respondents.

Sex of respondents

Sex describes the gender of respondent as either male or female. The study results as indicated in Table 2 shows that about 74.0 percent of the respondents were males while 26 percent were females. The high proportion of the male sample tends to suggest that most males were not insured at the time of the interview.

Table 2: Distribution of respondents by sex

Sex	Frequency	Percent
male	172	74.0
female	60	26.0
Total	232	100.0

Source: Field work, 2009 n = 232

Age of the respondents

Age is the number of months or years a person lives on earth. The study results indicated in Figure 3 show that the respondents were within age range of 10 to 70 years and above. The wide range of ages helped obtain information from different categories of people. The results revealed that about 25 percent of the male respondents and 11.6 percent for females were within the age range of 26-35 years. Generally, about 78 percent of the respondents whose ages were between ranges of 18 and 45 years were not insured. In addition, most of the respondents in this age group were males. This age range was within the adolescent age brackets who were usually healthier and mostly do not fall sick very often.

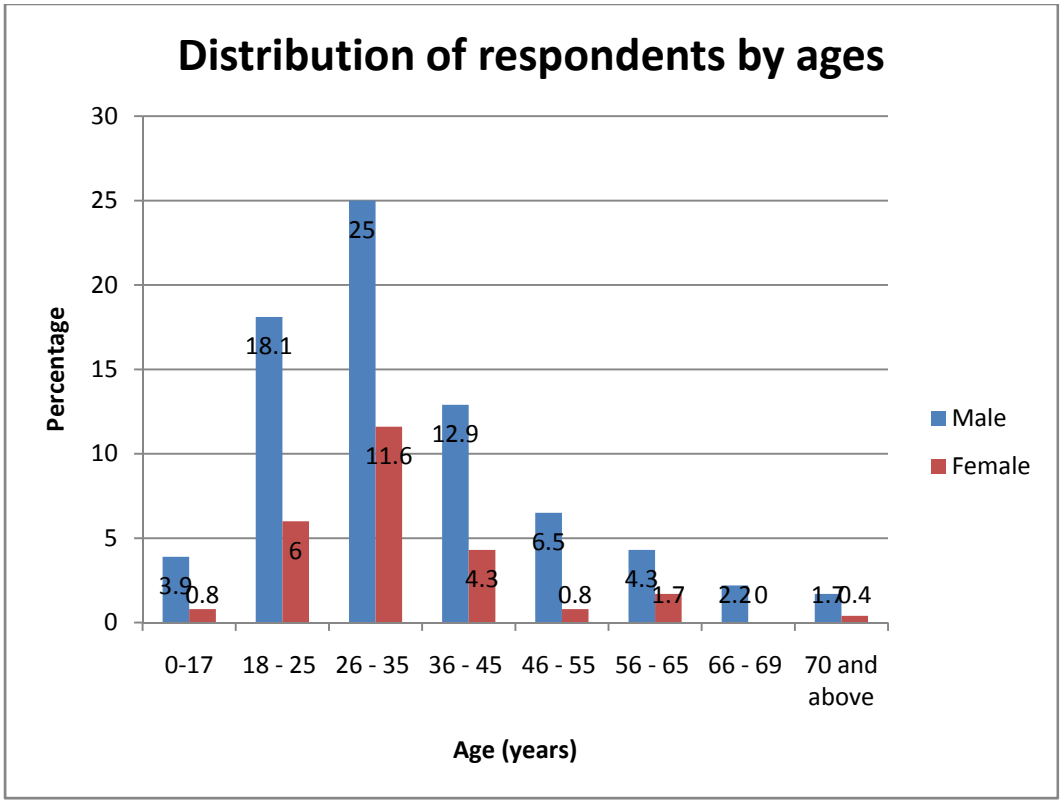

Figure 3: Distribution of respondents by ages
Source: Field work 2009

Ethnicity of respondents

Ethnicity represents a particular group of people from one ancestral origin living in a place. The study results in Table 3, showed that the rural populace of the district was ethnically heterogeneous with Dagaabas as the predominant ethnic group with 93.5 percent. However, the Waalas were the next dominant ethnic tribe in the District. Nevertheless, Ashantis, Sissalas and other tribes representing 0.9 percent each were also in the district. The perception of Dagaabas who constituted the highest respondents on the national health insurance scheme could therefore have an effect on the findings of the research.

Table 3: Distribution of respondents by ethnic groupings

Tribe	Frequency	Percent
Dagaabas	217	93.5
Waala	9	3.9
Sissala	2	0.9
Ashanti	2	0.9
Others (specify)	2	0.9
Total	232	100.0

Source: Field work 2009 n = 232

Marital status

Marriage is seen as a socially recognized union between a man and a woman. Results from the study in Table 4 indicated that about 61 percent of the respondents were married, 31 percent never married and 3 percent separated. It can be deduced from the results that marriage had a significant influence on the

scheme's membership. Most married people were not be able to register with the scheme possibly due to other financial burden on their families. Similarly, marriage people could also be exploring other means of solving their health issues that do not require health insurance.

Table 4: Distribution of respondents by marital status

Marital status	Frequency	Percent
Married	142	61.2
never married	72	31.0
Widowed	11	4.7
Separated	7	3.0
Total	232	100.0

Source: Field work, 2009 n = 232

Nationality of respondents

Nationality depicts the country of origin of the respondent. The study results in Table 5 showed that the majority (99.6%) of the respondents were Ghanaians. This implies that most residents in the district were Ghanaians and should have registered with the scheme.

Table 5: Distribution of respondents by nationality

Nationality	Frequency	Percent
Ghanaian	231	99.6
Ivorian	1	0.4
Total	232	100.0

Source: Field work, 2009 n = 232

Religious background of respondents

This has to do with the belief system of the respondent as that would influence on how disease situations would be interpreted and treated. The results gathered on the respondents on their religious backgrounds as presented in Table 6 showed that about 70.0 percent were Christians, 19.0 percent traditionalists and 0.4 percent belonging to other religions. This meant that majority of the residents in the district were Christians followed by traditionalists. It was believed that most Christians would normally seek orthodox methods of treatments before seeking other alternative means while most traditionalists would seek other forms of treatments before seeking the orthodox treatments. It was therefore expected that most respondents would go to hospital when sick.

