PRESBYTERIAN UNIVERSITY COLLEGE, GHANA

FACULTY OF DEVELOPMENT STUDIES

DEPARTMENT OF RURAL AND COMMUNITY DEVELOPMENT

THE EFFECTIVENESS OF THE NATIONAL HEALTH INSURANCE IN PROVIDING THE POOR WITH QUALITY HEALTH CARE

Dissertation submitted to the Department of Rural and Community Development of the Faculty of Development Studies at Presbyterian University College, Ghana in partial fulfillment of the requirements for the award of Master of Arts degree in International Development Studies

BY

PAULINA DANSOA ADJEI

SEPTEMBER 2019

DECLARATION

Candidate Declaration

I hereby declare that this dissertation is the result of my own original research and that no part of it has been presented for another degree in this University College or elsewhere except for portions duly referenced

Candidate Signature: ……. Date: ……

Name: Paulina Dansoa Adjei

Supervisor's Declaration

I hereby declare that the preparation and presentation of the dissertation supervised in accordance with guidance and supervision of project work laid down by the Presbyterian University College, Ghana.

Supervisor's Signature: …….. Date: ……

Lecturer: Rev. Dr. Benzies Isaac Adu-Okoree

ABSTRACT

The main objective of the study is to examine the effectiveness of the national health insurance on the poor. Both quantitative and qualitative approach was also used for the study which involved collecting and analyzing the data gathered in succession. To have a true reflection of the population a simple random sampling and purposive sampling method would be used to select the samples for this study. A simple random sampling method was found to be appropriate since all the people have the chance of been selected. For this study, the population were health insurance card users and accredited providers of health insurance services in Akuapem South District. One hundred people were selected from the respondents as sample for the study. SPSS was used to analyze the results from the data collected. The findings shows that the hospital facility is not closer to the respondents as well as the benefits derived from the NHIS is something that the respondents classified as fair. Although the benefits the respondents derived from the NHIS is classifies as fair they went on to say that they are not satisfied with the service provided by the service providers, that is, poor attention and bad treatment. The respondents sometimes bought drug from drug stores and also performed self-medication without authorization from the hospital. The respondents' also said the alternative facility they visited is cheaper than the hospital and it is also accessible. The following recommendations were made based on the findings stated above. Government should put up chips compounds in the other communities in and around Pakro so that they will not travel a longer distance to access health care. In addition other charges charged by the government facility should be stopped so that the people will not go to the alternative facilities. Furthermore, the services provided by the government facilities should be improved so that the respondents can have confidence in them that when they visit them they would be healed.

ACKNOWLEDGEMENTS

My gratitude goes to the Almighty God for seeing me through this programme successfully. I would like to say a big thank you to Rev. Dr. Isaac Benzes Adu-Okoree for his patience and the time he made out of the busy schedule to supervise my work. I want to appreciate Mr. Thomas Danso Mensah for assisting me in various ways not forgetting Mr. Joseph Ayete of GRA Kade, Mr. Charles Obrempong Ohene of University of Ghana Legon, Vanessa Ohene and the mum, Mad. Evelyn Odame for accommodating me when the need arose. I also appreciate Mad. Lydia Abosi my course mate and sister in-law who kept me on my toes during my studies, Mad. Christiana Agyabeng-Gyamera my course mate and teacher and Mr. Ebenezer Okine my affable course rep and teacher without whose contribution, my studies will not have seen the day light .My warmest gratitude goes to Mr. Patrick Owusu of Presbyterian Senior High Technical School for assisting me in diverse ways. Kwame, God richly bless you and your family, for responding to my calls even at odd times of the day. My deepest gratitude goes to my husband, Mr. Albert Kwasi Danso for his immense support during the programme and finally to parents and siblings for their prayers and support. God Bless you all.

DEDICATION

To My Husband, Albert Kwasi Danso

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE

INTRODUCTION

1.1 Background

The National Health Insurance is a form of formal sector social health insurance programme that pools risks across population and pay part of health-care expenses for defined members from a premium paid by individual employers, employees, unemployed, non-governmental organizations and government. It is a social health security system in which health care of an employee is paid by both the employer and the employee. The National Health Insurance Scheme in Ghana is also a social health security system which is financed by a National Health Insurance levy (NHIL) of 2.5% tax on selected goods and services. A 2.5% out of the18.5% SSNIT contribution which is made up of 5.5% of workers' pay (Social Security Law 1991 (PNDCL 247) and 13 % (Pensions Act 766) of employees contribution of Social Security and National Insurance Trust (SSNIT) deductions from the formal sector, premiums from the informal sector and government budget allocations.

Financial constraint is one of the major barriers of access to healthcare for marginalized sectionsof society in many countries (Garg and Karan 2009; Peters *et al.* 2002; Pradhan and Prescott 2002; Ranson 2002; Russell 2004; Wagstaff and van Doorslaer 2003; Xu *et al.* 2003). It has been estimated that a high proportion of the world's 1.3 billion poor have no access to health services simply because they cannot afford to pay at the time they need them (Dror and Preker *et al.* 2002. And many of those who do use services suffer financial hardship, or are even impoverished, because they have to pay (WHO 2010). For instance, around 5 percent of Latin American households spend 40 percent or more of 'non-subsistence income' on medical care each year (Xu *et al.* 2003). Of those households paying for hospitalisation care in India, 40 percent fall into poverty due to healthcare spending (Peters *et al.* 2002). In a seminal empirical

study, Robert Townsend (1994) showed that in rural India, health crisis in a household induced significant declines both in health and non-health consumption, a drop more severe than that associated with any other type of crisis. Townsend examined a household's ability to 'smooth consumption', i.e. the ability to maintain a stable level of consumption over a period of time. Health crises induce expenditure on health and may also induce declines in household income. The inability to smooth consumption over time due to a health crisis has been found in several other developing countries (Cohen & Sebstad 2003; Deaton 1997; Gertler and Gruber 2002; Wyszewianski 1986), defined here as low- and middle-income countries (LMICs) according to the World Bank classification (World Bank n.d.). A study of 59 countries found lack of health insurance to be one of the main causes for catastrophic payments, defined as expenditure for health care exceeding some threshold proportion of an income measure (Xu *et al.* 2003 and Mahal *et al.* 2010). The threshold value can range from 5 to 40 percent (Pradhan and Prescott 2002; Ranson 2002; Russell 2004; Wagstaff and van Doorslaer 2003; WHO 2000).

There are various reasons for introducing health insurance schemes in developing countries. One of the often stated reasons is improving health financing given the increasing evidence of a direct relationship between how a health system is financed and the performance of its functions and achievement of its goals. Some studies have drawn attention to the weaknesses and impact of health facility user fees on the poorest people of developing countries as being the main reason.

1.2 Problem statement

Mutual Health Organizations have exhibited promise in their ability to attract members, efficient finance care and to provide access to their members for their health care needs (Crier, 1999). However, the Mutual Health Organizations remain relatively young and work remains to be done to ensure their long-term sustainability and their potential to leverage quality improvements in the health sector. Evidence from a study undertaken by Kelly and Quijada (2001) in three

countries indicates that Mutual Health Organizations themselves consistently identify quality as a priority. Ghana has prioritized universal coverage of health care and has therefore put in place policies and programmes to meet this goal. Even though success has been achieved in different aspects of the health sector, health care delivery remains inadequate especially for the poor people and other disadvantaged groups. The task confronting the health sector remains difficult; life expectancy remains low (60 years), morbidity of preventable diseases remains high; malaria, diarrhoea and other preventable diseases account for about 40% of child mortality and maternal mortality is still high (WHO, 2003).

In recent times, most of the District Mutual Health Insurance Schemes in the country are running into distress by their indebtedness to health care providers which compelled the health care providers to deny services to card bearing members of the NHIS. Some of the service providers have threatened to withdraw the services of health insurance clients if the amount owed by the schemes is not paid (GHS, 2008). The concern therefore is whether the National Health Insurance Scheme is effective to cater for the poor or not. There is therefore the need to examine the concepts of the National Health Insurance Scheme to ascertain its effectiveness on the poor.

1.3 Objectives

The main objective of the study was to:

To examine the effectiveness of the national health insurance on the poor.

The specific objectives of the study were:

1. To examine the benefit criteria of the NHIS
2. To explore the accessibility of the scheme to the poor
3. To explore the alternative sources of accessing health services by the poor
4. To explore the impact of the alternative on the livelihood of the poor

1.4 Research questions

The research questions that will guide the research are:

1. What are the benefits criteria of the NHIS?
2. To what extent is the scheme accessible to the poor?
3. What are the alternatives sources of accessing health services by the poor?
4. To what extent does the alternative source of accessing health services impact on the livelihood of the poor?

1.5 Significance of the study

The purpose of this study was to assist other researchers in this field, to serve as a source of reference and to contribute to available literature in this area. The study is intended to the Ghana government and the managers of the scheme to formulate policies and implement administrative procedures that would improve service delivery and make the scheme more effective.

1.6 Scope of the study

The study was carried out to examine the effectiveness of the NHIS on the poor. This study focused on the Akuapem South district preferably Pakro town which is mostly dominated by farmers. Clients who are health insurance card users were selected from Akuapem South District by a simple random sampling method. This study could have been done in all the districts in the Eastern Region but because of time and other resource constraints the restriction was necessary.

1.7 Organization of study

This research covered five chapters. Chapter One introduces the dissertation topic. Chapter Two contained the review of the related literature used in the research study. Chapter Three looked at the methodology for the study, Chapter Four presented the results and discussion of the study and Chapter Five presented the summary, recommendation and conclusion of the study.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 National Health Insurance Scheme (NHIS) in perspective

Health insurance is a programme that pools risk across populations and pay part of all health-care expenses for their defined population of members (and possible dependents) from premium contributed by individual employers, non-governmental organizations or government (Mahal *et al.* 2010). The purpose of NHIS is to secure universal coverage and access to adequate and affordable health care.

In Nigeria, this is achieved by monthly deductions of 5% basic salary paid by the employee's employer which is then pooled together and used for all who have enrolled onto the scheme. In social insurance there is a cross subsidization where the healthy subsidizes for the ill, the young subsidize for the older and the higher income group subsidizes for the lower income group (PNDCL, 247). Social health insurance is a social security system that guarantees the provision of a benefit package of health care services paid from funds created by pooling the contributions of participants (PNDCL, 247). The health insurance fund in Ghana is mobilized from workers' pension contribution to SSNIT and a valued added tax on all goods and services purchased. This is achieved by a monthly deduction of 2.5% out of the 18.5% SSNIT which comprise of 5.5% of workers' pension and 13.% (Pensions Act 766) contribution to (PNDCL, 247) and 2.5% of value added tax on all goods and services purchased are pooled together and used to fund the health insurance in Ghana.

2.2 Global Perspective of Social Health Insurance

Most low- and middle-income nations face difficulties in funding health care, while nations declare admirable goals to provide their citizens with equal access to reasonable quality health care to prevent health-caused impoverishment. These exalted aims are not backed up with

adequate public funds or a rational financing system. As a result of poor health, impoverishment and disparity are prevalent. Many nations are now hoping that formally mandated social health insurance (SHI), involving payroll taxes, will provide the solution (WHO, 2005a).

In order to reduce the out of pocket payment, a wave of Social Health Insurance (SHI) initiatives has swept across Africa, Asia and Latin America. In May 2005, the World Health Assembly passed a policy resolution for the World Health Organization (WHO), where it would use the social health insurance (SHI) as the strategy for mobilizing more resources for health pooling risk by providing more equitable access to health care for the poor, and delivering better and quality health care (WHO, 2005a).

