UNIVERSITY OF CAPE COAST

SUSTAINABILITY OF THE NATIONAL HEALTH INSURANCE SCHEME: VIEWS OF HEALTH CARE PROVIDERS IN THE CAPE COAST METROPOLIS, GHANA

BY

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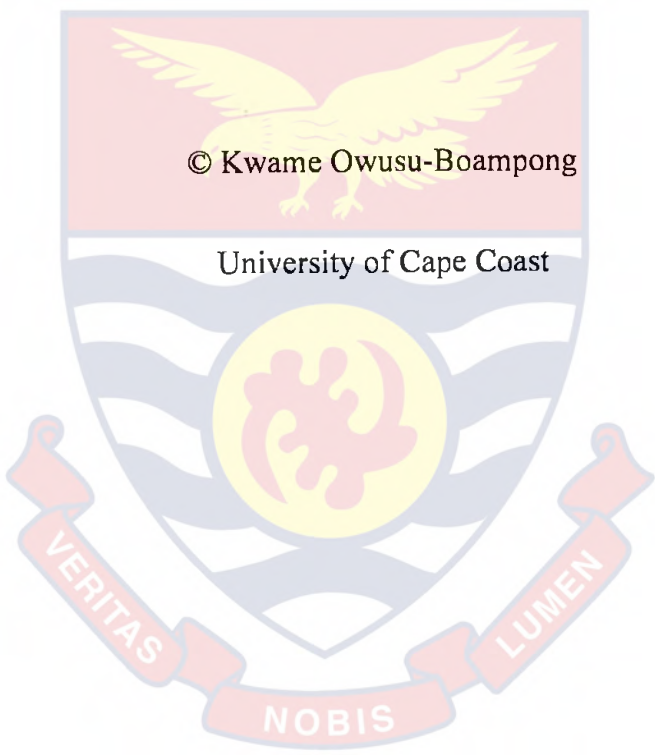

DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original work and that no part of it has been presented for another degree in this University or elsewhere.

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Supervisors' Declaration

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

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ABSTRACT

A National Health Insurance Scheme was introduced in Ghana in 2005 as part of strategies to ensure a sustainable health financing and improve access to services. After almost ten years of implementation, little is known about the views of health care providers as a major stakeholder on the critical issue of sustainability of the scheme. This study explored the views and experiences of health care providers on the implementation and sustainability of the National Health Insurance Scheme. It adopted in-depth interviews, observations and documentary review as methods of data collection. Forty health care providers working in 19 governments, private, quasi-government and mission health facilities in the Cape Coast metropolis were interviewed. Data from the interviews were analyzed using the Nvivo 7 software and by content analysis. There is a broad acknowledgement of the scheme as a pro-poor policy which has made a positive impact on access to health care. The involvement of front line health care providers in the policy formulation and processes was however, minimal. The sustainability of the scheme is largely threatened by the delayed and erratic reimbursement of claims and the unprofessional behaviour of providers and scheme managers. The proposed one-time premium payment policy can negatively affect the scheme. To ensure sustainability, bottlenecks in the release of funds should be streamlined for prompt reimbursement of claims, regular dialogue among stakeholders, explore additional funding sources and promote greater efficiency in the management of the scheme.

KEY WORDS

Health insurance

Policy Processes

In-depth interviews

Health care provider

Sustainability

Ghana

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DEDICATION

To the late Kwasi Owusu-Akyempim, the late Moses Kwame Boakye, Paulina Grace Amponsah, my mother and my wife Joyce Naana Owusu- Boampong.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF PLATES

LIST OF ACRONYMS

AHSAG	Association of Health Services Administrators (Ghana)
AIDS	Acquired Immune Deficiency Syndrome
ARIs	Acute Respiratory Infections
CEO	Chief Executive Officer
CHAG	Christian Health Association of Ghana
CHI	Community Health Insurance (Scheme)
CHN	Community Health Nurse
CHO	Community Health Officer
CHPS	Community-Based Health Planning and Services
CIPol	Co-Intelligence Institute
CMI	Commission on Macroeconomics Initiative
CSA	Civil Servants Association
CSOs	Civil Society Organizations
CVA	Cardio Vascular Accidents
DANIDA	Danish Development Agency
DFID	Department for International Development
DRGs	Diagnostic Related Groups
DWMHI	District Wide Mutual Health Insurance
EC	European Commission
FDA	Food and Drugs Authority
FFS	Fee for Service
GHS	Ghana Health Service
GMA	Ghana Medical Association
GMDC	Ghana Medical and Dental Council

GNAT	Ghana National Association of Teachers
GOG	Government of Ghana
GPRS	Ghana Poverty Reduction Strategy
GRNA	Ghana Registered Nurses Association
GSGDA	Ghana Shared Growth and Development Agenda
GSS	Ghana Statistical Service
HIPC	Highly Indebted Poor Country
HIV	Human Immunodeficiency Virus
IAPP	International Association of Public Participation
ICT	Information and Communication Technology
ILO	International Labour Organization
IMR	Infant Mortality Rate
LEAP	Livelihood Empowerment Against Poverty
LI	Legislative Instrument
MDGs	Millennium Development Goals
MHIOs	Mutual Health Insurance Organizations
MOF	Ministry of Finance
MOH	Ministry of Health
MTHS	Medium Term Health Strategy
NDC	National Democratic Congress
NDPC	National Development Planning Commission
NGOs	Non-Government Organizations
NHIA	National Health Insurance Authority
NHIC	National Health Insurance Council
NHIF	National Health Insurance Fund

NHIL	National Health Insurance Levy
NHIS	National Health Insurance Scheme
NMC	Nurses and Midwives Council
NPP	New Patriotic Party
NRCD	National Redemption Council Decree
OECD	Organization for Economic Cooperation and Development
OPD	Out-Patient Department
OTPPP	One -Time Premium Payment Policy
PHIR-plus	Partners for Health Reform-plus
PHMHB	Private Hospitals and Maternity Homes Board
PNDC	Provisional National Defence Council
POW	Programme of Work
PPAG	Planned Parenthood Association of Ghana
PPP	Preferred Primary Provider
PSG	Pharmaceutical Society of Ghana
RE-AIM	Reach Effectiveness Adoption Implementation Maintenance
SEWA	Self Employed Women Association
SHI	Social Health Insurance
SSNIT	Social Security and National Insurance Trust
TB	Tuberculosis
TBA	Traditional Birth Assistant
TUC	Trades Union Congress
U- 5 MR	Under-5 Mortality Rate
UK	United Kingdom
UN	United Nations

UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USA	United States of America
USAID	United States Agency for International Development
VAT	Value Added Tax
W H O	World Health Organization
WB	World Bank
WECD	World Economic Commission on Development