Table 6: Distribution of respondents by religion

Religion	Frequency	Percent
Christian	162	69.8
Muslim	25	10.8
Traditionalist	44	19.0
Others (specify)	1	0.4
Total	232	100.0

Source: Field work 2009. n = 232

Duration of stay of respondents

This variable was aimed at exploring the length of time the respondent lived in the district. This would determine whether the respondent could have heard about the scheme before or not. Out of the total respondents of 232, the

study results in Table 7 showed that majority (84.1%) of the respondents had lived in the district for more than 10 years while only 1.7 percent living less than one year. This means that most of the respondents lived in the district for more than a year and could have heard about the scheme to possibly subscribe to.

Table 7: Represents respondents length of stay in the District

Number of years of stay	Frequency	Percent
less than one year	4	1.7
1 - 5 years	21	9.1
6 - 10 years	12	5.2
more than 10 years	195	84.1
Total	232	100.0

Source: Field work, 2009 n = 232

Occupation of respondents

Occupation is the major legal economic activity one does for a living. Results of analysis of data collected from the field as shown in Figure 4 indicated that about 55.0 percent of the respondents were farmers, 29.7 percent civil servants and 5.2 percent artisans.

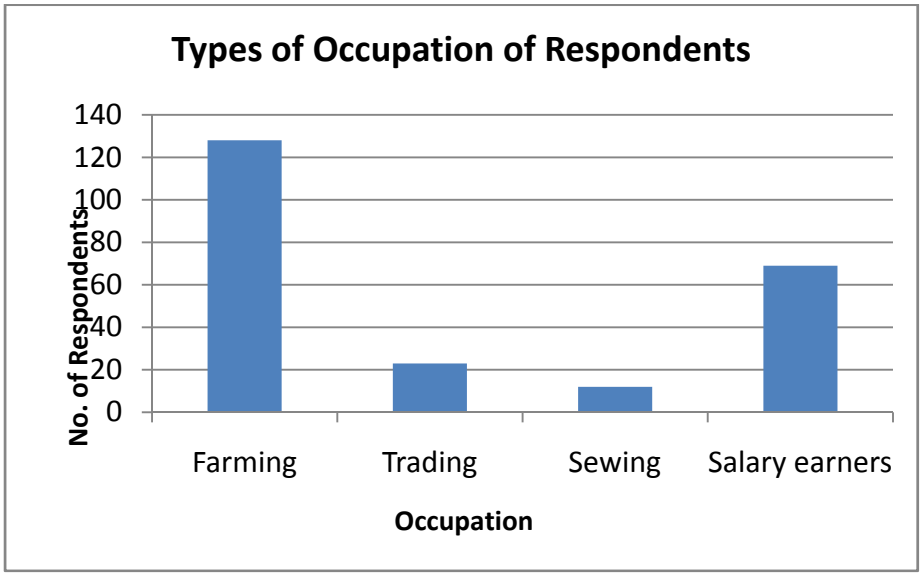

Figure 4: Distribution of respondents by occupation
Source: Field work 2009

Level of income of respondents

Income is the amount of money earned for a job done. This could be on daily, weekly or monthly basis. The data analysed on income has shown that more than half of the total respondents (51%) earned less than Gh¢10.00 at the end of the month while only 13 percent earned Gh¢50.00 and above as presented in Table 8. These amounts were woefully inadequate to meet the basic needs of the people and hence a likely contributory factor to their inability to register with the scheme.

However, the value of the Chi-square test between occupations and incomes of the respondents was 47.420 which was significant at the 1 percent level. This meant that incomes and occupations of the respondents were positively related.

As shown in Figure 4, farming was the most readily available job for most people in the district and yet, seriously challenged because only one raining season was usually experienced in that part of the country coupled with the fact that the land was infertile as the same piece of land was farmed virtually every year. Consequently, most people were poor and could not afford healthcare cost at the point of services used.

Table 8: Distribution of respondents by level of income

Income range	Frequency	Percent
Less than Gh10.00	112	51.0
Gh10.00 - Gh20.00	65	30.0
Gh20.00 - Gh30.00	8	4.0
Gh30.00 - Gh40.00	7	3.0
Gh50.00 and above	28	13.0
Total	220	100.0

Source: Field work, 2009. n= 232

Membership status of respondents

Analysis of the data in Table 9 showed that about 72 percent of the respondents ever registered with the scheme but never renewed their membership while 28 percent never registered at all. This finding confirmed Arhin-Tenkorang's, assertion that low-income households were initially reluctant to join insurance schemes because they do not readily accept the idea of 'paying' for services they might not use. This result may explain the reluctance of members to register in the first place and even those who register but do not benefit for the

whole year to renew membership. It could also be due to poor quality treatment offered to insured patients at the health facilities (Arhin-Tenkorang, 2001).

Table 9: Shows membership status of respondents

Membership status	Frequency	Percent
Ever registered	167	72.0
Never registered	65	28.0
Total	232	100.0

Source: Field work, 2009 n = 232

Distribution of premium with respect to year of registration and amount paid as presented

From the data analysis shown in Figure 5, about 33 percent of the respondents subscribed to the scheme in 2007 when the premium was GH¢7.20 but declined to 18.2 percent in 2008 when the premium increased from GH¢7.20 to GH¢8.00. Clearly, any increase in premium level will eliminate many potential subscribers from the scheme.