The WHO is using this strategy to encourage member states to move ahead with the social health insurance and to provide members with technical support to help them develop the social health insurance. In addition to its capacity to mobilize additional funds for health care, social health insurance (SHI) is also touted by several international aid agencies, such as the World Bank, the WHO and the German Agency for Technical Cooperation as a policy instrument that could help facilitate or stimulate the health sector reforms. According to (World Health Organization (WHO), 2000) health is a state of complete physical, mental and social wellbeing and not just the absence of disease or infirmity. Looking at the health state in Ghana and the above definition then one can say that no Ghanaian is said to be a healthy client for the insurance industry. Every country strives to provide for its citizen's affordable and accessible health care. In South Africa, for instance, there is no nationally operated public health insurance scheme, yet they can boast of better indices than in Ghana. They have a private health insurance scheme that is affordable, well developed and functioning efficiently (Gana, 2010). A look at the healthcare system of some countries will educate us more. In the United Kingdom (UK), there is a National Health Scheme (NHS) which is a publicly funded health care for all residents of UK. No premiums are collected,

costs are not charged at the patient level and costs are not prepaid from a pool. It is actually not an insurance system but it does achieve the main aim of an insurance which is to spread financial risk arising from ill health directly through general taxation. The United States health care on the other hand relies heavily on private health insurance which is the main source of coverage for most Americans (Gana, 2010).

In Canada, public and private schemes exist; most health insurance schemes in Canada are administered at the level of provinces under the Canada Health Act, which requires all people to have free access to health care. About 65% of Canadians have some form of supplementary private health insurance; many of them receive it through their employers. France operates a solidarity system. It has both public and private schemes. The peculiarity of the French is that; the more ill a person becomes, the less the person pays. This means that for people with serious or chronic illness, the insurance system reimburses them 100% of their health expenses and waives co-payment charges. Complementary private health insurance is also available. (Gana, 2010).

In Australia, functional public health insurance exists alongside private schemes. The public health system (Medicare) ensures free universal access to hospital treatment and subsidized out-of- hospital medical treatment. The Medicare is funded by 1% levy on all taxpayers, an extra 1% levy of high-income earners as well as general Government revenue. Some private health insurers are for profit while some nonprofit health insurance organizations are also operational (Allin *et al*, 2005).

The Sickness fund of Germany is a health insurance scheme paid by employers and employees and managed by not for profit organizations. It is characterized by private provider base, efficient management, adequate investment and effective control of provider and purchaser behavior. In Chile, public and private scheme exist, but like in most countries of Latin America, patients are

migrating from public to private schemes (Griffin, 1992). There is dearth of literature on the effect of various health financing options for low- and middle-income countries (Ekman, 2007). Moreover, enrolment in insurance has been found to result in altered behavior, such as utilizing unnecessary medical care, a concept known as 'moral hazard' (Allin *et al*, 2005).

Furthermore, evidences from countries that have institutionalized national health insurance programme indicate positive impact on the health care system (Sanusi and Awe, 2009; Collins, *et al*, 2007). In a study in Baltimore, USA, health insurance was to lead an increase in non-urgent utilization of health facilities (Dixon *et al*, 2003). Similarly, in Taiwan, the utilization of most prenatal and intrapartum care services increased after commencement of NHIS (Atim *et al*, 2001). Also, in a related study about public insurance in North Carolina, USA, it was reported that publicly insured children were most likely to have emergency department visit than un-insured children (Fink *et al*, 2003). The same trend was also noticed in Minnesota, USA (Kane *et al*, 2002). Also, in Jordan, insurance was found to have a positive effect on utilization of curative care and significantly increased the number of visits per illness episode. (Witter S. *et al*, 2009). Generally, insurance is found to increase the intensity of utilization and reduce out of pocket spending (Ekman, 2004). However, in Nigeria since the NHIS was established, not much has been carried out to investigate utilization and access to quality health care as a result of the introduction of the Scheme (Carrin G. *et al*, 2008).

2.3 The Role of Health Insurance in Health Care Delivery

The World Health Organization defines health as complete physical, mental and social well-being, not merely the absence of disease and injury (Parekh, 2003). Accordingly, a country's health system comprises of all the organizations, institutions and resources devoted to produce health services.

Health care has always been a problem area in India, a nation with a large population and substantial portion of people living below the poverty line. Consequently, health care access and equity have become important issues and health insurance has been developed to its immense potential in the world's fifth largest economy. An estimated 1.3 billion people worldwide lack access to effective and affordable health care, whiles more than 150 million people in 44 million households worldwide every year face financial ruins as a direct result of large medical bills. The goal of providing universal access to health care based upon the universal declaration of Human Right is a laudable one. In nearly all African countries, "Demand from international donors for increased efficiency and competition are leading governments to play a smaller role in providing health care" (Panos Report, 1994).

Health Insurance has played a major role in facilitating access to health care services and has also helped to protect one against high cost of catastrophic illness. Insurance has also led to an increased use of health services in developing countries. Evidence from countries that have institutionalized health insurance programmes indicates positive impact on the health system. A study in North Carolina, USA, shows that publicly insured children are more likely to have emergency visits than un-insured children. It is also found that insurance has increased the intensity of utilization and reduced out of pocket spending.

In America, the insured are likely to obtain recommended screening and care for chronic condition and are less likely to suffer from undiagnosed chronic condition or to receive substandard medical care. Apart from health insurance, increasing access to health care, it has also reduced rate of death. Numerous investigations have showed an association between uninsured and death. The Institute of Medicine (IOM) estimated that 18,314 Americans aged between 25 and 64 years die annually because of lack of health insurance. Studies have also showed that poor health prevails in many developing countries due to lack of health insurance.

The average infant mortality rate in many African countries still exceed 100 per 1000 live births compared with 4 per 1000 live births in advance economies. Asian nations usually do better but results are still high. China has an infant mortality rate of 30 per 1000 live births and figures stand at 31 per 1000 live births in Indonesia and 62 per 1000 live births in India (World Bank, 2005). The implementation of Social Health Insurance (SHI) is to minimize the mortality rate in developing countries. The extension of Health Insurance to a large number of poor households through both indigent programmes and IPP has to greater access to health care delivery and financial protection for the poorer segments of society.

2.4 Health Care Financing in Africa

Healthcare financing in Africa has gained a lot of prominence and gone through several phases with governments promising different forms and mechanisms to achieve equity and access (Leighton, 1995). Undoubtedly, many methods of health financing mechanisms practiced in Europe were geared towards containing costs, yet in developing countries particularly Africa, health financing reforms emanated as a result of growing demand for improved healthcare when governments could no longer provide free healthcare with shrinking resources (Korankye, 2012). Given the emphasis on cost recovery in Africa, it is often argued whether cost recovery affects access to healthcare. It is however posited that user-fees serve as a blockade to utilization notably in the primary and preventive healthcare services. A study by Leighton (1995), in Cameroon found that the tendency for a sick person to visit a government hospital was 25 percent higher when fees were charged and quality improved. Yet this could hinder access to the service by the poor households because they have less money and may not borrow funds or trade-off any asset to pay for health cost, so African countries must consequently find alternative healthcare financing methods to deal with the mounting healthcare issues (Mwabu, 2008). University As a way of financing healthcare, social and private mutual health insurance schemes are some of the

financing options being practiced in Africa. This involves spreading risk and cost of medical care by pooling resources mainly through premiums or tax related payments (Ndiaye, 2006). Individual financing in Sub-Saharan Africa prevailed in traditional healthcare, with social financing predominating in the western medical care; although in Africa, government provides and finances healthcare through taxation for the whole population (Vogel, 1990; Ekman, 2004). In countries such as Senegal and Mali, health financing has been made mandatory for all formal sector workers via social security. Kenya practices the National Hospital Insurance Funds for formal employees, which has been replicated in other countries like Zambia, Nigeria, Liberia and DR Congo (Vogel, 1990). Yet countries like Burkina Faso, Ghana, Tanzania and Rwanda have reviewed and revised their financing mechanisms and have moved towards a more public social protection measure (Rosner et. al, 2012). Social insurance financing, when successful, can ensure equitable accesses to quality care by keeping premiums affordable to enhance utilization for all especially the poor.

2.5 The Development of Health Insurance in Ghana

The search for an alternative means of financing and the provision of sustainable health care service for Ghanaians has been the priorities of many successive governments since independence. During the First republic (1960-1966) a nation-wide passive health insurance from the tax revenue was introduced in the country. A free health care service was made available from all the country's healthcare facilities. In 1970, during the Second Republic, the government instituted a committee to make a proposal for the introduction of a health insurance scheme and this was headed by Dr. Konotey Ahulu. This led to the enactment of the hospital free Act 387 of 1971 which replaced the free health services scheme initiated by the first Republic, but the subsequent military government of 1972 did not continue with the process. The preparation of the Legislative Instrument to operationalized Act 387 was stated by the third

republic government but this was distorted by the military regime of 1981 (Agyepong, *et al,* 2008).

In July 1983, when the country's economy was on the verge of collapse, the government introduced what was called partial cost sharing of health service through the enactment degree of "The Hospital Fee Regulation which was updated by L.I 1313 of 1985. In 1985 the government-initiated studies into alternative means of financing health care by entering into a bilateral technical assistance contract with a German firm that has studied the feasibility of creating a national health insurance scheme Programme. The German contract did not materialize, and a local consultant was also engaged to carry out studies on the health insurance and the outcome was not followed up.

In 1997 the MOH set up its first Directorate for the National Health Insurance and a forum on health insurance was conveyed. Social Security and National Insurance Trust (SSNIT) also set up the Ghana Healthcare company with the intention of providing other sources of health financing. The MOH also initiated a pilot scheme in Koforidua, Eastern Region, with the intention of registering a National Health Company and appointed Board of Directors to manage the scheme, but this also could not materialize. Aside the schemes initiated by the MOH and SSNIT, some health insurance schemes were set up in urban areas of the country at that time. These insurance schemes were initiated by some private for-profit insurance companies such as the Vanguard Assurance Company. Vanguard Assurance Company initiated the scheme with the Association of Private Medical Practitioners as the service providers. The Metropolitan Insurance Company also formed the Metcare Health Insurance Scheme, Provident Insurance and the Medex Health Insurance Scheme. All these private insurance schemes failed until September 5th ,2005 when the then parliament passed the National Health Insurance Act 650, which sought to secure the promotion of basic healthcare service to persons resident in Ghana through a

mutual and private health insurance scheme which is mandated to put in place a body to register, license and regulate health insurance schemes, to accredit and monitor health care providers operating under the scheme, to establish a National Mutual Insurance Fund that will provide subsidy to licensed District Mutual Health Scheme, to impose a health levy and to provide funds for purposes connected with the establishment of the scheme in Ghana.

The legislative Instrument, Act 650, 2003 and L .I 1809, 2004 are the legal framework guiding the implementation of the health insurance scheme in Ghana. The Governance of the health insurance scheme is made up of a fifteen-member National Health Insurance Council established to manage a National Health Insurance Fund, to provide subsidies to District wide Mutual Health Insurance Schemes, regulate the insurance market and license and monitor service providers under the scheme. A National Health Insurance Secretariat will provide administrative support to the National Health Council in the implementation of the Scheme.