CHAPTER ONE

INTRODUCTION

Health care systems cannot be sustained without addressing the trade-off between restricted financial resources and reaching overall health policy goals. It seems to be crucial to generate new strategies controlling the complex mechanisms that affect expenditure and performance of health care schemes and striving for the achievement of core objectives of health care policies, such as universal access, high quality standards, efficiency and effectiveness of schemes, adequate funding and satisfaction of patients (International Social Security Association Initiative, 2003 p33)

Background to the Study

The pursuit of sustainable development and the attainment of the Millennium Development Goals (MDGs) continue to engage the attention of many governments as they attempt to address issues of human development (UNDP, 2007). As Dussault, Dubois and Ardy (2003) noted, concerns with growing inequalities in health status, problems of access and falling returns for investments in health care and the difficulty of controlling the increasing health cost have prompted most countries to engage in reforms of the health sector. Since independence, Ghana has undertaken key reforms in sectors such as education, the economy, health, energy, agriculture, housing and industry. Among them are cost recovery in health care, duration and cost sharing in education and provision of subsidies in the agriculture and energy sectors (Killick, 2009; Sowa, 2003). Others are the Livelihood Empowerment Against Poverty (LEAP), School Capitation Grant Policy, the Ghana School Feeding Programme and the Ghana Poverty Reduction Strategy (GPRS 1 &

11) and the Ghana Shared Growth and Development Agenda (GSGDA), (NDPC, 2010)

These strategies are geared towards the development of human capital to ensure healthy workforce, increased productivity and capacity to create wealth (United Nations Development Programme, (UNDP, 2007; National Development Planning Commission (NDPC, 2006, 2005). The idea behind the strategy is that health is a productive good that produces high economic returns. Ill-health and disease are barriers to economic growth (Commission on Health, 2001) while good health boosts labour productivity, income and contribute to overall development. Frenk, Knaul, Gonzalez-Pier and Barraza-Llorens (2005) maintain that a country's economic development is closely related with the health status of its population and efficient and equitable healthcare system. Health is therefore, an important instrument in breaking the vicious cycle of poverty and under- development.

Improving access to health services also implies that the services should be adequately funded. According to Wieczorek-Zeul (2005) over 1.3 billion people have no access to adequate or affordable health care. Ten million infants die every year of preventable diseases while 500,000 women die during pregnancy and childbirth because of adequate medical care is unavailable or they are unable to pay for it (Wieczorek-Zeul, 2005).

The United Nations Universal Declaration of Human Rights (UN, 1948) stated that medical care is a right of all people. As Helming (2005) also observed, health is an inalienable human right. Kasule (2012) argued that health insurance is a component of social security and social justice. According to Kasule, healthcare can be both a right and a privilege and that it is a natural

right of every human being but we may not reach consensus on the difference between services that are a right and those that are a privilege. It may also be debated as to who pays for the citizen's right to health care. There is, thus, a continuing debate about individual rights and government's ability to maximize the quality of health care and minimize cost. A classic example is the debate over the Health Reform Policy in the United States of America introduced by President Obama (Suderman, 2012; Obama, 2009). The flagship policy was aimed at reforming the American health care system but is reported to have run into implementation challenges leaving some Americans frustrated and unable to sign up due to high taxes. The Affordable Care Act is a reform law that seeks to expand and improve access to care and curbs spending through regulations and taxes.

Equity in health care policy continues to be a matter of debate. Kasule (2012) observed that equity is the central ethical issue in health insurance and considerations related to the purpose of protecting health care include access and equitable coverage. Other equity considerations related to the purpose of resources are essentially assurance that patients of various socio- demographic profiles are treated equitably in the allocation of type of health care resources by type of services, utilization and financial burden. The nature of access to health care and utilization of health services and their role in shaping health policy has been extensively explored by Blanchet, Fink and Osei-Akoto, (2012); Buor, (2000); Anderson, (1995); Aday and Anderson (1974); Anderson and Newman (1973). Buor (2008), for instance argues that inequities in health care are demonstrated by factors such as financial inaccessibility, unfair distribution of health facilities and gender disparity.

Achieving universal coverage is consistent with World Health Organization's concept of health for all and primary health care (WHO, 1978). Several policies have been introduced to achieve equity in access. These include health insurance schemes and the realization of universal health care coverage. Their implementation depends on organizational mechanisms that make it possible to collect financial contributions for the health system efficiently and equitably from different sources, to pool these contributions so that the risk of having to pay for health services is shared by all (Evans,2005). Strategies to generate sufficient funds for health, improving efficiency or reducing costs, reducing the financial risks involved in obtaining care and ensuring that the cost of care does not prevent people from receiving needed services are being adopted in many countries.

Sustainable health financing is generally acknowledged to be a major factor affecting the quality of health delivery. Secondly, equitable health financing can create incentives for both the provider and the consumer. Changes in the way health care is financed can have far reaching consequences as it alters the structure of incentives, changes the method of financing care and paying of care providers, as well as the relationship between providers and consumers (WHO, 1993).

Studies by Sakyi (2008); Bierschenk, Thioleron, Bako and Afrifari, (2003); Dante, Gautier, Marouni and Raffinot (2003); Evans and Ngalewa (2003), Falck, Lanfald and Rebelo (2003); Hammer, Ikiara, Eberlei and Bang (2003); Jenkins and Tsoka, (2003); Mutebi, Stone and Thin, (2003), Nyonator, Diamenu and Eleeza (2002), have reported that implementation of health policy reform programmes in developing countries have been met

with challenges making the attainment and sustainability of the goals of the policies an arduous task.

Statement of the Problem

The aim of the Ghana Health Insurance Scheme was to enable the government achieve its set goal within the context of the 1994 Population Policy, Ghana Poverty Reduction Strategy (2003-2005),the Growth and Poverty Reduction Strategy (2006-2009); Ghana Shared Growth Development Strategy (2010-13) and the Ministry of Health Five–Year Programmes of Work (1997-2001; 2002-2006). The Population Policy advocated for mechanisms and strategies including the pilot of a health insurance scheme to improve the health of the population and reduce poverty. The Poverty Reduction Strategies recognized the importance of human development in national development. They envisaged the transformation of the economy through human resource development, productivity and employment. The two programmes of work sought to improve both financial and geographical access to health care, quality and efficiency in service delivery and promote sustainable financing mechanisms. They provided the implementation framework for the attainment of strategic health sector objectives.