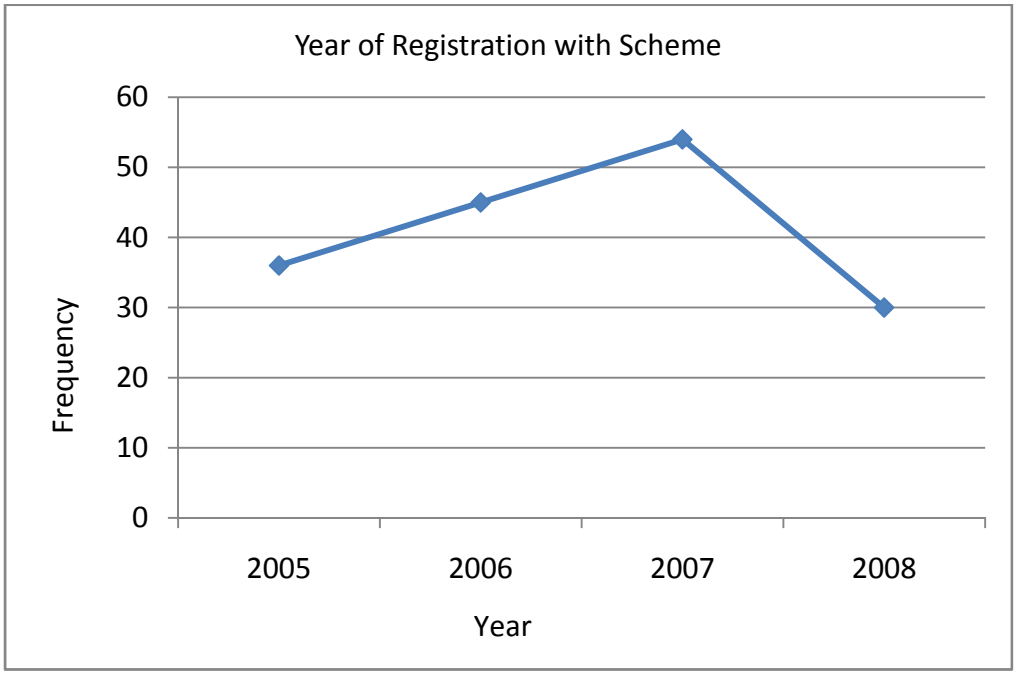

Figure 5: Distribution of respondents with respect to year of registration.
Source: Field work 2009

Premium payment

Out of 165 respondents who were interviewed, 88.5 percent had earlier registered with the scheme and paid premium of GH¢7.20 but failed to renew their membership in the subsequent years when the premium was slightly increased to GH¢8.00 (Table 10). Thus increase in premium could reduce enrolment as many people would not be able to pay. The result is similar to findings by Nyonator and Kutzin (1999) and Gilson (1998). In their study they found that higher premium served as a barrier to access healthcare by the poor. Thus the increase in premium could account for the low enrolment as well as the low membership renewal since most people especially the poor could not afford the high premium to subscribe to the scheme.

Table 10: Distribution of respondents by amount paid as Premium

Premium Paid	Frequency	Percent
Gh7.20	146	88.5
Gh8.00	18	10.9
Gh12.00	1	0.6
Gh18.00	0	0.0
Gh24.00	0	0.0
Total	165	100.0

Source: Field work, 2009 n = 165

Reasons why respondents do not renew membership

Financial inability was the main reason why many subscribers failed to renew their membership after expiry. As presented in Table 11, about 58 percent of the respondents had no money to renew their membership while about14 percent did not renew because they never benefited. This observation has also confirmed Platteau's assertion that any "gift" given must be returned at some future time (Platteau's, 1997). However this differs from insurance as a member who contributed into the scheme may benefit or never benefit in future and those who will even benefit remain unknown at the time of contribution.

Table 11: Reasons for non-renewal of membership

Reasons/Causes	Frequency	Percent
no money	92	57.5
I forgot	20	12.5
I didn't benefit since I join the scheme	23	14.4
my parents did not renew	13	8.1
contribution at source and so I don't need to	8	5.0
health services at health centers are poor	4	2.5
Total	160	100.0

Source: Field work, 2009 n = 232

Perception on payment of premium

The study results as presented in Table 12 showed that almost half of the respondents 48.3 percent agreed that every member of the scheme should pay premium yearly to renew the membership. In all, about 58 percent of the respondents were of the opinion that premium should be paid yearly to renew one's membership while 38 percent disagreed. This arrangement was to ensure that people especially the poor could raise the premium involved so as to benefit from the scheme.

Similarly, about 68 percent of the respondents agreed that only people between 18-69 years of age in the informal sector should pay premium. In fact, about 81 percent of the respondents held the view that those in this age bracket only should pay the premium. It is believed that this category of people in the informal sector who were strong and active to work to earn income for the

payment of premium. The rest of the people in this sector were considered as the vulnerable group and hence should be exempted.

In addition, more than half (about 55%) of the respondents disagreed that everybody should pay the premium and only about 3 percent strongly agreed. In all, about 88 percent did not approve of everybody paying premium. As a result of the poverty level of the people in the district, the principle of ability to pay being the mode of determining premium payment levels had greatly influenced accessibility to healthcare but a threat to the sustainability if alternative modes of funding were not sought. This conforms to similar finding by Gertler, Locay and Sanderson (1987). In their study in Peru on adoption of a flat consultation user fee in Ministry of Health facilities, it was found to promote inequality in access to healthcare and thus, demand by the poor for healthcare accordingly had dropped significantly in response to a price increase and a simultaneous improvement in quality. The principle of ability to pay was therefore recommended.

Invariably, majority (about 90%) of the respondents acknowledged that children, aged and indigents should not pay premium. Eggers and Prihoda (1982) however, found that as a source of adverse selection in Health Management Organization since only the vulnerable will be members of the scheme and hence a threat to its sustainability.

For cost of medical treatment at hospital for a single visit, about 40 percent of the respondents agreed that the cost of one visit to the hospital was more than the premium charged for health insurance which covers a whole year.

Thus a total of 76 percent of the respondents preferred to pay premium to belong to the scheme than paying cash at the point of services used.

About 84 percent of the respondents acknowledged that the income levels of the people were low and therefore, their inability to join the scheme. However, about 10 percent disagreed while about 7 percent were not sure of the income levels of the people.

Due to the high poverty level of the people, it is important to risk by paying the insurance premium which covers a whole year so that in the event of sickness one would be catered for than to pay at the point of service use. According to Friedman and Savage (1948) as cited by Nyman (2002), a small insurance premium is preferred to a large, but actuarially equivalent, uncertain loss. It meant that purchasing insurance was choosing certainty in preference to uncertainty.