The District Mutual Health Schemes, established by sponsors, identified by the District Assemblies or established by the Council as corporate bodies for the implementation of the scheme at the district. Private sector schemes may be established but do not receive subsidies from government. These private schemes operate as insurance schemes based on a premium, contract and policy. A Health Complaint Committee of the NHIC with decentralized and established in every district office of the Council. Membership enrollment and membership in a District Mutual Health Insurance Scheme is mandatory for all residents of Ghana, those working with the Ghana Armed Forces, the Ghana Police Service or those who have proof of holding a health insurance policy. Persons eligible to membership are expected to pay a contribution of GH₵7.2 per year (equivalent of US$7.74 at the time of passage of the Act. A period of six months may lapse between payment and issuance of membership cards for accessing service. The scheme provides for persons to be exempted from paying membership fees. These are;

- Contributors to the national Social Security and National Insurance Trust (SSNIT) or drawing pension benefit on SSNIT.
- Persons under the age of 18 with at least one paying membership fees or covered by exemption clause.
- Persons above age 70 years.
- Persons classified as indigents according to the criteria set by the Act and LI.

The Legislative Instrument defines a benefit and exclusion package for which a member of the scheme may have access. Any service provider wishing to provide services to members of the scheme have to apply to the NHIC for accreditation and licensing to provide specified set of services from the benefit package according to their assessed competency.

There are five main sources of funds that accrue from a National Health Insurance Fund used primarily to finance service provided and cover administrative overhead of the NHIC.

- Appropriation of 2.5% of all funds mobilized from worker pension contribution to SSNIT
- Ad valorem tax of 2.5% levied specifically for health insurance over all goods and services purchased or provided that are eligible for Value Added Tax.
- Government annual budgetary allocations proposed and approved by parliament to the National Health Insurance Fund (NHIF).
- Accruals from investment of surplus funds held in the NHIF by the NHIC.
- Gifts and donations made by benevolent individuals or organizations to the NHIF and Services of NHIS.

The NHIS package has certain health care services that are not covered in the Scheme. These exclusion are either total or partial. When you request for any of these excluded services, you may need to pay more and they are;

- Appliance and prostheses including optical aids, heart aids, orthopaedicaid, dentures, etc

- Cosmetics surgeries and aesthetic treatment.
- Anti-retroviral drugs for HIV.
- Assisted Reproduction (e.g artificial insemination) and gynecological hormone replacement therapy.
- Echocardiography.
- Photography.
- Angiography.
- Dialysis for chronic renal (kidney) failure.
- Organ transplants.
- All drugs that are not listed on NHIS list.
- Heart and Brain Surgery other than those resulting from accidents.
- Cancer treatment other than breast and cervical.
- Mortuary Services.
- Diagnosis and treatment abroad.
- Medical examinations for purpose other than treatment in accident health facilities (eg. Visa application, Education, Institutional, Driving licensing etc.)
- VIP ward (accommodation). **Financing of Health Insurance in Ghana**
- Since independence in 1957, health care financing in Ghana has gone through a number of significant transformations. At independence, the new Government committed itself to a welfare state system that include a "free health care for all'' policy. User fees for health services were relatively low and were not aimed at cost recovery.
- In 1982, user fees were introduced in government-run health facilities, in order to supplement limited health financing resources (aiming to recover 15 percent of health

sector operating cost) and also to discourage unnecessary use of services (World Bank Report, 2007). Whiles meeting both of these goals the payment known as " Cash and Carry" led to dramatic decline in health care utilization, with outpatient visits to hospital dropping from 4.6 million to 1.6 million in 1985,when charges were first increased substantially.

- In 1989, Community – Based Health Insurance (CBHI) schemes, also known as mutual health organizations (MHOs), were introduced in certain districts throughout the country. Coverage rates were highly variable by districts ranging from 2 to 25 percent. By 2003, such community schemes covered only a small portion (1 percent) of the country's 19 million population, leaving many Ghanaians vulnerable in the event of a catastrophic illness. A critical observation of the various related literature reveals that the health insurance instituted by countries all over the world including Ghana was implemented with the intention of making health care accessible, affordable and also to reduce deaths related to sickness covered by the Health Insurance. The essence of this study is to review existing literature in this area and also add to those that have not been captured by previous researches to enable researchers who have the interest to research in this area make reference to and review accordingly.

2.6 Challenges of NHIS in Developing Countries

After independence in 1957, Ghana adopted a socialist centralist development approach where the state took absolute control of all services, including health and education. In line with the policy, all user charges were abolished by government in 1957 though certain services attracted nominal charges affordable to most, if not all of the population. Free provision of health care was accompanied by increasing usage, abuse of facilities and commodities, increasing cost and inefficiency leading eventually to a reduced quality of health care delivery.

In order to reverse this trend, the hospital Fees Decree (1969, later amended into Hospital Fees Act (1971) and Hospital Regulation 1985 (L.I 1313), introduced forms of payment for health care delivery. The Act specified fees to be charged for consultation, laboratory and other diagnostic procedures, medical, surgical and dental services, medical examination and hospital accommodation in Ghana. L.I 1313 was specifically introduced to enable hospitals to totally recover all costs (except staff wages) involved in their operations and was hugely successful in ensuring availability of medicines and medical supplies. However, it lacked a human face and led to a huge reduction uptake of services, as well as refusal of health professional to treat patients, including those requiring emergency care, without upfront payment.

The exemptions scheme which was introduced alongside the cost recovery scheme to care for the poor and vulnerable failed woefully and was subject to abuse, misinterpretation and arbitrary implementation. The human capacity for managing the complex exemption scheme for the poor and vulnerable was simply not available and or was not developed in some cases.

The absence of clear guidelines, lack of monitoring and supervision, transparency, ownership and knowledge of these schemes by heads of institutions all contributed to the failure of this system. Many studies have concluded that access to health care was generally reduced, especially during the initial stages of implementation of the out of pocket payment. The absence of governing structures of the mutual health insurance as mandated by law to ensure transparency and accountability was also seen as one of challenges confronting health insurance in Ghana. The absence of these governing structures caused suspicion in the community members about how the funds were being disbursed by the officials' appointees of the scheme. This was compounded by attempt to politicize by leading political figures in the district. As a result, the confidence of the communities in the scheme began to erode, leading to decline in membership and correspondingly also led to the reduction of the pool fund to the scheme which

is the most valuable in every health insurance scheme. Access to medicine is an essential ingredient in any health care policy. As a result, any health care that does not guarantee access to medicine is bound to fail. The supply of drugs to service providers has become one of the major challenges facing the health insurance scheme since a number of service providers are in arrears for non-payment of claims submitted to the NHIS. There are many health care facilities whose reputation among suppliers of pharmaceuticals have been seriously undermined by non-payment of claims submitted by these providers. In response to these challenges, governments are in the process of implementing or considering reforms in this sector.

2.7 Objectives of the Ghanaian National Health Insurance Scheme

The national health insurance ensures first of all that opportunity is provided for all Ghanaians to have access to the functional structures of health insurance. Secondly, it ensures that Ghanaians do not move from an unaffordable, cash and carry" regime to another unaffordable health Insurance Scheme. Thirdly, it must ensure a sustainable health insurance option is made available to all Ghanaians and fourthly, the quality of health care provision is not compromised under Health Insurance (MoH., 2015) According to the policy it is compulsory for every person living in Ghana to belong to a health insurance type and all Ghanaians pay 2.5% on selected expenditures and transactions to be put into the NHIS fund. The formal sector contributes 2.5% of their 17.5% Social Security and Insurance Trust (SSNIT) contribution whereas the informal sector contributes GH72.00 per annum (MoH., 2015). The scheme has some underlying principles such as Equity, Risk Equalization, Cross-subsidization, Solidarity, Quality care, Efficiency in premium collection and claims administration, Community or subscriber ownership, Partnership, Reinsurance and Sustainability. Contribution is based on stratification. The policy comes out with six main categories being the core poor, very poor, poor, middle income, rich and the very rich according to the ability to pay. Health insurances have governing

bodies which are responsible for the direction of policies of the scheme. They are registered under the companies code ACT 1973 as either limited by guarantee or liability. There is no restriction on the number and type of scheme that one can join. Initially, the Health Insurance Scheme was financed entirely by tax revenue. As the sustainability of this form of financing became questionable, there was the need to look at other sources of funds.

2.8 Benefits of the NHIS in Ghana

The World Health Assembly (2005) called for all health systems to move towards universal coverage, defined as "access to adequate health care for all at an affordable price". A crucial aspect in achieving universal coverage is the extent to which there are income and risk cross subsidies in health systems (McIntyre *et al.*, 2005). Health policies in many nations have been revised and reformed to address increasing public healthcare demands and increasing limited resources in order to reach the less privileged. The successes of the NHIS in Ghana have been achieved in various sectors of the economy. It covers about 95% of all diseases that occur in Ghana. The coverage is from out-patient services to emergencies including mental health cases once it is being handled by accredited institutions. For instance National Health Insurance Authority (NHIA) in collaboration with key stakeholders updated medicines list with an aim of improving quality health care. Significant additions which include new malaria drugs for children and pregnant women making up to about 522 medicines have been included and it took effect from March 1, 2011 with the aim of achieving the Millennium Development Goals 4 and 5 (NHIA., 2011). These developments enhance the progress of the scheme. In consequence patronage of health services has improved with the introduction of health insurance schemes in several sub-Sahara African countries. A classic example is Ghana where OPD attendance has increased tremendously with the full implementation of the National Health Insurance Scheme in 2004 (Buor., 2008).

Since February, 2011 there have been add ups such as childhood immunizations, tuberculosis and mental health care into the program all geared towards improvement of health care in Ghana (NHIA., 2011). The benefits of the National Health Insurance have been categorized according to the services provided. The outpatient services include general and specialist consultations reviews, general and specialist diagnostics testing including laboratory investigation, x-rays, ultra sound scanning, medicines on the NHIS medicine lists surgical operations such as hernia repair and physiotherapy. On the other hand the in-patient services are made up of General and Specialist in patient care, diagnostic test, surgical operations, in-patient physiotherapy, accommodation in the general ward and feeding.

In addition, there is oral health which includes pain relief (tooth extractions, temporal incision and drainage) and dental restoration (simple amalgam filling, temporary dressing). Maternal care which is of the core reasons for the health insurance to reduce maternal mortality rate includes antenatal, deliveries (normal and assisted), caesarian session and postnatal care. (www.nhis.gov.gh).

Nonetheless, there are various emergencies the scheme covers which involve cases in health situation that demand urgent attention such as Medical emergencies, surgical emergencies, pediatric emergencies, obstetric and gynecological emergencies and road traffic accidents. However, there are some health cases that the NHIS does not cover and as such the individual must pay out of his or her pocket. These include appliance and prostheses including optical aid, heart aids, orthopedic aids among others, cosmetic surgeries and aesthetic treatment, HIV retroviral drugs and assisted reproduction (artificial insemination and gynecological hormone placement therapy) (www.nhis.gov.gh).

Others include echocardiography, photography and angiography, dialysis for chronic renal failure and organ transplant. It also includes all drugs not listed on the NHIS medicine list, heart

and brain surgery, cancer treatment other than breast and cervical cancers, mortuary services, medical exams for purposes other than treatment in accredited health facilities for example for visa, educational or driving licenses and VIP ward. (www.nhis.gov.gh).