Specifically the NHIS is meant to provide a more humane and a sustainable health financing mechanism that focuses on the poor. The scheme was, thus, fashioned to provide accessible, affordable and quality health care services to all people living in Ghana especially the poor and the most vulnerable in society. Various studies by Witter, Garshong, Riddle (2013); Akazili, Garshong, Aikins, Gyapong and Macintyre (2012); Witter (2011);

Agyepong and Adjei (2008); have been conducted on health insurance both in and outside the country. Studies on health insurance in Ghana and elsewhere have focused on "evolution of insurance" (Arhinful, 2003); "feasibility of rural health insurance schemes", "financial access to health care", "ability to pay" (Asenso-Okyere, Osei-Akoto, Anum and Appiah (1997), "equity dimensions of premium payment" (Amporfu, 2013); "incidence of premium payment "and "management of the schemes" (Kamuzora and Gilson , 2007). Other studies focused on willingness and ability of patients to pay for health insurance and participation of health workers in the design and formulation of the national health insurance scheme (Seddoh and Akor, 2012).

A few had examined the sustainability of the health insurance scheme as a policy (Odame, Akweongo, Yankah, Asenso-Boadi and Agyepong, 2013; Yevutsey and Aikins, 2010; Yankah, 2009; Bruce, Narh-Bana and Agyepong, 2008). Studies focusing on the views and opinions of frontline health workers are also minimal. Insights into sustainability from the perspective of providers are thus lacking (Dalinjong and Laar, 2012). Little work has been done on the issue on the sustainability of the insurance schemes that relate to the views of health care providers alone and a few studies have been conducted by health care providers by investigating the views of their peers on the National Health Insurance Scheme (NHIS).

There is a continuing debate as to whether the scheme can be sustained especially with the change in the government of the New Patriotic Party (NPP) that initiated the process. The divergent views on sustainability of the policy have been expressed in various ways. One group is of the view that the scheme is not sustainable and this has found expression in statements such as

'the NHIS is dying', 'Let's sustain the scheme', 'the NHIS is collapsing', "NHIS is dead"; NHIS to collapse and "NHIS risks total collapse" (Nana Akuffo Addo, 2012; Martey, 2012; Anane, 2011; Ibrahim, 2010; Atuguba, 2009). The other group made up of mainly sympathizers and the members of the ruling party, National Democratic Party (NDC), officials of the National Health Insurance Authority (NHIA) and insurance scheme managers maintain that the scheme is vibrant. According to them the NHIS is not dying, arguing that enrolment and utilization have increased, adding that there have been reforms and improvements (NHIA, 2012; NHIA, 2010; Idrissu, 2009).

Globally, health insurance scheme are associated with problems of increasing costs, organizational and management, weak political economies especially in developing countries and asymmetry of information which affect their sustainability (WHO, 2005). Experience with insurance policies in both developed and developing countries indicates challenges with coverage, access and quality of services provided e.g. Thailand, United States of America and Germany (International Labour Organization (ILO), 2006).

Available evidence also indicates that the implementation of the health insurance scheme is characterized by challenges including delays in reimbursements to providers leading to outstanding debts, threats to suspend services to clients by some provider institutions, inadequate skills in processing/ delays in submission of claims by providers (Dalinjong and Laar, 2012; MOH, 2010; MOH, 2009). Several District Health Mutual Insurance Organizations DHMIOs) owe providers (Markinen, Sealy, Bitran Adjei & Munoz, 2011). As observed by Markinen, Sealy, Bitran, Adjei and Murioz, (2011). NHIA reimbursement is not sufficient to cover the exempt population

but the NHIA counters that the deficits are a matter of poor financial forecasting.

Despite the assurances from some quarters about the sustainability of the scheme, others have expressed concerns about its survival. Sustaining the scheme has become an important issue with regard to the proposal to introduce a one-time premium payment policy by the present government. Given the position of the current National Democratic Congress (NDC) government which was in opposition at the onset of the introduction of the scheme in the country there are some concerns as to its commitment and ability to manage the scheme efficiently (NPP/USA Branch, 2012; Zoure 2009).

Moreover, there are instances of policies being abandoned with changes in government for reasons including lack of resources and political commitment (Ohemeng, 2012; Ohemeng, Caroll and Aryee, 2012; Kpessa, 2011; Mornah, 2006; Abbey, 2003).

There are concerns with the quality of services at the health facilities. Poor quality of services defined to include negative health staff attitudes, non-availability of essential medical supplies continue to militate against the smooth delivery of health services. The increased workload due to increased utilization at the health facilities coupled with the inadequate health professionals such as doctors, nurses, pharmacists, midwives pose problems in the efficient implementation of the scheme.

Cases of fraudulent practices including overbilling in the Cape Coast Metropolis, Ketu District in the Volta Region and in the Asokwa sub-metropolis in the Ashanti Region (NHIA, 2010) have been reported across the

country. Malpractices and corrupt practices have been widely cited in the media (Mills, 2011, Ghana News Agency, 2010).

There are complaints of frivolous use of services by some clients and induced demand for health services. There have been consistent and increasing expenditure on subsidies, payments in respect of claims to providers and also Members of Parliament may have implications for sustainability of the Scheme.

Experience with insurance policies in Thailand, Germany and the United States of America indicate problems with sustainability, reach, inequity and inefficiency (Somekotra and Lagrada, 2009; Flores, 2008). According to Bennett, Creese and Monasch (1998), of the life span of 37 community health schemes in developing countries, six of them had been terminated.

Health care providers operate under severe working conditions, low staff morale, shortages of essential supplies, inadequate and obsolete medical equipment, increased workload, poor environmental conditions as well as weak and slow administrative management. The experiences of schemes elsewhere have some relevance and lessons for the health insurance scheme in Ghana.

According to Markinen, et al. (2011) concerns have been expressed that the NHIS may not be financially sustainable due to widespread corruption, deficits and the potential increases in membership in the face decline in funding.

Another frequently raised coverage issue is whether the NHIS is reaching the poor. Although the indigent are technically exempted from paying premiums, many of the district schemes find the process of verifying a

person as indigent to be cumbersome and in some cases, the process is ignored (Asante and Aikins, 2008). This has led to calls for the scheme to be scrapped or reformed (Apoya and Marriot, 2011).

The health sector is characterized by a high degree of asymmetry of information (information is not shared equally among health sector actors) leading to significant inefficiency and vulnerabilities to corruption (Department for International Development, 2010). These asymmetries of information and power work in favour of health care providers. The discretion given to providers puts patients in a vulnerable position if providers choose to abuse their position. Asymmetry of information also affects prescribing decisions. It is important to understand how this can affect the sustainability of the scheme.

Walt & Gilson (1994) proposed a *policy triangle* to help think more systematically about the multitude of factors (content, process, context and actors) affecting policy and the interrelations among these factors. At the heart of the framework is actors and this underlines the important role of health care providers in the implementation and influencing the sustainability of the scheme. Similarly, Hogwood and Gunn (1995) model on prefect implementation provides a framework for assessing factors which affect implementation of policies. One of the arguments in the study is that sustainability of the scheme is closely related to how it is successfully implemented. Using the policy making approach, the study attempted to explore the extent to which it can explain or influence the sustainability of the scheme and examine the role of health care providers in the design , formulation, implementation and sustainability of the scheme.