Table 12: Perception on payment of insurance premium

Perceptions	Strongly disagree Freq.(%)	Disagree Freq.(%)	Not sure Freq.(%)	Agree Freq.(%)	strongly agree Freq.(%)
Paying premium every year	23(9.9)	65(28)	9(3.9)	112(48.3)	23(9.9)
Only people between 18-69 years should pay	6(2.6)	31(13.4)	8(3.4)	158(68.1)	29(12.5)
Everybody should pay the premium	128(55.2)	76(32.8)	5(2.2)	15(6.5)	8(3.4)
Children, aged and indigents should not pay	9(3.9)	14(6.0)	0(0.0)	105(45.3)	104(44.8)
Cost of one hospital visit more than the premium	6(2.6)	13(5.6)	37(15.9)	102(44.0)	74(31.9)
Income level of the people is low	4(1.7)	19(8.2)	15(6.5)	126(54.3)	68(29.3)
Many people don't attend hospital	26(11.2)	35(15.1)	35(15.1)	116(50.0)	20(8.6)
The premium is too high	20(8.6)	31(13.4)	12(5.2)	136(58.6)	32(13.8)
The premium is too low	73(31.5)	121(52.2)	11(4.7)	16(6.9)	10(4.3)

Source: Field work, 2009

Perception on health insurance policy

The policy is the legal regulations enacted by the government that governs the operations of the scheme. The policy is embodied in the National Health Insurance 2003 (ACT 650) and Legislation Instrument 1809**.**

Table 13: Perception on national health insurance policy

Perception	very unsatisfactory Freq.(%)	Not satisfactory Freq.(%)	not sure Freq(%)	Satisfactory Freq.(%)	very satisfactory Freq.(%)
Membership renewable yearly	20(8.6)	86(37.1)	6(2.6)	106(45.7)	14(6.0)
Three months waiting period	67(28.9)	121(52.2)	0(0.0)	31(13.4)	13(5.6)
Premium payment according to income level	10(4.3)	46(19.8)	6(2.6)	124(53.4)	46(19.8)
Children can benefit only when both parents have registered	50(21.6)	92(39.7)	5(2.2)	54(23.3)	31(13.4)
Cross-subsidization is good practice	3(1.3)	5(2.2)	17(7.3)	153(65.9)	54(23.3)
Community ownership of scheme is best option for sustainability	44(19.0)	70(30.2)	25(10.8)	70(30.2)	(9.9)

Source: Field work, 2009

The results of the data analysis as presented in Table 13 showed that about 52 percent of the total respondents were satisfied with the current policy of renewing membership yearly while about 46 percent were unsatisfied. With the current waiting period of three months, majority (81.1%) of the respondents were unsatisfied that subscribers should wait for three months before benefiting from the scheme. Similarly, about 73 percent of the respondents were satisfied with the premium payment on the basis of ability to pay and 24 percent unsatisfied with

the premium payment principle while about 3 percent of the respondents were not sure.

Nevertheless, about 61 percent of the respondents were not satisfied with the policy that children could only register when both of their parents were registered but 37 percent were satisfied that children could register only when their parents were registered while about 2 percent had no idea about the policy. Creese and Bennett (1997), in their studies also noted that universal coverage of health insurance was not feasible in an environment where most people were self-employed or informal sector workers.

From Table 13, majority of the respondents representing about 89 percent acknowledged that the cross-subsidization policy was good. It is believed that solidarity is similar to cross-subsidization among members. In practice therefore, it meant that all members of a solidarity fund should provide mutual financial support to those who need it in order to improve basic social and economic indicators.

Almost half (49%) of the respondents were unsatisfied that the scheme should be owned by the respective communities that is where it is located but about 40 percent were satisfied with that.

Suggestions to improve scheme's policy

The results from Figure 6 showed that about 64 percent of the respondents said that the waiting period of three months after registration before the subscriber could benefit from the scheme should be reduced to two months.

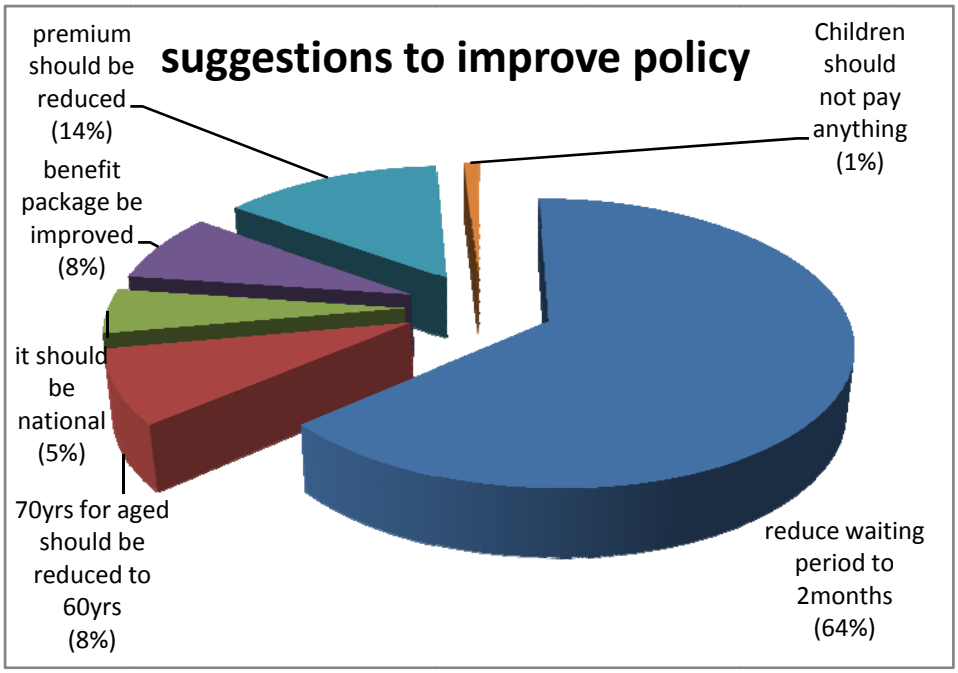

Figure 6: Suggestions to improve policy
Source: Field Work 2009

Quality of healthcare services provided by providers

The data collected on the above included: types of treatments sort during sickness, cost of treatment and the perception of some quality indicators of healthcare services offered to insured clients. The study results showed that about 66 percent of the respondents fell sick and were not insured or their cards were expired at the time of sickness while only about 35 percent never fell sick at the time of the data collection. This implied majority of the respondents felt sick and treated themselves without using the insurance cards thus paying for the cost.

From Figure 7, about 39 percent of the respondents said they were never sick while uninsured. Those respondents who went to hospital for treatment were about 28 percent, while about 23 percent who were sick undertook local treatment but about 10 percent did self medication.