Though national health insurance schemes are instituted by government it is the contributions of the clients that are the citizens which build up to become a substantial amount to take care of them when they are sick. But many countries exhibit the flaw removing consumers from participating in decisions regarding their health care. Thus the approach to health insurance ignores the important role clients play in controlling costs and enhancing quality. Gorman (2008) found in Wisconsin that people who pay for their own healthcare cut utilization by 10% to 30% with no discernable effect on health. Saving even 10% of Wisconsin's 2002-2003 health care spending would have saved $260 million. Fortunately a movement has begun to put consumers in the central role where they belong. In Ghana there have been reported situations where individuals take minor cases to hospitals in the name of health insurance when they could just access a clinic. This goes a long way to affect the cost of health insurance and affect the scheme in the end. Another dimension is the fact that clients may be registered with the scheme alright showing a large population of registered scheme members but in reality just a few may be able to access healthcare due to unequal distribution of health facilities or difficulty in using healthcare facilities with their card for various reasons such as delay in clients receiving their membership University cards. For instance a survey revealed that not all subscribers of the NHIS are able to access health services after completing the recommended waiting period due to delays in the issuance of identification cards and other forms of identification to members (SEND, 2010). Yet another Non -Governmental Organization (NGO) observed in their study of the use of the NHIS in Ghana found out that only 18% of the 80% registered persons benefit from the NHIS (Oxfam, 2010).

Further in another analysis, it has been observed that perceptions related to providers, schemes and community attributes play an important role, albeit to a varying extent in household decisions to voluntarily enroll and remain enrolled in insurance schemes. Thus, scheme factors are of key importance and therefore policy makers need to recognize household perceptions as potential barriers or enablers to enrolment and invest in understanding them in their design of interventions to stimulate enrolment (Jehu-Appiah *et al.*, 2011).

2.9 Access to Healthcare

Access to health care is an important component of an overall health system and has a direct impact on the burden of disease that affects many countries in the developing world. Measuring accessibility to health care contributes to a wider understanding of the performance of health systems within and between countries which facilitates the development of evidence based health policies. Accessibility per se is one of the most frequently used terms and yet little defined in urban and regional studies (Olujimi, 2007). Accessibility has a number of dimensions, thereby making it to face both definitional and measurement problems (Lasker, 1981). WHO defines accessibility as measure of the proportion of the population that reaches appropriate health services (WHO, 2002). Ingram (1971) also defines accessibility as the inherent characteristics or advantage of a place with respect to overcoming some form of friction. In Ingram‟s definition, location (i.e. a place) is enjoying the access.

However, Ingram went a step further by classifying accessibility into two, thus Relative accessibility and Integral accessibility. Relative accessibility measures the degree to which two places or things are connected while Integral accessibility measures the degree of interconnection of points of things in the system (Ingram, 1971). Hargerstand (1974) also made a distinction between social and physical accessibility. Social accessibility he says connotes the ability to pay (as determine by age and income) to pass the barrier around the supply point consumer wants to

reach and physical accessibility as the ability to get transportation facilities which are needed for reaching the supply points at suitable times. (Hagerstand, 1974). The capacity to overcome space is central to all the definitions hence the words "ease" ability to reach and overcoming friction. A bothering question in relation to all the above definition to accessibility is who or what experiences accessibility, the people or location? To Wachs, Kumagai, and Ingram, (1973) it is the location (place) whereas to other scholars it is the people. Accessibility to health care is concerned with the ability of a population to obtain a specified set of health care services, with the concept of "specific" having the potential to vary depending on the policy focus or impact of disease (Oliver & Mossialos, 2004).

Many factors affect a population's ability to access appropriate levels of health care. According to both Penchansky & Thomas, (1981) and Oliver & Mossialos, (2004) these factors can be grouped into three categories of availability, acceptability and affordability and geography. Geographic accessibility often referred to as spatial or physical accessibility is concerned with the complex relationship between the spatial separation of the population and the supply of health care facilities and thus has a strong underlying geographic component. This concept can also be extended to incorporate different types of health intervention (Shengelia *et al,* 2003). Although it is intuitive that the level of public health of a population may be affected negatively by the distance to health care services, there remains limited quantitative information regarding this impact (Guagliardo, 2004).

2.10 Access barriers

According to Busse *et al,* (2006) access to health care delivery is usually hindered by several factors. Even where universal access to health services is formally in place, individuals can face a range of barriers hindering the actual utilization of that service. They added that if persisting inequities in access are to be addressed, it is necessary to look beyond the assumption of

universal coverage. Barriers to access of quality healthcare may stem from factors within the health system itself that is at the supply side or be due to patient-related (demand side) aspects. Supply-side barriers to health care delivery include gaps in population coverage of health insurance, the scope of the public health benefit package, financial factors such as cost-sharing and geographical factors such as distance. In addition, organizational factors, including waiting lists and opening hours as well as lack/appropriateness of information also hinder access to healthcare (Anderson, 2004). Inequality of access at the demand side is related to the characteristics of the potential service users, such as income, age, gender, cultural background, health literacy, or health beliefs. Some access hurdles have relatively more impact on disadvantaged groups than others (Tamsma & Berman, 2004). Examples of these are costs and distance, as well as demand-side factors such as communication skills and health beliefs (Dixon *et al*, 2003). Evidence based on the 2003 European Quality of Life Survey suggests income-related inequalities in access existed in all current EU Member States as regards distance, delay, waiting and cost factors. Differences are most pronounced as regards the proportion of people who indicated that their most recent visit to the doctor was made very difficult by cost factors (Anderson, 2004). The overall picture emerging from the survey is that richer, better-educated people find their way to medical specialists and dentist more easily and more frequent, while people in the lower income brackets tend to use more emergency services. However, access to general practice services seems fairly equally distributed across income although the poor are more likely to consult them more often. In contrast, the level of pro-rich inequality as regards access to medical specialist increases with the total number of specialist visits. Education appears to be a more important cause of inequality in specialist care than in other health care services (Allin *et al*, 2005).

2.11 Measuring access to health care

Accessibility is more than mere ease of getting to a place (Olujimi, 2007) .Access to healthcare is a variable that does not lend itself to easy observation and measurement. Alternatively, a range of indicators can be used to measure its dimensions, and the various barriers to access. Service utilisation is most commonly used as a proxy measure for access (Allin, 2006). Other indicators of access hurdles such a user charges or waiting times can also be used to measure access to healthcare. In order to measure access, inequality in utilization of health care must be standardized for differences in need (O"Donnell *et al,* 2007). In most cases, qualitative aspects of access that may help understand inequalities tend to receive less attention because they cannot be quantitatively measured. For instance, need for services are often ignored or attempts made to measure it by levels of self-reported ill health (Allin *et al,* 2007). However, personal accessibility measurement does not only include some of the proportion of people who indicated that their most recent visit to the doctor was made very difficult by cost factors (Anderson, 2004). The overall picture emerging from the survey is that richer, better-educated people find their way to medical specialists and dentist more easily and more frequent, while people in the lower income brackets tend to use more emergency services.

However, access to general practice services seems fairly equally distributed across income although the poor are more likely to consult them more often. In contrast, the level of pro-rich inequality as regards access to medical specialist increases with the total number of specialist visits. Education appears to be a more important cause of inequality in specialist care than in other health care services (Allin *et al,* 2005). However, personal accessibility measurement does not only include some of the attributes of locational accessibility (such as distance and road conditions) but also connotes the effects of constraints of movement (such as mode, travel time,

waiting time and cost travel in cash) on the individual or groups being considered (Olujimi, 2007).

This approach is also reflected in the way access is measured within EU related frameworks. While the EU framework shortlist does not include one specific indicator for access, it does include indicators of access barriers such as the population coverage by public insurance and the waiting times for elective surgeries. Indicators of service utilisation are included, even though not specified for differences by socio-economic status as regards uptake. The service utilisation indicators used in measuring equitable access include vaccination coverage for children, breast cancer screening, cervical cancer screening and general medical practise utilization. Within the EU‟s social protection and social inclusion process, the following common indicators are especially relevant in measuring access to healthcare. These are unmet need for medical care, unmet need for dental care, population coverage by public insurance infant mortality, life expectancy and self-perceived health (CEU, 2006).

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter focused on methods that were used to collect and analyze data gathered from the field for the study. These included population, sample size determination, sources of data, sampling procedures, research design, data collection methods, research instrument and data analysis methods. The data analyzed from the field was both primary and secondary.

3.2 Research design

Descriptive method of research was used for this study. A descriptive method of research is defined by Creswell (1994) as a method of gathering information about present existing condition. The emphasis was on describing rather than judging or interpreting. The descriptive approach was found to be quick and practical. Moreover, this method allows for a flexible approach. Thus when important issues and questions arose during the duration of a study, a further investigation was conducted. Descriptive research on the other hand, is a type of research that is mainly concerned with describing the nature, condition and degree in detail of the present situation. In this study, a descriptive method was employed so as to identify the role and significance of using questionnaire in examining the effectiveness of the Health Insurance Scheme on the poor in Akuapem South District. The researcher saw the descriptive method as advantageous due to its flexibility. This method was used for both quantitative and qualitative data and it has greater option when it comes to selecting instrument for data gathering.

3.3 The Study Area

The Akuapem South District was established on 6th February 2012 by an Act of Parliament (Legislative Instrument 2040). The district was carved out from the old Akuapem South Municipality. The district has Aburi as the capital, and it is about 20km from Accra, the national capital and has a population of 37,501.

The Akuapem South District is located at the south eastern part of the Eastern Region of Ghana. It is bordered to the west by the Nsawam-Adoagyiri Municipality, to the south-east by the Kpone-Katamanso District, to the south by the Ga East District and to the North-East by the Akuapem North Municipality.

Pakro is situated in Nsawam-Aburi, Eastern, Ghana. Its geographical coordinates are 5° 54' 0" North, 0° 19' 0" West and its original name (with diacritics) is Pakro. The surrounding towns are Dego, Obodan and Adwaso. It has an estimated population of 7889 and it is bounded to the east by Akuapem North District to the North by Ayensuano and to the west by Nsawam Adoagyiri Municipality.