Despite the fact that there are several studies on the Ghana Health Insurance Scheme there appear to be little information concerning the views of health care providers on the sustainability of the scheme. Though several studies on health insurance have been conducted in Ghana (Bauchani and Tenkorang, 2014; Nguyen, Rajkotia ,and Wang. 2011; Witter and Garshong, 2009) only a few involved health professionals as a group of people who provide the services to keep the health system running which is essential to the sustainability of the scheme. It is not clear whether or not health care providers agree on the main factors affecting the sustainability of the scheme.

A combination of both qualitative and quantitative methods had been used to examine the influences on schemes at the community and national levels. The study explored the extent to which policy making approach can explain or influence the sustainability of the scheme using the interpretative paradigm.

Study Objectives

The main objective of the study is to explore the sustainability of the National Health Insurance Scheme from the perspective of health care providers. Specifically the study sought to:

1. Examine the opinions of health care providers on the design and formulation processes of the scheme;
2. Assess the views and experiences of health care providers on the implementation of the scheme;

3. Explore factors influencing the sustainability of the Ghana National Health Insurance Scheme, including the one-time premium payment policy.

Justification of the Study

Health insurance is known to improve access to health care. The National Health Insurance Scheme is critical in ensuring equity to health care in the country. The insurance scheme represents substantial investment in terms of human resources, equipment and infrastructure. Sustaining the scheme is therefore appropriate.

The study is justified by the fact that several well intentioned policies and programmes formulated since independence could not be endured and be continued due to circumstances, people, situations and problems encountered during the formulation and implementation stages. They were changed, discontinued or simply discarded for a number of reasons. Examining the issues in implementation and sustainability of the scheme can help address these problems.

The study will inform the current debate on the sustainability and review of the scheme. By documenting the lessons learnt on the design, implementation and sustainability, the study can guide the implementation of both existing and future pro- poor policies interventions in the country and elsewhere.

The focus of the study is health care providers. The study argues that the long term sustainability of the scheme will largely be influenced by the role of health care providers which is broadly defined to include their

behaviour, motivation, performance and attitudes towards their work and the scheme. As Appiah-Denkyira and Preker (2005) noted, provider behaviour has always been a challenge to all health insurance schemes. One of the growing complaints from public health care providers is work overload with its attendant implications for poor staff attitudes, stress, motivation and quality health care.

They provide the services which in turn affect cost and payment; the quality of health services, - the efficacy, efficiency, accessibility and viability depend partly on the performance of those who deliver them. Dussault, Dubois and Ardy (2003), asserted that the growth and development of any organization depend on the availability of appropriate work force, its competence and level of efficiency in performance.

Health care providers interact and relate with those who manage the scheme (scheme managers) and with the ultimate users- patients almost on a daily basis. Health care providers are required, under the policy, to prepare and submit claims to the scheme management for reimbursement of services provided under the scheme. Their views are, therefore, crucial for the implementation and sustainability of the scheme.

Health care providers have been known to be strong advocates for health financing reforms the country (Sodzi-Tetteh, 2007). In Ghana, health care providers and hospital managers had had to deal with increasing number of patients absconding from hospitals without paying for their hospital bills (Association of Health Services Administrators-Ghana, 1998), while other patients were detained for longer periods in the hospitals after discharge on account of their inability to settle their bills. Associations of health

professionals such as the Ghana Medical Association, the Ghana Registered Nurses Association (GRNA) and the Association of Health Services Administrators (Ghana) (AHSAG) had, in communiqués issued at their past annual general meeting/conferences in 1998 at Koforidua and Takoradi in 2010 supported the introduction of health insurance as a measure to provide a sustainable form of financing health services in the country. This is presumably on account of the challenges and shortfalls in health care delivery. Seeking their views on the sustainability of the scheme after its introduction is therefore justified.

Health care providers form a critical part of the actors in the implementation of any health insurance policy. As Lipsky (2010) asserted, 'street level bureaucrats' have a role to play in implementing or sustaining any policy. The study by Lipsky of 'street-level bureaucracy' provided a perceptive analysis of front line practice in public organizations that has continuing relevance to recent literature, which has debated whether discretion continues to operate in social work or whether it has been curtailed. As actors they have insights on account of their knowledge and power which enables them to act autonomously and mould outcomes (Evans and Harris, 2004; Hudson and Howe, 2004; Long, 1992). Health care professionals fall into this category of actors as they exert considerable influence on how health policies are put into practice.

Coker, Atum and McKee (2004) have argued that health care providers are powerful stakeholders in the health reform process. Health care providers have a high degree of professional autonomy and this could be a realistic catalyst for the sustainability of the Scheme. By their training and experience,

health care workers can provide expert opinion on the implementation and sustainability of the scheme.

Furthermore, mechanisms for optimizing the understanding and commitment of health care providers to the scheme can provide further insights in to the sustainability of the scheme. The scheme has been in operation for about ten years now and there is the need to understand the behaviour and motivation of health care providers within the context of the sustainability of the scheme. Though sustainability is gaining attention in project and programme implementation, it is argued that sustainability of policies and programmes has not been given much attention in the policy making processes (Dye, Mertens and Hirnschall, 2013; Leach-Kemon, Chou, Schneider (2012).

Access to available quality health services remains a challenge in Ghana (Buor, 2008). Policies such as the NHIS aimed at improving access to health services offer promise to the improvement in the health of the population. It has been demonstrated in several studies that health insurance enrolment have contributed to protection of life by increased overall access to health care (Pagan, Puig and Soldo, 2007; Devadasan, Criel, Van Damme, Manoharan, Sarman and Stuyft, 2010; Kempe, Beaty, Crane, Stokstad, Barrow, Belman and Steiner, 2005).

Organization of the Thesis

The thesis is structured into eight chapters. Chapter one provides the background and motivation to the study, the statement of the problem, objectives of the study and the rationale of the study. Chapter two examined

the related literature on concepts, theories and empirical evidence on health policy analysis, sustainability, health financing, health insurance, accreditation, regulation and the one- time premium payment policy.

Chapter three provides the context to the study; an overview of health services policy, historical context of health financing and the development and implementation of the National Health Insurance Scheme. Chapter Four outlines the methods of data collection and analysis and justifies the choice of the study design. It examines the study area, the study population, the sample, sampling procedure, sources of data, data collection instruments, the fieldwork and data analysis, ethical procedures and credibility of the study.

In Chapter Five, the views of health care providers on the processes and involvement in the design and formulation of the scheme are discussed. Chapter Six examines the findings in respect of the views respondents on the implementation of the scheme. Chapter Seven discusses the main issue of sustainability including factors affecting the sustainability of the scheme and the one-time premium payment. Chapter Eight provides the summary, conclusions, recommendations, policy implications, limitations of the study and areas for further research.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

A good theory is especially important for the further refinement of evidence-based policy research. It will identify processes, issues, events and actors that have facilitated or compromised the effectiveness of policy (Brewer & de Leon, 1983).