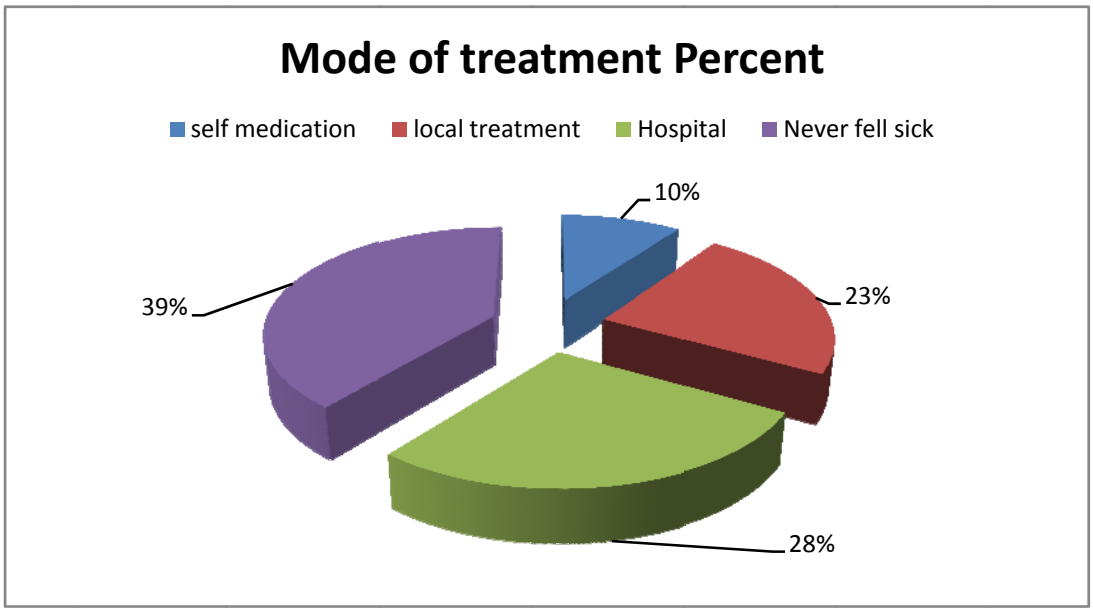

Figure 7: Mode of treatments of respondents
Source: Field Work 2009

The results in Table 14 shows that out of 20 respondents who did self medication 17 of them paid between GH¢1.00 and GH¢5.00 with only one person paying between GH¢26.00- Gh¢30.00. For local treatment, about 28 people accessed it with majority paying between GH¢1.00-GH¢5.00 while the highest payment was between GH¢16.00- GH¢20.00. However about 58 people attended hospital with about 23 people paying between GH¢26.00 and GH¢30.00. It is clear from the results that cost of treatment at the hospital was higher than the premium paid and yet many people went to the hospital to pay cash.

Table 14: Cost of various treatments during sickness without insurance.

Amount paid for treatments (GH¢)	Mode treatment			
	self medication	local treatment	Hospital	Total
1.00 - 5.00	17	21	6	46
6.00 - 10.00	2	1	1	5
11.00 - 15.00	0	4	17	21
16.00 - 20.00	0	2	6	8
21.00 - 25.00	0	0	5	5
26.00 - 30.00	1	0	23	24
Total	20	28	58	109

Source: Field work, 2009

The acronyms on Table 15 are S D A (strongly disagree), D (disagree), N S (not sure), A (agree) and S A (strongly agree). The results of data analysed show that about 43 percent of the respondents were given enough attention by health providers. For quality of treatment, half of the respondents (50%) said patients were given high quality treatment. The study results have also showed that about 41 percent of the respondents disagreed that patients were charged extra fees at the hospital. About 57 percent of the respondents agreed that insured patients pay for drugs not in the drugs list of the insurance scheme. From Table 9, about 45 percent of the respondents were of the opinion that providers did not discriminate against insured patients while about 35 percent disagreed. Similar to the finding of Sheppard, criticism of client perception of health care services may be valid in some instances for research with clients of mental health services

suggested that they could effectively discriminate between services that were different in quality (Sheppard, 1993).

As indicated in Table 15, about 47 percent of the respondents said non-insured patients were given preferential treatment while about 37 percent disagreed. Similarly, about 44 percent of the respondents agreed that treatments given by providers were poor while about 32 percent disagreed. However, Linder-Pelz`s has found out that client satisfaction with health care as an attitude, is based on the summation of the very subjective assessments of the dimensions of the care experienced (Linder-Pelz, 1982). Similarly, Ruggeri has also found that many satisfaction surveys of clients of health and social services have shown high levels of satisfaction partly because they had used insensitive measures (Ruggeri, 1994). These findings suggest that the above perceptions may not be valid since clients did not use any standard measure in the services provided.

The results also showed that, majority (91%) of the respondents said the doctors are inadequate while about 75 percent of the respondents said nurses were inadequate in the district. Invariably, about 80 percent of the respondents stated that there are inadequate drugs in the health facilities in the district. Similarly, about 88 percent of the respondents also said that health facilities in the district were few.

However, about 47 percent of the respondents said drugs given to insured clients are not potent while about 33 percent disagreed. Nevertheless, how patients understand healthcare indicators and the functions of health professionals is a major challenge since most people are illiterates and have very little

knowledge about health. Jessie and Shiela (2001) has found that understanding of how clients evaluate their healthcare and how their health insurance scheme is managed is critical to the development of sound initiatives aimed at increasing health insurance coverage and healthcare delivery improvement ultimately.

Table 15: Quality of healthcare services provided to patients

Quality indicators	S D A	D	N S	A	S A
Enough attention by providers	6.0	35.3	15.5	40.5	2.6
High quality treatment by providers	4.3	32.8	22.0	40.1	0.9
Insured charged extra fees	16.4	24.1	33.6	24.1	1.7
Insured pays for drugs not in NHI drugs list	4.7	9.9	0.0	56.9	28.4
Discriminate against insured clients	8.6	36.6	19.4	29.3	6.0
Non-insured preferentially treated	8.6	28.0	15.9	37.9	9.5
Treatment to insured clients is poor	6.5	26.3	18.5	44.4	4.3
Inadequate doctors in the district	4.3	1.7	3.0	56.5	34.5
Inadequate nurses in the district	3.9	22.4	8.6	54.3	10.8
Inadequate drugs in the facilities	0.9	8.6	10.3	61.2	19.0
Few health facilities in the district	3.9	6.0	2.6	72.4	15.1
Drugs to insured clients not potent	6.0	27.2	19.4	35.3	12.1

Source: Field work, 2009 n=232

Suggestions to improve the scheme

In view of the challenges confronting the operations of the scheme, the respondents suggested ways of solving the challenges. As presented in Table 16,

about 35 percent suggested that in order to solve the challenges confronting the scheme, more doctors and nurses should be trained and posted to the district. In addition, they should be motivated by way of provision of incentives to retain them in the district. Another significant suggestion given is that more drugs should be provided in the various health facilities so that patients would be served the drugs there instead of buying some at the private chemical shops. However, a negligible percentage (0.6%) suggested that health officials who mishandle patients should be punished.