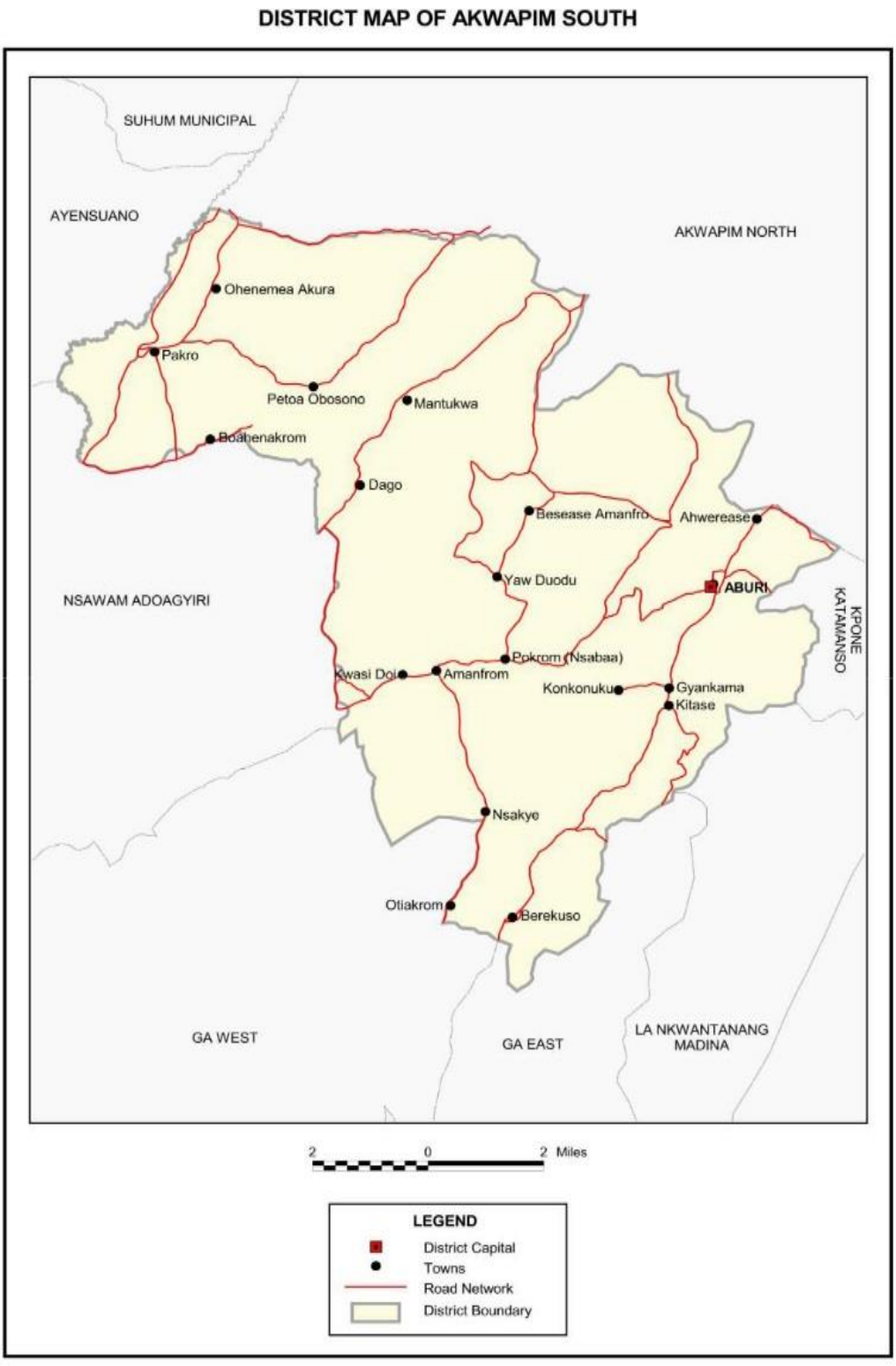

Figure 1: Map of Akuapem South District

3.4 Sampling procedures

Accredited service providers, Health Insurance card users in Akuapem South District constituted the population. Though the population is finite, my focus was on the Health centre in Pakro in Akuapem South District that provide health insurance services to health insurance card users. To have a true reflection of the population a simple random sampling purposive sampling method were used to select the samples for this study.

A Simple Random sampling method was found to be appropriate since all the people have the chance of been selected.

4.5 Study population

Population of a study is defined as the elements or people to be studied and from whom data is obtained (Keller & Warrack, 2003). The population or universe is any clearly defined set of objects about which we want to obtain information. The populations for this study were health insurance card users and accredited providers of health insurance services in Akuapem South District preferably Pakro town.

For this study, the population was health insurance card users and accredited providers of health insurance services in Akuapem South District. According to the 2010 population and Housing census, the total population of Akuapem South District is 129 297. However, since it is not feasible to reach the entire population of 129 297, a sample was determined.

A total of one hundred (100) respondents were selected for this study. The researcher visited the health centre on four occasions after permission has been sought from the management of the health centre. Those who came to the records section were approached and selected for the study based on their availability and willingness to participate in the study. This was done until the researcher had the 100 respondents.

3.6 Sources of data

Data was collected from both primary and secondary sources. The primary source was obtained from the responses of respondents through a questionnaire. The secondary data was obtained from published articles, journals, Nsawam Government Hospital, New Life Hospital, Pakro Health Centre attendance records, claims and enrollment data of the Akuapem South Mutual Health Insurance scheme.

3.7 Data collection instruments

Questionnaire as the instrument of choice in this study and was originally developed by Parasuraman, Berry and Zeithahaml (1985).Quick MBA (Questionnaire Design 2002) explains the three major question-types available to the researcher, namely: Open ended, Dichotomous, and Multichotomous. But the researcher chose the dichotomous (closed-ended): They were used for questions with two possible opposing outcomes, for example 'Yes' and 'No'. They tend to be easier to answer and require less effort when interpreting the results - they are directly comparable to answers by other respondents

3.8 Data collection procedure

For this research two types of data were gathered. This comprised both primary and secondary data. The primary data was derived from the responses given by the respondents on whether the health insurance scheme is effective or not, during the survey. The secondary data on the other hand was obtained from the Akuapem South Mutual health claims and enrollment register.

3.9 Data Analysis

Data analysis consists of getting meaning out of the data collected in a particular study. Data analysis includes the usage of statistical procedures to analyze and summarize the data collected to derive a meaning. Data cleansing began immediately after data collection. This the researcher did by going through each questionnaire to find out if all the questions have been answered before entering the data into the management tool. The data was coded after the cleansing to facilitate categorization and analysis by transforming the data into suitable format for computer-aided analysis. Descriptive statistics including frequency tables and simple percentages were computed. This analysis was done using Statistical Package for Social Sciences (SPSS) software and Microsoft Excel.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

The purpose of this study was to examine the benefit criteria of the NHIS and to explore the accessibility of the scheme to the poor. In addition to the above objectives, the study again sought to explore the alternative of accessing health services by the poor and to explore the impact of the assessment of the alternative to the livelihood of the poor. This chapter presents the findings from the study and analyzed them vis-à-vis the objectives. This chapter was structured into two sections, the first section summarized, the general information about the respondents while the second section concentrated on the presentation of data relating to the research questions. The discussion of the findings was attached to the data analysis.

4.2 Demographic characteristics of respondents

The demographic characteristics were very important as these had influence on the research questions and thus, explained the views and opinions on issues expressed in the study. The demographic characteristics of respondents used in this study included gender, age and religion.

4.2.1 Age of respondents

Table1 shows the age distribution of the respondents used for the study. Forty-five percent (45%) fell under the age bracket of 18 whiles 40% are in the age bracket of 19 – 69 years. Finally, the above 70 years respondents were the minority which represented 15%. This shows that the majority of the respondents used for this were in the ages of under 18 years.

Table 1: Age of respondents

Response	Frequency	Percent
Under 18	45	45.0
19– 69 years	40	40.0
Above 70 years	15	15.0
Total	**100**	**100.0**

Source: Field survey, 2019

4.2.2 Sex distribution

The Table 2 talks about the sex of the respondents. Thirty-four percent (34%) were males whiles 66% were females. This indicates that majority of the respondents are females.

Table 2: Sex Distribution

Response	Frequency	Percent
Male	34	34
Female	66	66
Total	**100**	**100**

Source: Field survey, 2019

4.2.3Marital Status

Table 3 looks at the marital status of the respondents. The table shows that 15% of respondents were married whiles 35% of the respondents were single. In addition, it was realized that 5% of the respondents were divorcees while the remaining 45% of respondents were just co-habiting. This indicates that most of the respondents used for this study were not married but cohabiters.

Table 3: Marital Status

Response	Frequency	Percent
Married	15	15
Single	35	35
Divorce	5	5
Co-habitation	45	45
Total	**100**	**100**

Source: Field survey, 2019

4.2.4 Occupation

Table 4 below shows that majority of the respondents were farmers. It is evident from the table 55% of the respondents said that were farmers while 37% said that they were traders. The study had only 8% respondents who were public servants.

Table 4: Occupation

Response	Frequency	Percent
Trader	37	37
Farmer	55	55
Public Servant	8	8
Total	**100**	**100**

Source: Field survey, 2019

4.3 Membership of the Scheme

Table 5 shows that majority of the respondents were registered members of the NHIS. This is evident from the table below when 87% of the respondents were registered members who had enrolled on the scheme for different length of time whiles only 13% were not registered members.

Table 5: Membership of the Scheme

Reponse	Frequency	Percent
Yes	87	87
No	13	13
Total	**100**	**100**

Source: Field survey, 2019

Enrollment of the NHIS

Table 6 sought to find out the years in which the respondents enrolled on the NHIS. The table shows that 18% of the respondents registered before 2008 whiles 33% of the respondents said that registered for the NHIS the years 2008-2012. Finally 49% of the respondents said that they registered for the cards in the year 2012-2019. This clearly shows that majority of the respondents registered in the years 2012 to 2019.

Table 6: Enrollment of the NHIS

Response	Frequency	Percent
Before 2008	18	18
2008-2012	33	33
2012-2019	**49**	**49**

Source: Field survey, 2019

4.4 Registered family members on the NHIS

In Table 7, the researcher sought to find out from the respondents if all the family members belonged to the NHIS or not? Evidence from the table shows that 87% of the respondents said that their family members belonged to the NHIS while the remaining 13% said that their family members did not belong to the NHIS. This indicates that majority of the respondents family members were part of the NHIS.

Table 7: Registered family members on the NHIS

Response	Frequency	Percent
Yes	87	87
No	13	13
Total	**100**	**100**

Source: Field survey, 2019

4.5 Validity of NHIS card

The Table 8 below shows majority of the respondents had valid NHIS cards. This is true when 85percent of the respondents said that they held valid NHIS cards while 15% of the respondents said that they did hold valid NHIS cards.

Table 8: Valid NHIS card

Response	Frequency	Percent
Yes	85	85
No	15	15
Total	**100**	**100**

Source: Field survey, 2019

4.6 The days used to obtain NHIS

In Table 9, the researcher realized that 55% of the respondents said that it took them less than one month to secure the NHIS whiles 45% of the respondents said that they got their cards at exactly one month. This is evident that the cards were obtained within one month.

Table 9: The days used to obtain NHIS

Response	Frequency	Percent
Less than a month	55	55
One month	45	45
Total	**100**	**100**

Source: Field survey, 2019

4.7 Access to a health delivery facility

Table 10 shows that some of the respondents had health facility in their town/village whiles others did not have a health facility within their town. This is shown in the table when 50% of the respondents said that they had a health facility within their town whiles the remaining 50% of the respondents said otherwise. The researcher saw that it is only Pakro that can boast of a health facility but the nearby communities did not have a health facility.

Table 10: Access to a health delivery facility

Response	Frequency	Percent
Yes	50	50
No	50	50
Total	**100**	**100**

Source: Field survey, 2019

4.8 Types of facilities available

Table 11 sought to find out from the respondents the type of facility found in their locality. 55% said that they have government facility while the remaining 45% said that they had either Pharmacy shop or a Chemist shop. This is to say majority had a government clinic whiles the minority had a pharmacy/chemist shop.

Table 11: Types of facilities available

Response	Frequency	Percent
Government Clinic	55	55
Pharmacy/Chemist	45	45
Total	**100**	**100**

Source: Field survey, 2019

4.9 Nearest health facility from your home

This question was asked to find out how far the health facility was form their homes. The Table 12 shows that 45% of the respondents said that the facility is less than 1km whiles the 45% also said that the facility is 2-3km from their houses. Finally, the remaining 10% said that the facility is 4-5km from the house. This indicates that the facility is not nearer to the majority of the people. This finding support the findings of (Olujimi, 2007) postulates that distance can be

hindrance to people who are seeking health care. He measured distance as to how long does it take you to visit a facility.