Introduction

The purpose of the study was to explore the experiences and views of health providers in the Cape Coast metropolis on the implementation and sustainability of the National Health Insurance Scheme. To achieve the objective, the literature review employed the thematic approach which sought to discuss issues that relate to implementation and sustainability of the scheme.

The review explored theories and studies on the policy making process, health financing, health insurance, sustainability, accreditation and regulation and the one- time premium policy. A number of policy frameworks, models and theoretical concepts, empirical evidence and the principal -agent theory as they relate to health settings were reviewed in this chapter.

Sources of literature included policy journal articles, conference papers, books on policy, newspaper and media articles, official policy documents and reports, Acts of Parliament, parliamentary proceedings and papers, websites and online materials, previous projects, dissertations and theses, key dictionaries, encyclopedia and indexes.

The study adopts a policy analysis approach drawing on concepts from a number of models such as the Walt and Gilson policy triangle, Kingdom's convergence of three 'streams' Hogwood and Gunn perfect implementation model and agency theory.

Overview of Public Policy

According to Dye (2001), a policy is "whatever governments choose to do or not do". He argued that failure to decide or act on a particular issue also constitutes policy. Anderson (2006) also defined public policy as the broad framework of ideas and values within which decisions are taken or an action is pursued by government in relation to some issue or problem. It is defined as " a broad guide present and future decisions, selected in light of given conditions from a number of attenuating, the actual decisions or sofa of decisions designed to carry out the chosen course of actions; a projected programme consisting of designed objectives (goals) and the means of achieving them" (Daneke and Steiss, 1978).

Venus (2011) defined public policies as an attempt by government to address a public issue. 'The government whether it is a city, state or federal, develops public policy in terms of laws, regulations, decisions and actions (Venus, 2011). Dror (1989), defined public policy as a very complex and dynamic process whose various components make different contributions to it. A policy decides the major guidelines for actions directed at the future mainly by government organizations. These guidelines on policies formally aim at achieving what is in the public interest by the best possible means.

The definition by Dror (1989) identifies that apart from public policy being a tool used by government to solve the problems and meet the needs of its population; it is a process which brings together different parts within the whole system. Laswell (1977) suggested that decision making is involved in the determination of "who gets what" and "who does not get what".

Some policy analysts describe politics related to public policy in terms of power, elitism and pluralism. In politics it has been described in terms of institutions, actors and pressure groups that shape public policy. Still others describe it in terms of demands, issues, process and policy (Stewart, 1998).

The policy process defines how the multitudes of demands are translated into the output that meets these demands (Stewart, 1998). In this sense, the policy process articulates the approaches, systems and mechanisms that delimit how the demands expressed in the form of needs and aspirations of citizens would be satisfied through public or private interventions. The policy process is thus not an action limited to the public sector only but to organizations and institutions not under the purview of the government.

In this study, policy making is defined to include the implementation of decisions by government departments, as the basis for delivering services or other outputs to citizens to bring about desired outcomes. These include, for example, goals to bring about better education for children, to improve industrial competitiveness, or to protect the population from disease.

Policies are often implemented through agencies or other organizations such as non-departmental public bodies and local authorities (for example the provision of social housing) or through partnership arrangements with other

departments (for example addressing educational, health and environmental factors or to reduce crime) or with private sector organizations.

Policy making process can therefore be seen broadly as all the mechanisms and means by which governments take to determine policies to satisfy and sustain the hopes and concerns of the people through state and private institutions.

Steps in Policy Design

Policy-making has a number of key steps (United Kingdom (UK) Cabinet Office 1999). The first step is an understanding of the problem which involves defining outcomes, resolving tensions, identifying stakeholders and deciding their role. Second is a review of information and evidence about the problem to assess the historical context and generate and assess policy options and examine how options will play out in the real world. Implicit in this is setting an objective or objectives for the policy developing solutions – collecting evidence, appraising options, consultation, and working with others and managing risks (UK Cabinet Office, 1999).

Third is the identification and assessment of the risks to implementation and delivery. This may include time, skills, financial and other resources needed, training of staff to acquire the right skills to implement the policy. It also entails monitoring staff effort, time and resources, keeping it on course and engaging partners and stakeholders.

The final step consists of monitoring, measuring and evaluation of performance against objectives, review of the resources allocated and skills to

maintain effective delivery and the identification and dissemination of good practices where possible.

Features of Policy Making

A policy-making process should define out comes; have a long term and holistic view capable of facilitating change, innovation and efficiency. According to Smith (2003), policy issues can be divided into two categories: those already on the public policy agenda and those that are not. If an issue is already on the public policy agenda it has a sufficiently high profile and informal process is to be in place. If an issue is not on the public policy agenda, the job of the stakeholders/community is to provide information and education and to take other steps to raise awareness and get it on to the agenda.

Gerston (1997) suggests than an issue will appear and remain on the public agenda when it meets one or more of three criteria. It must have sufficient scope (a significant number of people or countries are affected), intensity (the magnitude of the impact is high) and/or time (it has been an issue over a long time). The Ghana Health Insurance scheme provides a typical example.

Policy development can be reactive or proactive. Policy development is reactive when it responds to issues and factors that emergency, sometimes with little warning, from the internal and external environment by resolving problems and issues meeting stakeholders/public concerns, reacting to decisions by governments, other levels of government and allocating fiscal

resources, natural resources, reacting to media attention (generally adverse) and reacting to crisis or emergencies.

Policy development is proactive when it responds to triggers that are recognized through the scanning of the operating environment, identifying potential issues and factors that could affect the organization and predicting and preparing for mitigation and/or contingency through planning, strategic choice, risk management, criteria determination, priority establishing and getting issues resolved (Brownson, Chirqui and Stamatakis, 2009). Generally, it can be said that policy development is reactive as they tend to address prevailing issues of concern or affect the living conditions of the people.

Smith (2003) provides a number of key factors which should be considered in public policy development. They include public interest (i.e. What is the best interest of society as a whole, is the process fully inclusive, especially those who are often overlooked or unable to participate), effectiveness (i.e. which deals with how well the policy achieves its stated goals and/or objectives) efficiency (i.e. how resources are utilized in achieving goals and implementing the policy consistency, is the degree of alignment with broader goals and strategies of government, with constitutional, legislative and regulatory mechanisms). Fairness and equity also measure the degree to which the policy increases equity of all members and sectors of society. This may link directly to consideration of public interest. The last factor is reflectivity, which looks at the other values of society and/or the community, such as freedom, security, diversity, communality, choice and privacy.