Table 16: Suggestions to improve the scheme

Suggestion	Frequency	Percent
motivate doctors/nurses in district	41	20.4
train and post more doctors/nurses to district	71	35.3
provide more drugs at facilities	40	19.9
include all drugs in NHIS	24	11.9
treat clients properly	24	11.9
punish officials who mishandle people	1	0.6
Total	201	100.0

Source: Field work, 2009 n = 201

Transmission media of scheme messages

The study results presented in Figure 8 showed that about 39 percent of the respondents heard about the scheme through radio broadcast, thus the most effective and efficient means of communicating the scheme's messages to the populace. Apart from the radio, the scheme staff and registration agents

constituted another effective way of disseminating information about the scheme. Print media was the least medium used possibly because of the high illiteracy rate of the populace in the district. In this regard, Atim (2000) found that, many aspects of mutual health organizations impinge directly or indirectly on their viability as institutions and that the major problems remain in the area of institutional development and the skills required for mutual health organization specific tasks.

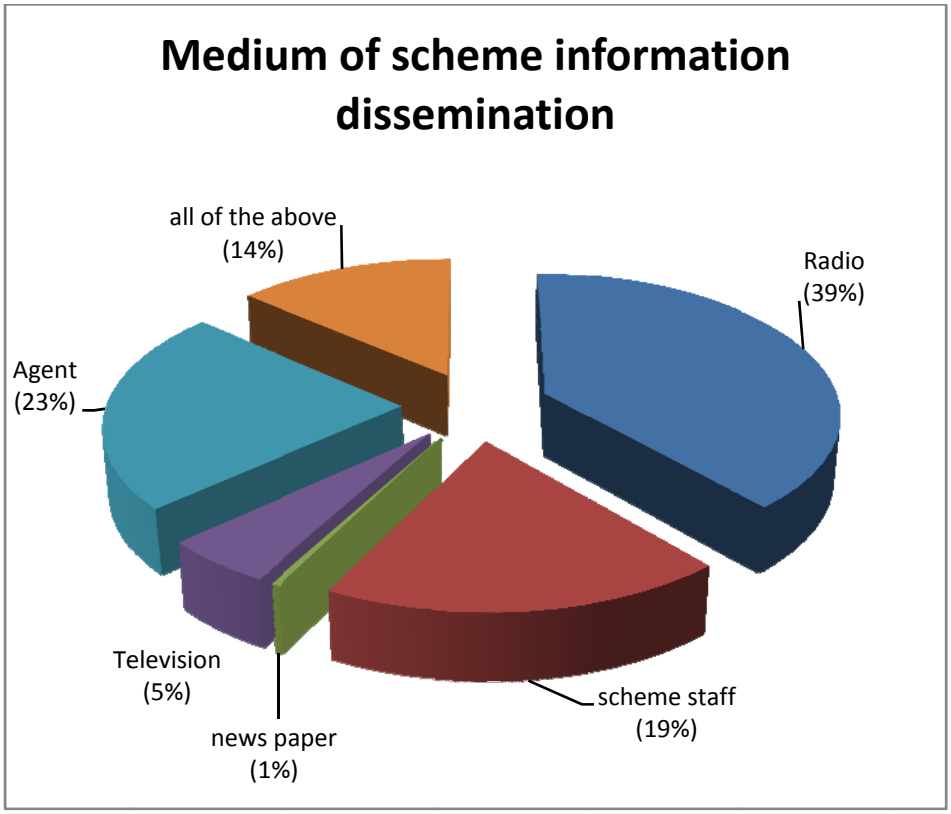

Figure 8: Medium of dissemination of scheme messages.
Source: Field Work 2009

Perception on scheme staff

As indicated in Table 17, about 45 percent of the respondents rated the staff ability to register and snap photos as very good (VG), while about 19.0% said it was good (G). However, about 38 percent of the respondents rated their

ability to produce and distribute ID cards as average (A). For regular visit to communities by staff, about 38 percent of the respondents said it was very good. In the same vein, about 37 percent of the respondents rated attitudes of scheme staff towards agents as very good. Similarly, for sensitization of the populace on the concepts of the scheme, about 42 percent of the respondents rated the scheme very good with a negligible percentage of 0.4 percent rating it as poor (P).

It is however, important to recognize that evidence of positive client satisfaction is not, in itself, sufficient to establish the effectiveness or accessibility of treatment. Clients with no basis for comparison may be satisfied with services that are ineffective as determined by more objective outcome evaluations. Nevertheless, client satisfaction ratings have been criticized as indicators of the quality of human services because they may reflect unrealistic expectations. On the Table 16, E stands for excellent.

Table 17: Perception on scheme staff

Perception	P	A	G	V G	E
	Freq.(%)	Freq.(%)	Freq.(%)	Freq.(%)	Freq.(%)
Register and snap	6(2.6)	42(18.1)	44(19.0)	104(44.8)	36(15.5)
Distribute ID of cards	61(26.3)	87(37.5)	24(10.3)	46(19.8)	14(6.0)
Visit communities	14(6.0)	58(25.0)	57(24.6)	87(37.5)	16(6.9)
Attitude of staff towards agents/clients	19(8.2)	30(12.9)	85(36.6)	86(37.1)	12(5.2)
Sensitization	1(0.4)	44(19.0)	47(20.3)	98(42.2)	42(18.1)

Source: Field work, 2009

Problems associated with operation of scheme

Although the scheme was established four years ago, it was still faced with some challenges. The study results enumerated some of them as presented in Table 18. About 37 percent of the respondents said delay in photo-taking affected the operations of the scheme while 18.5 percent identified few staff as the major problem that affected the staff operations.