Table 12: Nearest health facility from your home

Response	Frequency	Percent
Less than 1km	45	45
2-3km	45	45
4-5km	10	10
Total	**100**	**100**

Source: Field survey, 2019

4.10 Satisfaction with Services rendered by service providers

Table 13 indicates that majority (58%) of the respondents were not satisfied with the services/benefits rendered by the service providers. Their reasons being that customer care was poor and could not get the needed drugs. Forty two percent (42%) of the respondents were however satisfied with the service rendered by the service providers because they got good customer care and the needed drugs and services. Again this results supports the reports of (Oxfam, 2010).

Table 13: Satisfaction with services rendered by service providers

Response	Frequency	Percent
Yes	42	42
No	58	58
Total	**100**	**100**

Source: Field survey, 2019

4.11 Benefits from the national health insurance scheme

The respondents were asked about their opinion on the benefits they derived from the NHIS scheme. Table 14 shows that 7% of the respondents said their benefits of NHIS can be classified as good whiles 36% also said that their benefits can be classified as good. Finally 57% of the respondents representing 57% said that benefits from the NHIS can be classified as fair. This shows that the benefits of the NHIS from this work can be classified as fair. Oxfam, (2010) report observed in their study of the use of the NHIS in Ghana found out that only 18% of the 80% registered persons benefit from the NHIS. This is to confirm our results which shows that majority do not believe benefits from the NHIS.

Table 14: Benefits from the national health insurance scheme

Response	Frequency	Percent
Good	7	7
Satisfactory	36	36
Fair	57	57
Total	**100**	**100**

Source: Field survey, 2019

4.12 Satisfaction with Service Provided (Yes respondents)

Table 15 indicates that Forty-two percent (42%) of the respondents said that they were satisfied with the service providers and went on to give further reasons why they are satisfied with them. 73.8% of the forty-two respondents said that they get good customer care whiles the remaining 26.2% said that they get the needed drugs and services from the service providers. This is to say that they are satisfied with the service providers based on the good customer care and also get the needed drugs and services.

Table 15: If Yes how?

Response	Frequency	Percent
Good customer care	31	73.8
Get needed drugs and service	11	26.2
Total	**42**	**100**

Source: Field survey, 2019

4.13 Attention/treatment from service provider

In Table 16, majority of the respondents said that they did not get the attention/treatment they expect anytime they visit the service provider. This is evident when 46% of the respondents said that they got the needed attention/treatment from the service providers' whiles the remaining 54% on the hand disagreed with the assertion**.** A survey conducted by SEND (2010) revealed that not all subscribers of the NHIS are able to access health services or treatment anytime they visit the hospital. This shows that these findings support that of the SEND (2010).

Table 16: Attention/treatment from service provider

Response	Frequency	Percent
Yes	46	46
No	54	54
Total	**100**	**100**

Source: Field survey, 2019

Table 17 below shows that the majority of the respondents' family members fell sick under the past twelve months. This is evident from the table when 80% said that their family members fell sick under the past one year while the remaining 20% on the other hands said that their family members did not fall sick.

Table 17: Respondents/Family Members who fell ill within the last 12 months

Response	Frequency	Percent
Yes	80	80
No	20	20
Total	**100**	**100**

Source: Field survey, 2019

4.15 Duration of illness

In Table 18, the researcher asked the respondents how long it lasted when their family members visited the service providers. 84% of the respondents said that the family members' sickness lasted for less than three days while the remaining 16% also said that their family members' sickness lasted up to seven days. This showed that most of the respondents' family members' sickness lasted for less than three days.

Table 18: Duration of illness

Response	Frequency	Percent
Less than 3 days	84	84
Up to 7 days	16	16
Total	**100**	**100**

Source: Field survey, 2019

4.16 Bill settlement with the NHIS card

The respondents were asked if they were able to pay the bill or not? The Table 19 shows that 9% of the respondents said that they were able to pay the bill but the other 91% said that they were not able to pay the bill. This indicates that majority of the respondents could not pay the bill charged on them.

Table 19: Bill settlement with the NHIS card

Response	Frequency	Percentage
Yes	**9**	**9**
No	**91**	**91**
Total	**100**	**100**

Source: Field survey, 2019

4.17 Bill payment

In Table 20 the respondents were again asked if they were not asked to pay the entire bill, then how much were they asked to pay. 66% said that they were asked to pay less than GH₵5 whiles the remaining 34% also said that they were asked to pay GH₵5 - GH₵15. This shows that the respondents were ask to pay something even though there have a valid NHIS card.

Table 20: Bill payment

Response	Frequency	Percentage
Less than GH₵5	66	66
GH₵5 - GH₵15	34	34
Total	**100**	**100**

Source: Field survey, 2019

4.18 Services Received/Opinion of Satisfaction

4.18.1 Hospital admission

Table 21 showed that some of the respondents' had been admitted to the hospital during the past two years. 14% of the respondents said 'Yes' meaning they had been admitted to the hospital during the past two years while the remaining 86% also said that they had not gone on

admission to the hospital for the past two years. This showed that majority of the respondents had not been admitted to the hospital for the past two years.

Table 21: Hospital admission

Response	Frequency	Percentage
Yes	14	14
No	86	86
Total	**100**	**100**

Source: Field survey, 2019

4.18.2 Period of admission

In the Table 22 fourteen respondents who said they have been admitted to the hospital before said that their admission lasted for less than one week.

Table 22: Period of admission

Response	Frequency	Percentage
Less than 1 week	14	100
Total	**100**	**100**

Source: Field survey, 2019

4.18.3 Settlement of the entire bill with the NHIS card

In Table 23, out of the one hundred respondents 14% of them said they were able to settle the entire bill with the NHIS card whiles the remaining 86% said they were not able to settle their bill with the NHIS. This shows that majority of the respondents were not able to use their NHIS to access health care. The results from this table corroborated the work of (Anderson, 2004**). I**n his work he argued that supply-side barriers to health care delivery include gaps in population

coverage of health insurance, the scope of the public health benefit package, financial factors such as cost-sharing and geographical factors such as distance hinder access to health care.

Table 23: Settlement of the entire bill with the NHIS card

Response	Frequency	Percentage
Yes	14	14
No	86	86
Total	**100**	**100**

Source: Field survey, 2019

4.19 Accessibility of any alternative health care in your locality

In Table 24, Seventy-two respondents out of the eighty-six respondents who said they could not settle their bill with the NHIS said that they had no option than to seek an alternative health care. The other 16.28% said that they did not visit any alternative health care facility. This shows that majority of those who could not pay the bills resorted to the other health care such as self-medication, herbal medicine, pharmacy and others which looked cheaper.

Table 24: Accessibility of any alternative health care in your locality

Response	Frequency	Percentage
Yes	72	83.72
No	14	16.28
Total	**86**	**100**

Source: Field survey, 2019

4.20 Alternative health care

From Table 25, the researcher sought to find out from the respondents if they visited the alternative health facility because they could not pay the hospital bill? The table shows that 54%

saying that 'Yes' meaning they visited the alternative facility because of the bills while the other 46% said that they visited the alternative facility not because of the hospital bill. This indicates that they visited the alternative facility because of the hospital bills. This results also supports Anderson 2004. In his work he argued that supply-side barriers to health care delivery include gaps in population coverage of health insurance, the scope of the public health benefit package, financial factors such as cost-sharing and geographical factors such as distance hinder access to health care.

Table 25: Alternative health care

Response	Frequency	Percentage
Yes	54	54
No	46	46
Total	**100**	**100**

Source: Field survey, 2019

4.21 Accessibility of the hospital in the locality

In Table 26, Forty-seven respondents representing 47% said that they the health facility is accessible to them while the remaining 53% on the other hand said that the health facility is not accessible to them. This evidence in table 29 shows that the hospital or the health facility is not accessible to them due to the distance they have to walk before they can access the health care. This finding is in support of Tamsma & Berman (2004) who looked at the barriers to health care. In their study they argued that distance can deny people access to the facility of their choice which may force them to resort to other alternatives

Table 26: Accessibility of the hospital in the locality

Response	Frequency	Percentage
Yes	47	47
No	53	53
Total	**100**	**100**

Source: Field survey, 2019

4.22 Alternative facility visited in locality

In Table 27, the respondents were then to list the alternative facilities they do visit within their locality. 30% of the fifty-one respondents representing 58.82% said that they do self-medication while the other 41.18% said that they buy their drugs from drug situated in their locality. This is to say that self-medication and buying drugs from the drug store is the order of the day for the people of Pakro community.

Table 27: Alternative facility visited in locality

Response	Frequency	Percentage
Self-Medication	30	58.82
Drug Store	21	41.18
Total	**51**	**100**

Source: Field survey, 2019

4.23 Cost of alternative health care

Most of the respondents said that the alternative facility they visited was cheaper than the hospital. This is exactly what has been stated in the table 32. In Table 28, 51% of the respondents said that the alternative facility visited is cheaper than the hospital with the remaining 49% also said that the alternative facility is not cheaper than the hospital. Hargerstand (1974) argued that

patients are likely to patronize the alternative facility if they do not have money for pay for health care. So according this finding, the respondents said that the alternative is cheaper than the public health care especially when accessibility is an issue. This finding corroborated what Hargerstand (1974) said.

Table 28: Cost of alternative health care

Response	Frequency	Percentage
Yes	51	51
No	49	49
Total	**100**	**100**

Source: Field survey, 2019

4.24 If not the entire bill, how much did you have to pay?

In Table 29, 61% of the respondents said that they could not pay the entire bill so they have to pay less than GH₵5 while the remaining 39% also said that they had to pay GH₵6 - GH₵15 as a bill to the hospital. Although the amount differs, the main thing is that they paid some amount of money at the hospital.

Table 29: Payment of entire bill

Response	Frequency	Percentage
Less than GH₵5	61	61
GH₵6 - GH₵15	39	39
Total	**100**	**100**

Source: Field survey, 2019

4.25 Services rendered by the alternative health facility

Table 30 was to find out from the respondents a whole a lot of questions on the services rendered by the service providers. 30% of the respondents said that the there is an information dissemination while the 70% of the respondents on the other hand said they were not happy with services rendered by the health facility in terms of information dissemination. Furthermore customer care services rendered by the facility was also seen to be poor. This is evident when 30% said that the services rendered by the health facility in terms of customer is not satisfactory while 70% of the respondents said that they are happy with the services rendered by the health facility. This shows that the respondents were not happy with the services rendered by the alternative health facility in terms of Information dissemination, Customer care, Complaints handling and Services rendered although they patronize the facility.

Table 30: Services rendered by the alternative health facility

	Yes	No	**Total**
Information dissemination	30	70	**100**
Customer care	30	70	**100**
Complaints handling	33	67	**100**
Services rendered	40	60	**100**

Source: Field survey, 2019

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.2 Introduction

This chapter summarized and drew conclusions of the study. It offered some policy recommendations. The first aspect dealt with summary of the findings of the study; the second section provided the conclusions from the findings. Finally, the last section presented recommendations based on the findings from the topic.

5.2 Summary of Findings

The purpose of this study was to examine the benefit criteria of the NHIS and to explore the accessibility of the scheme to the poor. In addition to the above objectives, the study again soughts to explore the alternative of accessing health services by the poor and to explore the impact of the assessment of the alternative to the livelihood of the poor. Both quantitative and qualitative approach was also used for the study which involved collecting and analyzing the data gathered in succession. The qualitative data was collected and analyzed in the sequence to help explain, or elaborate on, the quantitative results obtained in the first phase. The researcher used several methods under the qualitative method to collect information for the study.

Objective one

1. **Membership of the Scheme**

This finding shows majority of the respondents were registered members of the NHIS. This is evident when 87% of the respondents said that they were registered members of the scheme whiles only 13% were not registered members.