Policy making has been implicitly seen as linear by some policy analysts. The linear model assumes the existence of a continuum from research to policy change. The process is taken to be implying a neat, incremental, highly rational and structured approach (Young and Quinn, 2002). This is rarely the case. Nevertheless, some policy analysts (Sutcliffe and Court, 2005; Pollart and Court, 2005) treat the policy development process as a logical progression through five steps: problem definition, goal clarification, option generation, selection implementation and evaluation. The stage model divides the policy process into a series of stages that can be useful as entry points for influencing policy making. The model often includes the stages of:

- **Identification and agenda setting of a policy problem**. This stage is associated with identification of the need for policy in response to current and perceived problems and challenges
- **Formulation of policy options**- This involves reconciling priorities and risks through analysis and judgment to arrive at the most cost effective option and to determine the management required to implement and maintain policies over the longer term so that sustainable outcomes such as improvements in health, education are achieved.
- **Approval of policy**. This stage may involve legislative, cabinet, executive and judicial approvals, expression in policy regulations, instruments and adoption
- **Implementation of policy**. This is the process of testing different policy options and putting the chosen option into effect.

- **Evaluation of policy**. This stage represents the final process in which the policy is assesses or evaluated for effectiveness and efficiency.

In the first stage, governance assessment may assist in identifying new policy issues and set these on the political agenda. Civil society organizations in particular may use governance assessments for this purpose. In the second stage, governance assessments may assist in developing policy recommendations for policy reform. In the final stage, governance indicators may be used in the evaluation of policy, such as National Development Plans. While this model is the most common way practitioners think about the policy process, it is important to be aware of some of its shortcomings:

The proposed sequence of stages is often jumbled. For example, policies may be approved post implementation, or the evaluation of a policy may simultaneously lead to the formulation of new policies. Governance assessment exercises may therefore wish to target policy-making across the stages of policy-making and not only focus on agenda setting, evaluation or any other single stage.

There is not one policy cycle, but a process of multiple, interacting cycles, involving numerous policy proposals at multiple levels of Government. Governance assessment exercise that covers a broad range of issues will in particular see that inserting findings and recommendations into policy- making may occur across a wide range of policy initiatives at local and central Government, in Parliament, within sectors and within the Judiciary.

The policy cycle may not be effective, and it may therefore not be a good entry point. For example, if governance assessments align themselves

with national monitoring and evaluation plans, this is only helpful if these plans are acted upon and followed up by Government.

The stages model is not a causal model. It does not identify a set of causal drivers that govern he process within and across stage. In particular, it provides no answer as to why or why not governance assessment and policy recommendations are acted upon or not in the approval stage. This will require an additional understanding of actors, interests, institutions and incentives.

Shaw (2010) noted that approaches to thinking about policy come from three epistemological frameworks. First, a rationalist framework that conceives of policy making in terms of clear 'stages' that actors simply feed evidence into. Secondly, a political rationalist framework that recognizes the way that ideas, values, interests and actors interact in a more complex non-linear way to shape policy. Thirdly a policy discourse framework that recognizes that language and social interaction shape policy. Shaw observes that authors focus briefly on the second and not all and the third.

Whilst this perhaps reflects the dominance of rationalist thinking about policy by not acknowledging policy as discourse, they fail to provide the realities in policy making process. A policy as discourse approach has relevance for those seeking to shape health policy because among others, it acknowledges that social problems are identified and addressed through the activities of different interest groups including clinicians, managers and patients. By drawing attention to the language and argument used by groups, such approach encourages public health practitioners and researchers to consider how policy problems are framed by whom and why.

According to Buse, Mays and Walt (2005), while the notion of there being formal 'stages' is far from the messy reality of the most policy processes, it remains a useful device for drawing attention to different activities and actors.

Policy Process

The policy process is the way in which policies are initiated, developed or formulated, negotiated, communicated, implemented and evaluated. The issues in the policy process are described as follows (UK Cabinet Office, 1999):

First, recognizing and identifying key factors that inform the policy process is also critical to furthering evidence-based policy. Policymaking is complicated and the factors that inhibit or facilitate the process are equally complex. There are distinct stages or "streams" (Kingdon, 2002, 1989) when together, increase the odds of a policy being adopted. The first stream is the problem – agenda setting and how certain problems or conditions come to be regarded as problems worthy of intervention. It includes avenues for broad participation in an attempt to bring public attention to a problem. The second stream is the alternative policy approaches that may be taken to address those problems. The solution stream is popularized almost entirely by elite policy specialists or bureaucrats. The third stream represents the general policy environment and decision opportunities e.g. general elections and public education. Public policies must be not only "technically sound, but also politically and administratively feasible (Kingdon, 2002).

Documenting influential factors can comprise an evidence base for the process domain of evidence-based policy. Factors such as the national mood, organized political forces (e.g. interest groups, lobbyists), changes in governmental participants such as legislative or administrative turn-over, jurisdictional boundaries or turf "wars" between governmental agencies, and the bargaining all affect the policy process.

Several factors can affect the policymaking process (Smith, 2003). In the study of social movements, progress hinges on the standing of those articulating an issue and the presence of a policy "sparkplug". Case studies show that policy entrepreneurs or champions (i.e. leaders from professional, political, or interest groups who effectively advocate policy) have played key roles in policy reforms. For example, Thomas and Gilson (2004) outlined the role of the actors in the development of health insurance policy in South Africa.

Policy Content and Context

Policy content describes the nature, impact and evaluation of policy (Anderson, 2006; Buse, 2007; Wayne, 2001). Policy context focuses on identifying the specific policy elements that are likely to be effective. The formulation and drafting of legal objects starts during the policy phase. Policy objects define aspects such as policy goals, effects, leading principles, approaches, target groups, conditions, constraints and types of outcome. These objects are part of the best practices for policy formulation. Both quantitative and qualitative data can be used by policymakers to determine the appropriate policy intervention. Such information may be gleaned from systematic

reviews and other scientific research including content analyses that offer an evidence base to inform decision-making. A better understanding and description of evidence-based elements within existing or proposed policy is necessary.

Participation in the policy process

There is an increased desire among citizens to participate in decisions that will affect them and an increasing need for the policy development process to be informed by input from diverse sources especially from those involved or decisions that will affect. Consulting stakeholders is also important in testing whether a policy is likely to work in practice.

It is crucial, however, that policy makers consult all major stakeholders. If only well-organized stakeholders are consulted those who are less well organized may become marginalized because they may not be able to express their views so effectively. Public participation is a framework of policies, principles and techniques which ensure that citizens and communities- individuals, groups and organizations have the opportunity to be involved in a meaningful way in making decisions that will affect them or in which they have an interest (Smith, 2003).

It is critical for those developing public policy to know who has important information about an issue or policy area, who will be affected by a decision and who may be able to affect a decision. It is essential for policy makers to know who the stakeholders are, how they interact, their interests and their concerns.