Table 18: Problem(s) associated with the work of the scheme staff

Problem	Frequency	Percent
congestion in office during photo-taking	31	17.4
agents spending scheme's money	13	7.3
no regular visits to community	8	4.4
delay in photo-taking	66	37.1
few staff	33	18.5
poor mode of passing information	8	4.4
lack of staff motivation	8	4.4
delay in distribution of ID cards	11	6.2
Total	178	100.0

Source: Field work, 2009 n = 178

Suggestions to improve staff operation

In order to address the operational challenges confronting the scheme, the respondents gave the following suggestions for consideration. In that regard, about 23 percent of the respondents suggested that more staff should be employed while about 19 percent stated that more registration centers should be opened in

the district to avoid congestion in the office. However, 16 percent of the respondents suggested that cameras should be provided for agents to take photos of subscribers on behalf of staff (Table 19).

Table 19: Suggested ways for improvement of work of scheme staff

Suggestion	Frequency	Percent
open more centers in town	34	18.8
reduce waiting period	2	1.1
monitor agents regularly	20	11.0
prompt snapping of photos	28	15.5
provide cameras for agents to snap	29	16.0
employ more staff	42	23.2
improve mode of passing information	8	4.4
improve human relations	9	5.0
improve staff motivation	8	4.4
reduce premium	1	0.5
Total	181	100.0

Source: Field work, 2009 n = 181

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter focuses on the summary of the research findings, conclusions and recommendations. The findings and recommendations would enrich the literature in the subject area and also serve as basis for further research.

Summary of the findings

The study examined why some residents in Jirapa District were still not members of the National Health Insurance Scheme although it was established about five years ago. Its introduction was mainly to eliminate the cash and carry system that has been a hindrance to accessing healthcare. In achieving this, the study sought to explore those people who had never subscribed to the scheme and those who were members but failed to renew their membership after the expiry.

An interview schedule was used to collect the data on the non-insured members of the scheme in the district. Research assistants were orientated on the instrument for data collection and in all 232 respondents were interviewed consisting of 172 males and 60 females. The respondents also included 165 persons who could not renew their membership and 67 who never registered with the scheme. The following findings emerged from the study;

The results showed that about 74 percent of respondents were males implying that most of the non-insured in the district were males. In addition, about 80 percent of respondents who were not insured were within the age range of 18years to 45 years. It was also clear that most of the respondents were involved in farming and earned very little monthly incomes and were therefore unable to meet their basic needs including being members of the scheme. The study also showed that, about 71 percent of the respondents did not renew their membership after expiry due to inadequate funds and the fact that they registered but never benefited for the whole year.

With respect to the insurance premium charged, the respondents had the following perception; premium should be paid yearly, only people within the age group of 18-69 years in the informal sector should pay premium, children, aged, indigents should not pay premium, respondents preferred to pay premium to belong to the scheme than to pay cash at point of service utilization, respondents attested to the fact that poverty contributed largely to their inability to enroll with the scheme.

On the nature of the insurance policy, the following perceptions were raised: the waiting period of three months should be reduced to two months, premium payment should be based on ability to pay, registration of children should not be linked to their parents, cross-subsidization was seen as a good strategy for the scheme's sustainability. The study results also showed that the non-insured had alternative sources of seeking healthcare which were not included in the insurance scheme but relatively cheaper.

The views of respondents on quality of healthcare services provided to clients were as follows: there were inadequate number of doctors and nurses in the district. In addition, there were inadequate drugs in the health facilities. For information dissemination about the scheme, radio and the scheme staff were the most efficient and effective media for information dissemination. The scheme staff were most effective and efficient at registration and photo-taking of subscribers but weak at production and distribution of ID cards.

Conclusions

Clearly, negative perception of the populace on the operation of the scheme would ultimately deter others from registering with the scheme. Therefore the following conclusions could be drawn from the above findings;

Mostly males and generally the youth were not members of the scheme. The youth particularly the males always thought they were strong and would not easily fall sick and hence insuring themselves was not necessary. However sickness does not announce when it attacks a person and besides would not discriminate between old and young.

It could also be concluded that people did not renew their membership due to poverty and inadequate knowledge about the operations of the scheme. The fact that they had not benefited for a whole year after registration means a loss.

Most of the residents in the district were peasant farmers who earned very little income as a result of poor rainfall pattern and infertile farming lands. In the light of the above current minimum premium charged should not be increased. An

increase in the premium could create a barrier to most people joining the scheme and hence eliminate the poor from accessing quality healthcare.

Waiting period is an operational strategy aimed at avoiding adverse selection hence a further reduction from three months to two months was an indication that most people would wanted to wait until there were symptoms of sickness before they would register. People had other relatively cheaper alternative sources of seeking care when sick although these sources were raveled with uncertainties.

For quality of healthcare services, it could be concluded that there were inadequate doctors, nurses and drugs at the health facilities. Patients with insurance cards who were not served drugs in the hospital were likely to interprete it to mean that they were denied the drugs because of their membership with the scheme. These indicators tended to suggest that quality of health care could be compromised.

Information dissemination is very vital to the survival of every human institution, therefore for the scheme to effectively and efficiently disseminate information, radio and the scheme staff should be used.

Although ID cards were the basic panaceas to accessing healthcare services under the scheme, the scheme was unable to produce and distribute them promptly to the subscribers. This situation posed a barrier to accessing the care. The scheme staff lacked the requisite human resource based with the needed skills to meet the demands of their clients.

Recommendations

The Public Relations Unit of the scheme should design specific sensitization programmes to educate the youth particularly the males on the benefits of joining the scheme. The sensitization programme should also be tailored towards those who registered and were not able to renew their membership. In this regard, people who had registered but never benefited for the whole year be given some incentives to serve as motivation. In addition, quality of healthcare should also be improved so that patients could receive the desired treatment each time they attend hospital.

To ensure increase in enrolment, registration officials should target premium collection during harvesting periods of the year since most farmers would have earned some income after selling their farm produce. In addition, the criteria for selection of indigents should be reviewed to allow many people to be enrolled under this category since poverty is a common problem in the district.

Any further increase in the minimum premium of GH¢8.00 charged would eliminate most people from the scheme since they will be unable to afford. Apart from that the premium should also be paid by installment.

District Assemblies should sponsor the training of health professionals especially doctors and nurses and bond them to serve in such districts. This could improve the human resource base of the health institutions.

Health providers and Ghana Health Service should ensure that adequate drugs are available at the facilities. In addition, private chemical sellers in the

district should be accredited to provide drugs to patients who are not served at the health facilities.