2. **Enrollment of the NHIS**

The results from chapter four showed that 18% of the respondents registered before 2008 whiles 33% of the respondents said they registered for the NHIS in the years 2008-2012. Finally 49% of the respondents said that they registered for the cards in the year 2012-2019. This clearly shows that majority of the respondents registered in the years 2012 to 2019.

3. **Validity of NHIS card**

Majority of the respondents had valid NHIS cards. This is true when 85percent of the respondents said that they held valid NHIS cards while 15% of the respondents said that they did hold valid NHIS cards.

Objective two

1. **Types of facilities available**

Fifty- five percent (55%) said that, they had government facility while the remaining 45% said that they had either Pharmacy shop or a Chemist shop.

2. **Nearest health facility from your home**

The result showed that 45% of the respondents said the facility was less than 1km whiles the 45% also said that the facility was 2-3km from their houses. Finally, the remaining 10% said that the facility was 4-5km from their houses. This indicates that the facility was not nearer to the majority of the people.

3. **Benefits from the national health insurance scheme**

This result showed that 7% of the respondents said that their benefits of NHIS can be classified as good whiles 36% also said that their benefits can be classified as good. Finally 57% of the respondents said that benefits from the NHIS can be classified as fair. This shows that the benefits of the NHIS from this work can be classified as fair.

4. **Satisfaction with Services rendered by service providers**

Majority of the respondents (58%) were not satisfied with the services/benefits rendered by the service providers. Their reasons were that customer care was poor and could not get the needed drugs. Forty two percent (42%) of the respondents were however satisfied with the services rendered by the service providers because they got good customer care and the needed drugs and services.

Objective three

1. **Bill payment**

   Sixty-six percent (66%) said that they were asked to pay less than GH₵5 whiles the remaining 34% also said that they were asked to pay GH₵5 - GH₵15. This showed that the respondents were asked to pay something even though they had valid NHIS cards.

2. **Hospital admission**

   This result shows that majority of the respondents had not been admitted to the hospital for the past two years. 14% of the respondents said 'Yes' meaning they were admitted to the hospital during the past two years while the remaining 86% also said that they hads not been admitted to the hospital for the past two years.

3. **Settlement of the entire bill with the NHIS card**

   This evidence shows that majority of the respondents were not able to use their NHIS to access health care. Out of the one hundred respondents 14% of them said they were able to settle the entire bill with the NHIS card whiles the remaining 86% said they were not able to settle their bill with the NHIS.

Objective four

1. **Accessibility of any alternative health care in your locality**

   Seventy-two respondents out of the eighty-six respondents who said they could not settle their bill with the NHIS said that they had no option than to seek an alternative health care. The other fourteen respondents representing 16.28% said that they did not visit any alternative health care. This showed sthat majority of those who could not pay the bills resorted to the other health care.

2. **Alternative health facility**

   This evidence indicated that they visited the alternative facility because of the hospital bills.

   The results showed that 54% said 'Yes' meaning they visited the alternative facility because of the bills while the other 46% said that they visited the alternative facility not because of the hospital bill.

3. **Accessibility of the hospital in the locality**

   Forty-seven percent (s 47%) of the respondents said the health facility was accessible to them while the remaining 53% on the other hand said that the health facility was not accessible to them. It was evident that, the hospital or the health facility was not accessible to them due to the distance they had to walk before they could access the health care.

Objective five

Services rendered by the alternative health facility

The last table was to find out from the respondents a whole lot of questions on the services rendered by the service providers. 30% of the respondents said that there was information dissemination while the 70% of the respondents on the other hand said they were not happy with

services rendered by the health facility in terms of information dissemination. Furthermore customer care services rendered by the facility was also seen to be poor. This was evident when 30% said that the services rendered by the health facility in terms of customer care were not satisfactory while 70% of the respondents said that they were happy with the services rendered by the health facility. This shows that the respondents were not happy with the services rendered by the alternative health facility in terms of Information dissemination, Customer care, Complaints handling and Services rendered although they patronized the facility.

5.3 Conclusion

Based on the findings the following conclusions can be drawn. Although they hold valid NHIS cards they still pay for some the services rendered by the facility. They are able to access their NHIS cards within one month. There is also a government facility in Pakro but still the respondents find it difficult to access the facility because of the place the facility is located. They also attend the alternative facility which is considered cheaper than the NHIS and easily accessible to them. The services provided by the service providers is considered poor. Bills are also charged at the government facility

5.4 Recommendations

Our findings have several important policy ramifications.

- Government should put up chips compounds in the other communities in the Pakro so that they will not travel a longer distance to access health care.
- Other charges charged by the government facility should be stopped so that the people will go to the alternative facilities.
- The services provided by the government facility should be improved so that the respondents can have confidence in them when they visit them they would be healed.

- The respondents in Pakro and its environs should be educated on the consequences associated with the taking of drugs without authorization.
- LEAP should also be extended to some of the people in Pakro so that they can easily renew their NHIS without any hustle.

REFERENCES

Abekah-Nkrumah, G., Dinklo, T. & Abor, J. (2009). Financing the Health Sector in Ghana: a review of the Budgetary Process, *European Journal of Economics, Finance and Administrative Sciences*, 17, 45-59.

Agyepong, I. A. & Adjei, S. (2008). Public social policy development and implementation: a case study of the Ghana National Health Insurance Scheme, Health Policy and Planning, 23, 150-160

Agyapong, I. A. (1999), "Reforming service Delivery at District Level: The perspective of a Ghanaian District Health officer" Health Policy and Planning 14(1):59-69

Akhtar R (2005). Health Care Patterns and Planning in Developing Countries, Greenwood Press

Allin, S. (2006). Equity in the use of health services in Canada and its provinces. LSE Health Working Paper Number 3.

Allin, S., Masseria, C., Thomson, S. & Mossialos, E. (2005). Health status and living conditions in an enlarged Europe: final report. London: LSE/European Observatory on the Social Situation.

Anderson, R. (2004). Delivering Quality and Access to Social Care and Health in an Enlarged Europe: what people in Europe think about service quality and access.

Dublin: European Foundation for the Improvement of Living and Working Conditions.

Asenso-Okyere, W. K., Osei-Akoto, I., Anum, A. & Appiah, E. N. (1997). Willingness to pay for health insurance in a developing economy. A pilot study of the informal sector of Ghana using contingent valuation. Health Policy 42: 223-237.

Asenso-Okyere, W. K., Osei-Akoto, I., Anum, A., & Adukonu, A. (1999). The Behaviour of Health Workers in an Era of Cost Sharing: A Study of Ghana's Cash and Carry System. Tropical Medicine and International Health 4(8).

Asher, J (2004). The Right to Health: A Resource Manual for NGO'S.

Atim, C. & Sock, M. (2000). An External Evaluation of the Nkoranza Community Financing Health Insurance Scheme, Ghana. Technical Report No. 50. Bethesda, MD. Partnership for Health Reform, Abt. Associates Inc.

Atim, C., Grey S., Apoya P. Anie, S. J. and Aikins, M. (2001). A Survey of Health Financing Schemesi in Ghana. Bethesda, MD: The Partners for Health Reformplus Project, Abt Associates Inc.

Bennett, S. (2004). The role of community-based health insurance within the health care financing system: a framework for analysis. Health Policy and Planning, 19, 147-158.

Bosomtwi Atwima Kwanwoma District Mutaula Health Insurance Scheme (2009) Annual Report.

Braveman P. (1998). Monitoring equity in health: a policy-oriented approach in low- and middle-income countries. Geneva: World Health Organisation (WHO/CHS/HSS/98.1, Equity Initiative Paper No.3), 1998:92.

Bryne (2004). Enabling Good Health for All A reflection process for a new EU Strategy)

Busse R, Wörz M, Foubister T, Mossialos E, Berman P. (2006). Mapping Health Services Access: National and Cross-Border Issues (HealthACCESS) Final Report. Berlin/Dublin: EHMA.

Carrin G, Mathauer I, Xu K, Evans B, (2008). Universal Coverage: tailoring its implementation: Bull World Health Organ.

CEU (2006The Council of the European Union. Health insurance: the trade-off between risk pooling and moral hazard Geneva Convention

Chaudhury, A. & Roy, K. (2008). Changes in out-of-pocket payments for healthcare in Vietnam and its impact on equity in payments, 1992–2002, Health Policy, 88, 38-48.

Claeson, M., Griffin, T., Johnston, M., Mclachlan, A., Soucat, A., Wagstaff,A. & Yazbeck, A. (2001). Health, nutrition and population in Bank, W. (Ed.) Poverty Reduction Strategy Papers Sourcebook. Washington, World Bank.

Currie, J. & Madrian, B. (2005). Health, Health Insurance and the Labour Market, Handbook of Labour Economics, Volume 3, Chapter 50.

Davidson R. Gwatkin, Abbas Bhuiya, Cesar G. Victoria, (2004. Making Health Care More Equitable.

Dixon, A., LeGrand, J., Henderson, J., Murray, R. & Poteliakhoff, E. (2003). Is the NHIS Equitable? A review of evidence. LSE Health and Social Care, Discussion Paper Number 11. London: LSE.

Doane, D., Ofreneo, R. & Srikajon, D. (2002). Social protection for informal workers in the garments industry: a case study of the garments industry in Thailand and Phillipines. Paper presented at Technical Consultative Workshop on Social Protection for Workers in the Informal Economy, ILO, WIEGO, World Bank, Chamonix, April.

Ekman, B. (2004) Community-based health insurance in low-income countries: A systematic review of the evidence. Health Policy and Planning, 19, 249-270.

Fink, A. (2003a). How to Ask Survey Questions (2nd Ed.). Thousand Oaks, CA: Sage. Ghana Ministry of Health, (2004a). Legislative Instrument on National Health Insurance, Accra: National Parliament of Ghana Press.

Ghana Ministry of Health. (2004b). Guideline for Designing and Implementing District wide MHOs in Ghana, Accra: Government of Ghana Publishing House.

Ghana Ministry of Health. (2008). Health Sector Programme of Work-2007, Independent Review, Accra: Ministry of Health.

Ghana Health Service (2006), 2005 Annual Report.

Ghana Statistical Service. (2004, 2005, and 2009), Population Data Analysis Report policy Implications of population Trend. Accra Guagliardo, M. F., (2004). Spatial accessibility of primary care: concepts, methods and challenges", *International Journal of Health Geographics* 2004, 3:3.

Griffin, C. (1992), Health Care in Asia: a Comparative Study of Cost and Financing. World Bank Regional and Sectoral Studies, Washington, D.C.

Hagrstand T. 1974. The Impact of Transport on Quality of Life. A Transport Seminar Paper, White Transport Studies Group, Polythecnic of Central London, London.

Hart J.T. (1971The inverse care law. Lancet. 1971 Feb 27; 1(7696):405-412.

H.Thomas Ballatine (1983) Securing Access to Healthcare. A Report on the Ethical implications of the Differences in the Availability of Health Services Volume one Report.

Ingram,D.R, 1971. The concept of accessibility: A search for an operational form. Regional Studies:101-107

Jutting J. (2005). Health Insurance for the Poor in Developing Countries. England: Ashgate publication.

Lasker J.N, 1981. Choosing Among Therapies illness Brhaviour in the Ivory Coast Soc. Sci. Med, 15: 157-168

Leon D. A. & Walt G., eds .(2001) Poverty, inequality and health: an international perspective. Oxford: Oxford University Press

Mensah J., Oppong J., Bobi-Barimah K., Frempong G. and Sabi W. (2010), An Evaluation of the Ghana National Health Insurance Scheme in the Context of the Health MDGs, Working Paper No.40, Global Development Network 19992009, Working Paper Series.