Public participation may involve both individual and collective voices- individual voices coming directly from citizens who choose to express their views, collective voices from communities, interest groups or other organizations able to synthesize or aggregate shared messages. Effective public participation requires that citizens be informed and knowledgeable about the topic being discussed. They must be willing and able to be involved- having the interest, the time and the opportunity or access (Smith, 2003).

Public participation processes can take the form of information exchange, public consultation, and engagement, shared decisions and shared jurisdiction. Techniques used in public participation have traditionally included publications, public meetings, open house, advisory committee/ task forces, workshops, target briefings, focus groups, bilateral meetings, toll-free phone lines, interviews, surveys and public hearings (Smith, 2003).

Public participation can help to enhance effectiveness, meet a growing demand for public participation, resolve conflicts, increase fiscal responsibility, enhance public knowledge, understanding and awareness, meet legal and policy requirements, establish and solidify legitimacy and help allocate scarce resources (Khawaja, 2013).

Types of Evidence for Evidence-Based Policy

Good-quality policy making depends on high-quality information and evidence. Modern policy making requires governments to make the best possible use of evidence; it also requires the evidence available to policy makers to be more accessible (Guerts, 2013). For policy making, evidence can be both quantitative and qualitative information. Qualitative evidence involves

non-numerical observations, collected by methods such as participant observation, group interviews, or focus groups (Browson, Chiriquí and Stamatakis, 2009). Qualitative evidence relies on analysis of policy (Lin and Gibson, 2003, UK Cabinet Office, 1999) which recognizes the nature dynamics of political and social choice and stresses that conflict and argument are fundamental elements of policy making: politics is both inseparable from and preliminary to policy (Fox, 2004; Lewis, 2003). Health policy analysis is seen as the study of conflicting interests as they bear upon the process of making decisions about how to provide health services (Blank and Bureau, 2004).

Quantitative evidence, on the other, involves the extensive use of statistics, figures, tables generated from surveys to support policy decisions. Quantitative inquiry is experimental and quantitative and aims at verification, simple tangible reality and fragmented into variables. Analysis for policy focuses on the fit between policy problem and prescription, and assumes a rationalistic model of decision making. Policy making is seen as largely technical exercise: the critical evaluation of alternative therapies, technologies, modes of organization and funding. The product of this analytical product is positive knowledge, preferably in quantitative form, to provide evidence for policy development. The technical stream of policy analysis in policy making and research sets out to establish quantifiable measures of measures of the most efficient and sometimes most equitable ways that a society can invest in health (Smith–Merry, Gillespie and Leeder, 2007).

The act of simulating, analyzing and evaluating text-based policies and regulations is quite laborious. In contrast, model-based policies and regulations are a much better fit for evidence-based policy. The policy making process can be improved considerably by modeling policy candidates and reviewing the resulting models (Breton and de Leeuw, 2011). This makes it possible to integrate formal modeling techniques into the early decision stages.

The model-driven environment leads to better policies by allowing for consistency checking and 'what if' analyses. It also provides policy makers with a greater insight into the consistencies and interdependencies of laws (Breton and de Leeuw 2011). They can swiftly identify the possible effects of proposed policies and form their opinions accordingly. In addition, evaluations allow for a comparison of the realized outcome with the intended effects. The use of (semantic) modeling therefore helps to realize the ambitions of smart regulation.

One of the mechanisms used to gather evidence for policy is Impact assessment (European Commission, 2007). It assesses the potential economic, social and environmental consequences of a policy. Impact assessment is a set of logical steps that helps some government agencies to do this. It is a process that prepares evidence for political decision-makers about the advantages and disadvantages of possible policy options by assessing their potential impact.

Policy Implementation

The study recognizes the role of implementation in sustaining the

scheme and places emphasis on the institutional incentives and pressures, systemic bottlenecks, accountability, role of health care providers and issues around room for maneuver and professional and administrative autonomy. These relate to issues of skills and experiences, behaviour and attitudes and resources in the public health sector.

The Oxford Advanced Learner's Dictionary definition of the term implementation is simply to put into effect according to some definite plan or procedure. The idea of implementation is a deliberate and sequential set of activities directed toward putting a policy into effect, making it occur or methods and procedures adopted to achieve the desired outcomes of public policy.

The implementation stage is an important aspect of the policy process. While this is partly a false divide of policy processes between formulation and implementation, implementation issues are considered by some analysts as particularly important, often underestimated by people and different issues tend to be relevant (Buse, Mays and Walt, 2008). According to some policy commentators policy implementation is a neglected area in policy studies yet a policy which is not implemented or badly implemented is not a policy worth having (Hogwood and Gunn, 1984).

The challenges of moving from policy to practice, are immense but a consensus is growing around the issue of the "implementation gap" (McGuigan, 2008). Policies may be effective in the short term but unsustainable in the long term. For example a study on drug policies in twelve countries (WHO, 1997) demonstrated that policy making cannot be a technical process only but must also be a political process and that it does not

stop with the adoption of a policy but continues on through the phase of implementation. Lipsky (2010) examines what happens at the point where policy is translated into practice, in various human service bureaucracies such as schools, courts and welfare agencies. He argues that policy implementation in the end comes down to the people who actually implement it, the practitioners or street level bureaucrats. A policy can be implemented in a number of ways. These are referred to as policy tools or policy instruments (Smith, 2003). They include legislation, regulation, guidelines, standards, procedures, programmes, grants, subsidies and taxes.

Successful policy implementation has and continues to be a major challenge in developing countries. There is a phenomenon of policy instability or vulnerability in Ghana. The oft-heard or described variously as 'trajectory of implementation', 'policy failure', 'comedy of policy implementation, 'policy politicking', 'contradictions in the policy process', 'inconsistencies in policy implementation', 'implementation gap', 'futility of policy implementation' policy (Boven and Hart, 1996; Dunsire, 1978) aptly account for the lack of sustainable development in developing countries. Evidence of this phenomenon is found in many sectors e.g. constant review and non- implementation of policies in the health, industry, energy, education and economic sectors results in poor policy reach and outcomes, waste of scarce resources and poverty.

Various factors account for poor implementation. Atuahene (2007) has identified delays in the release of funds to headmasters, increase in enrolment, inflation of figures, and poor preparation as the lapses in the policy in the School Capitation policy in Ghana. According to Cassels

(1997), weak institutional capacity is one of the main constraints affecting the implementation of sector wide approaches. Aidoo (2010) also identified frustrating factors in policy formulation and implementation in Ghana as weak political will, partisan party politics, and concomitant intransigent position, weak institutional capacity, for instance personnel, financial and technological. He sums up as the absence of or low level of inter- ministerial or cross-sectoral co-operation and coordination as well as lack of problem anticipation in policy formulation.