To make information dissemination more effective, the government should establish community radios in all districts so that messages could be disseminated in the native languages of the respective districts. Identity cards processing should be decentralized to all regional capitals to ease the problem of delay. The employment authority should also recruit more staff since the scheme covers every person resident in the district.

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APPENDIX

INTERVIEW GUIDE

Interview Guide for non-insured members of Jirapa-Lambussie Mutual Health Insurance Scheme in the Jirapa District. These are people who have either registered with the scheme but failed to renew their membership after expiry or never registered since the inception of the scheme.

Introduction

Information is required on some aspects of the national health insurance scheme for a study. You have been selected to participate in the study. The information is needed purely for academic work and whatever information is given shall be treated confidentially. Thank you for agreeing to be part of the study.

Please respond appropriately to the questions below:

Module A: payment of insurance premium

1. What do you do for a living?

   a. farming b. trading c. fishing

   d. sewing e. others (specify)……

2. Does your work earn you enough income to meet your basic needs?

   Yes or No.

3. If no what else do you do to supplement your income?.....

4. How much do you normally earn at end of a month?

   a. less than GH10.00 b. GH10.00- GH20.00

c. GH20.00 – GH30.00 d. GH30.00 – GH40.00

e. GH50.00 and above

5. Have you ever registered with the NHIS? Yes/No

6. If yes to Q5, when did you register with the scheme? ……

7. How much did you pay as premium at that time?

a. GH7.20 b. GH8.00 c. GH12.00

b. d. GH18.00 e. GH24.00 f. others ……

8. Can you give the reason(s) why you did not renew your policy?

……

……

9. If no to Q5, why didn't you register with the scheme?

……

……

10. Using the scale below, would you say the premium GH8.00 charged is affordable with respect to the following statements below:

1= strongly disagree, 2= disagree, 3= not sure and 4= agree, 5=strong agree

A Paying premium every year 1 2 3 4 5

B Only people between 18-69 years should pay premium 1 2 3 4 5

C Every body should pay premium 1 2 3 4 5

D Children, aged and indigents should not pay premium 1 2 3 4 5

E Cost of one visit at hospital for treatment is more than the premium 1234 5

F The income level of the people is low 1 2 3 4 5

H Many people don't attend hospital 1 2 3 4 5

I The amount is too high for the people 1 2 3 4 5

J The amount is too low for the people 1 2 3 4 5

K Others (specify)……..

11. Should the premium be increased? Yes/ No

12. If yes to Q11, how much premium should be charged?.....

13. If no to Q11, what are your reasons?.....

Module B: The health insurance policy

14. Has any of your family members joined the scheme? Yes or No.

15. If yes has any of them benefited from the scheme by attending hospital without being charged? Yes or No.

16. How would you rate the operations of the national health insurance policy on the following statements below;

1= very unsatisfied, 2= unsatisfied, 3= not sure, 4=Satisfied and 5= Very satisfied

A One year renewable benefit period 1 2 3 4 5

B Three months waiting period before benefiting 1 2 3 4 5

C Contribution of premium according to ability to pay 1 2 3 4 5

D Children can benefit only when both parents are insured 1 2 3 4 5

E Cross-subsidization is good 1 2 3 4 5

F Community ownership of scheme is best option for sustainability 1 2 3 4 5

H Others (specify)…….

17. Which aspects of the insurance policy should be changed or modified?……

Module C: quality of healthcare services provided by providers

18. Have you ever fallen sick when you were not registered or your card became expired? Yes or No.

19. If yes to Q18, how were you treated?……

20. How much did you pay for the hospital bills?……

21. To what extend would you agree or disagree with the following statements on health care services provided to insured clients;

1= strongly disagree, 2= disagree 3= not sure 4= agree, 5= strongly agree

A. Patients are given enough attention 1 2 3 4 5

B. Treatment offered are usually of high quality 1 2 3 4 5

C. The insured is charged extra fees 1 2 3 4 5

D. The insured is made to pay for some drugs not in the NHI drugs list1234 5

E. Insured patients are discriminated against 1 2 3 4 5

F. The non-insured are usually preferentially treated 1 2 3 4 5

G. Quality of treatment to insured is usually poor 1 2 3 4 5

H. Others……

22. To what extend would you agree or disagree with the following problems associated health care system in the district?

1= strongly disagree, 2= disagree 3= not sure 4= agree, 5= strongly agree

A. There is inadequate number of doctors in the district 1 2 3 4 5

B. There is inadequate number of nurses in the district 1 2 3 4 5

C. There are inadequate drugs in the health facilities 1 2 3 4 5

D. There are few health facilities in the district 1 2 3 4 5

E. The attitude of health providers is bad towards the insured 1 2 3 4 5

F. Drugs given to insured clients are not potent 1 2 3 4 5

H. Others…….

23. Give one suggestion you would offer to resolve the above problems?

……

……...…….

Module D: the efficiency of the scheme staff

24. Have you ever heard about the NHIS? Yes or No.

25. If yes to Q24, through what means

a. radio b. scheme staff c. news paper d. TV e. agent f. others……

26. How would you rate the work of the scheme staff with regards to the following statements below;

1 = poor, 2 = average, 3 = good, 4 = very good, 5 = excellent

A. Ability to register and snap photos promptly 1 2 3 4 5

B. Ability to produce and distribute ID cards to subscribers1234 5

C. Regular visits to communities 1 2 3 4 5

D. Attitude towards agents/clients 1 2 3 4 5

E. Sensitization of populace on insurance policies 1 2 3 4 5

F. Others (specify)……..

27. Mention one problem associated with the work of the scheme staff.……

…….

28. What will you suggest for the improvement of the work of scheme staff?

…….

Module E: Background characteristics of respondents:

29. Sex ( ) male ( ) female

30. What is your age?.....years.

31. Marital status.

A. married B. never married C. divorced D. widowed E. separated.

32. What is your level of education?

A. none B. primary C. JSS D. SSS E. College D. Poly E. university F. others…….

33. What is your tribe?

a. dagao b. waala c. sissila d. Ashanti

e. gruni/fafara f. others ……..

34. What is your nationality?

a. Ghanaian b. Burkinabe c. Ivorian

d. Togolese e. Liberian f. others……

35. Which religion do you belong to?

a. Christian b. Muslim c. Traditionalist

d. Buddhist e. Others……..

36. How long have you being living in Jirapa district?

a. less than one year b. two years c. 1-5 years

d. 6-10 years e. more than 10 years

Thank you