Ministry of Health (2004). National Health Insurance Policy Framework for Ghana. Revise Version.

Ministry of Health (2008). Ministry of Health Independent Review: Health Sector Programme of Work 2007. Accra: Government of Ghana.

Noor A.M (2004) Increasing Coverage and Decreasing Inequity in Insecticide Treated Bed net use Among Rural Kenyan children ages 20-27.Public Library of Science

O"Donnell, O., Van-Doorslaer E., Wagstaff, A. & Lindelow M. Analysing Health Equity using Household Survey Data. Washington DC: World Bank, 2007

OECD, (2003), "Poverty and Health" DAC Guidelines and References Document.

OforiBirikorang, A. (2009), "Promoting New Health Policy in Ghana media: News Paper .

Oliver, A. & Mossialos, E. (2004). Equity of access to health care: outlining the foundations for Action, *Journal of Epidemiol Community Health*, 58 pp655–658.

Olujimi Bayode J. L(Accessibility of Rural Dwellers to Health Care Facilities in Nigeria, The OWO Region Experience).

Penchansky, R, & Thomas, J. W. (1981). The Concept of Access, Med Care 1981, 19(2): pp127-140.

Pritchette D. (1996), Risk management and Insurance (8thed) West Publishing Co.USA. Raska, K (1966) Concepts of Health Behavior Research, Reg. Health Paper No.13, SEARO, New Delhi

Republic of Ghana: National Health Insurance Bill, 2003

Republic of Ghana: Ghana"s Poverty and Prosperity. An Analysis and Policy Statement of Government of Ghana, vol. 1.

Saltman, R. B., Busse, R. & Figueras, J. (2004). Social health insurance systems in western Europe, Berkshire/New York: Open University Press/McGraw-Hill.

Shengelia, B. Murray, C. J. L. & Adams, O. B., (2003). Beyond Access and Utilization: Defining and Measuring Health System Coverage In C.J.L. Murray & D.B.

Evans (eds) Health systems performance assessment: debates, methods and empiricism, World Health Organization, Geneva Switzerland.

Smedley B, Galloway –Gilliam L, Chaimane R, Garvin C.(2008). Creating More Equity in Health, A Comprehenesive Approach to Health Reform.

Tamsma, N. & Berman, P. C. (2004). The Role of the Health Care Sector in Tackling Poverty and Social Exclusion in Europe. Brussels: EHMA/EuroHealthNet..

Wachs, M &T.G Kumagi 1973, Physical Accessibility as a Social Indicator Socio Economic Planning Sci, 7: 437-456

Whitehead M.(1992). The concepts and principles of equity in health. International Journal on Health Services 1992; 22:429–445. (first published with the same title from: Copenhagen: World Health Organisation Regional Office for Europe

WHO (1946) Constitution of the World Health Organization as adopted by the International Health Conference, New York 19–22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization no 2).

WHO (2002) World Health Organization: Core Health Indicators: The latest data from multiple WHO sources. A glossary of technical terms on the economics and finance of health services; EUR/ICP/CARE0401/CN01. WHO Regional Office for Europe 1998, 1998b

World Health Organisation, (2005). World Health Report, 2005. Geneva, World Health Organisation.

WHO (2006) Constitution of the World Health Organization- Basic Documents, Forty fifth edition, Supplement, October 2006.

WHO (2008). World Health Report, 2008, Geneva, World Health Organisation Witter, S. &

Garshong, B. (2009). Something old or something new? Social health insurance in Ghana, BMC International Health and Human Rights, retrieved on December 10, 2010 from http://www.biomedcentral.com/1472-698X/9/20

Witter S. (2009) Pulling together, achieving more: independent health sector review

World Health Organisation (2000) The World Health Report 2000: Health systems: Improving performance, Geneva, World Health Organisation.

World Health Organisation, (2005). World Health Report, 2005. Geneva, World Health Organisation.

Xu K, Evans DB, Kawabata K, Zeramdini R, Klavus J, Murray CJL. Household catastrophic health expenditure: a multi-country analysis. The Lancet. 2003 ;362: 111-7.

APPENDIX

QUESTIONNAIRE

(TO THE NATIONAL HEALTH INSURANCE SCHEME SUBSCRIBERS/CLIENTS)

PREAMBLE

This questionnaire is designed to help carry out a project work on the topic 'EXAMINATION OF THE EFFECTIVENESS OF THE NHIS ON THE POOR- AKUAPEM SOUTH DISTRICT. THE PURPOSE OF THIS RESEARCH IS IN PARTIAL FULFILMENT OF THE AWARD OF A MASTER OF ART DEGREE IN INTERNATIONAL DEVELOPMENT STUDIES AT THE PRESBYTERIAN UNIVERSITY COLLEGE AKROPONG CAMPUS. The results of this questionnaire will only be used objectively by the Researcher for the purpose of the project. Subsequent usage may be made of the project's results and recommendations by the NHIS-Akuapem branch and any other third party if the need arises. All answers to this questionnaire shall be treated unanimously and objectively.

DEMOGRAPHIC DATA

1. Age
   a) Under 18 [ ]
   b) Between 19 – 69 [ ]
   c) Above 70 years [ ]

2. Sex
   a) Male [ ]
   b) Female [ ]

3. Marital Status
   a) Married [ ]
   b) Single [ ]
   c) Divorced [ ]

4. Occupation
   a) Trader [ ]
   b) Farmer [ ]
   c) Civil Servant [ ]
   d) Others (Specify) ……..

Objective One

To examine the objectives of the NHIS

5. Have you registered for the NHIS?
   a) Yes [ ]
   b) No [ ]

6. In which year did you enroll in the NHIS?

7. Do all members of your family belong to the NHIS?
   a) Yes [ ]
   b) No [ ]

If not all members belong to the NHIS, why have others not joined?

8. Do you have a valid NHIS card?
   a) Yes [ ]
   b) No [ ]

9. If YES, how long did it take you to obtain the card?
   a) One month [ ]
   b) Two months [ ]
   c) Three months [ ]
   d) Four months [ ]
   e) More than four months [ ]

10. Do you have access to a health delivery facility in this town/village?
    a) Yes [ ]
    b) No [ ]

Objective two

To examine the benefit criteria of the NHIS

11. What is your opinion about benefits you have derived from the national health insurance scheme?
    a) Excellent [ ]
    b) Good [ ]
    c) Satisfactory [ ]
    d) Fair [ ]

12. Are you satisfied with the services/benefits rendered by service providers?
    a) Yes [ ]
    b) No [ ]

12.1. If Yes, how?
    a) Good customer care [ ]
    b) Get needed drugs and services [ ]

12.2.If No, why?
    a) Poor customer care [ ]
    b) Don't get needed services and drugs [ ]

13. Do you get the attention/treatment you expect anytime you visit a service provider?
    a) Yes [ ]
    b) No [ ]

Objective Three

To explore the accessibility of the scheme to the poor

14. What types of facilities are available to you? (tick all boxes that apply, multiple response)
    a) Private clinic [ ]
    b) Chemist/Pharmacy [ ]
    c) Government clinic [ ]
    d) Government Hospital [ ]
    e) Mission Hospital [ ]
    f) Herbalist [ ]
    g) Others (give details)……

15. How far is the nearest health facility from your home?
    a) Less than 1km [ ]
    b) 2-3km [ ]
    c) 4-5km [ ]
    d) 6-10km [ ]
    e) Over 10km [ ]

16. During the past twelve months did you or any member of your family fall ill?
    a) Yes [ ]
    b) No [ ]

17. How long did it last?
    a) Less than 3 days [ ]
    b) Up to 7 days [ ]

c) More than 7 days [ ]
d) Two weeks and more [ ]

18. How much was your bill?
a) Nothing [ ]
b) GH₵5 - GH₵15 [ ]
c) GH₵16 - GH₵30 [ ]
d) GH₵31 - GH₵50 [ ]
e) GH₵51 - GH₵75 [ ]
f) GH₵76 - GH₵100 [ ]
g) GH₵101 - GH₵200 [ ]
h) GH₵201- GH₵500 [ ]
i) More than GH₵500 [ ]
j) Don't know [ ]

19. Were you able to settle the entire bill with the NHIS card?
a) YES [ ]
b) NO [ ]

20. If not the entire bill, how much did you have to pay?
a) Less than GH₵5 [ ]
b) GH₵5 - GH₵15 [ ]
c) GH₵16 - GH₵30 [ ]
d) GH₵31 - GH₵50 [ ]
e) GH₵51 - GH₵75 [ ]
f) GH₵76 - GH₵100 [ ]
g) GH₵101 - GH₵200 [ ]
h) GH₵201- GH₵500 [ ]
i) More than GH₵500 [ ]
j) Don't know [ ]

Objective Four

To explore the alternative of accessing health services by the poor

21. Do you access an alternative health facility because you could not pay hospital bill charge by the hospital?
    a) Yes [ ]
    b) No [ ]

22. Is the hospital accessible to the people of the locality?
    a) Yes [ ]
    b) No [ ]

23. If 'No' do you visit any other facility because the hospital is not accessible to you?
    a) Yes [ ]
    b) No [ ]

24. What alternative facility do you visit in your locality?
    a) Herbalist [ ]
    b) Traditionalist [ ]
    c) Self-Medication [ ]
    d) Drug Store [ ]

Objective Five

To explore the impact of the assessment of the alternative to the livelihood of the poor

25. Have you or any member of your household been on hospital admission during the past two years?
    a) Yes [ ]
    b) No [ ]

26. If yes, for how long was the admission period?
    a) Less than 1 week [ ]
    b) Between 1 & 2 weeks [ ]
    c) More than 2 weeks [ ]

27. How much was your bill (estimate)?
    a) Nothing [ ]
    b) GH₵5 - GH₵15 [ ]
    c) GH₵16 - GH₵30 [ ]
    d) GH₵31- GH₵50 [ ]
    e) GH₵51- GH₵75 [ ]
    f) GH₵76 - GH₵100 [ ]

g) GH₵101 - GH₵200 [ ]
h) GH₵201- GH₵500 [ ]
i) More than GH₵501 [ ]
j) Don't know [ ]

28. Were you able to settle the entire bill with the NHIS card?
    a) Yes [ ]
    b) No [ ]

29. If 'No' do you access any other alternative health facility in your locality?
    a) Yes [ ]
    b) No [ ]

30. Is the alternative facility visited cheaper than the hospital?
    a) Yes [ ]
    b) No [ ]

31. If not the entire bill, how much did you have to pay?
    a) Less than GH₵5 [ ]
    b) GH₵6 - GH₵15 [ ]
    c) GH₵16 - GH₵30 [ ]
    d) GH₵31- GH₵50 [ ]
    e) GH₵51 - GH₵75 [ ]
    f) GH₵76 - GH₵100 [ ]
    g) GH₵101- GH₵200 [ ]
    h) GH₵201- GH₵500 [ ]
    i) More than GH₵500 [ ]

32. Are you happy with the services / activities rendered by the alternative Health facility in terms of the following?
    32.1.Information dissemination
        a) Yes [ ]
        b) No [ ]
    32.2.Customer Care
        a) Yes [ ]
        b) No [ ]
    32.3.Complaints handling
        1) Yes [ ]
        2) No [ ]
    32.4. Services rendered
        a) Yes [ ]
        b) No [ ]