Although more than three decades ago, experts highlighted the existence of gap between policy formulation and policy implementation (Grindle, 1980; Van Meter and Van Horn, 1975) researchers and policy makers are yet to address this anomaly adequately. Mamman and Rees (2007) have asserted that progress in addressing poverty will depend as much on human, organizational and institutional capacity as well as good governance. This is so because successful implementation of good governance is dependent on the three dimensions of capacity (human, institutional and organizational).

Agyepong and Adjei (2008) writing on the public policy implementation described and analyzed challenges in the implementation of the National Health Insurance Scheme in Ghana. The implementation of policies such as the Free Maternal Health Policy, Exemptions Policy, and User fee Policy was said to be poor (Nyonator, 2002). Similar experiences in other sectors such as education can also be cited. Atuahene (2007) identified delays in the release of funds to headmasters, increase in enrolment, inflation of figures and poor preparations as factors that accounted for the poor

implementation of the Capitation grant policy in Ghana.

As Kwarteng and Ahia (2007) pointed out that well intentioned social policies have had little effect and impact due to non-implementation of existing social continental policy standards contained in various African Union decisions, declarations and the Millennium Development Goals (MDGS) as a major challenge.

An implementation plan for delivering a policy, the roles and responsibilities of all those involved in delivery, the resources allocated to the policy including money, skills, and infrastructure, how potential barriers are to be tackled and how performance is to be reported and monitored to ensure appropriate accountability (Cairney, 2012). An assessment of a policy's implementation critical path can help identify the key stages in delivering the policy so that these can be organized efficiently or where there are potential problems corrective action can be taken.

Policy Outcome and Evaluation

Documenting the effects of implemented policies (policy outcome) is equally important in supporting evidence-based policy. Policy evaluations are critical to the understanding of the impact and effects of policies on community and individual-level behaviour changes. They should include "upstream"; "midstream" and "down-stream" factors. By far, a number of quantitative measures are available for downstream outcomes. One evaluation framework, the Reach Effectiveness Adoption Implementation Maintenance (RE-AIM) framework, can be applied to evaluations of a policy and its impact. RE-AIM has 5 dimensions: (1) reach (who or how many will

be affected by the policy. (2) Effectiveness (proximal or distant impacts and unintended consequences), (3) adoption (policy diffusion and participation level, (4) implementation (costs as well as enforcement and compliance), and (5) maintenance -institutionalizing the policy or programme (Reich, 1994).

Policy evaluation may employ both qualitative and quantitative methodologies and may make use of "natural experiments" surrounding the adoption and implementation of the policy. These evaluations involve naturally occurring circumstances where different populations are exposed or not exposed to a potentially causal factor (e.g. a new policy) such that it resembles a true experiment in which study participants are assigned to exposed and unexposed groups (Lavis, Osman, Lewin and Fretheim, 2009).

Health Policy

According to the WHO (2011) a national health policy is "a set of decisions to pursue courses of action aimed at achieving defined goals for improving the health situation". Public health policy is the collated laws, regulations and approaches taken to decide on issues that affects the health of the wider community (Wayne, 2001). Buse (2008), defined health policy to embrace courses of action and (inaction) that affect the set of institutions, organizations, services and funding arrangements of the health system. It includes policy made in the public sector by government as well policies in the private sector. As Bennet, Agyepong, Sheik, Hanson, Seengoba and Gilson (2011) observed, health policy is commonly seen as formal written documents, rules and guidelines that present policy makers decisions about what actions are deemed legitimate and necessary to strengthen the health

system and improve health.

Public health policy includes a wide range of topics including health care reforms, and the introduction of health insurance. Health policy has been understood to encompass the process of decision-making at all levels of the health system and influences that underpin the presentation of policy issues, the formulation of policies, the process of bringing them alive in practice and their evaluation (Walt and Gilson, 1994). Walt and Gilson's (1994) view of health policy as about process and power and defined health policy as who influences whom in the making of policy, and how that happens.

According to Walt (1994) health policy is about the best method of financing health services (private vs. public health insurance systems, for instance or about improving ante natal health care delivery. Walt considered health policy to be largely an issue of process and power and concerned with who influences whom in the making of policy and how that happens. Walt's approach to health policy is mainly from the perspective of actors and processes-factors influencing policy formulation and implementation in both developing and developed countries. This observation appears to be no different from the general policy.

An explicit health policy can achieve several things. It defines a vision for the future which in turn helps to establish targets and points of reference for the short and medium term. It outlines priorities and the expected roles of different groups and builds consensus and informs people (WHO, 2011). Furthermore, health policy analysis can help in understanding important stages of the health policy process such as agenda building and policy formulating, planning, monitoring and evaluation and which factors as

well as actors affect the process.

Health policy analysis according to Smith-Merry, Gillespie and Leeder (2007), is the discovery through critical appraisal of the strengths and weaknesses of health policies or types of policy, including how they have been formulated and how they function in practice. Health policy analysis seeks to answer the questions: how can current health policy be improved, or how can new health policy be best developed to meet social, political, economic or legal ends in relation to a health problem, taking heed of what has gone before. Since the 1990s, health policy analysis is widely acknowledged and viewed as an instrument to act more effectively to combat health problems and improve life conditions (Ham, 1992; Sabatier 1998, Sutton 1999, Walt and Gilson, 1994; Wuyts, Mackintosh and Hewitt, 1992).

Health policy analysis helps in understanding how policy makers set objectives, make decisions on health priorities and take actions (Barker, 1996). It also explains how policy context (political, economic and socio-cultural) influences the health policy process and its outcomes (Brewer and Leon, 1999; Sachs, 2001). Most reported health policy analyses have been retrospective case studies looking at the success or failure of past policies (Walt, Shiffman, Schneider, Murray, Brugha and Gilson, 2008) yet policy makers need prospective studies to help analyze strategies before they are implemented.

Health policy analysis draws on two prominent discourses, based on different disciplinary influences. These are the positivist and post positivist approaches. While not mutually exclusive, their traditions differ slightly with public policy analysis rooted in the social and political economy frameworks

of public policy while evidence informed policymaking is rooted in the scientific and health care domains and draws on, the evidence- based traditions.

From the health policy field, some authors (describe successful examples of evidence-based advocacy and provide a guide for those who seek to move from research to advocacy. Partnership of researchers and advocates ensures that policies are grounded in science, so messages are tailored to the target audience; and models of persuasive communication (e.g. social marketing) are applied.

Within the health field, one approach to examining policy is to utilize the 'policy triangle' - a tool which identifies the content of policy, contextual factors, processes and actors (Walt and Gilson, 1994).These factors have been found to be intertwined and therefore need to be systematically considered to achieve a holistic understanding (Buse, Mays and Walt, 2005).

Buse (2008) an advocate of prospective policy analysis, has developed a policy engagement framework to prospectively analyse policy that incorporates strategies for change (see Figure 1).

Political Situational Analysis

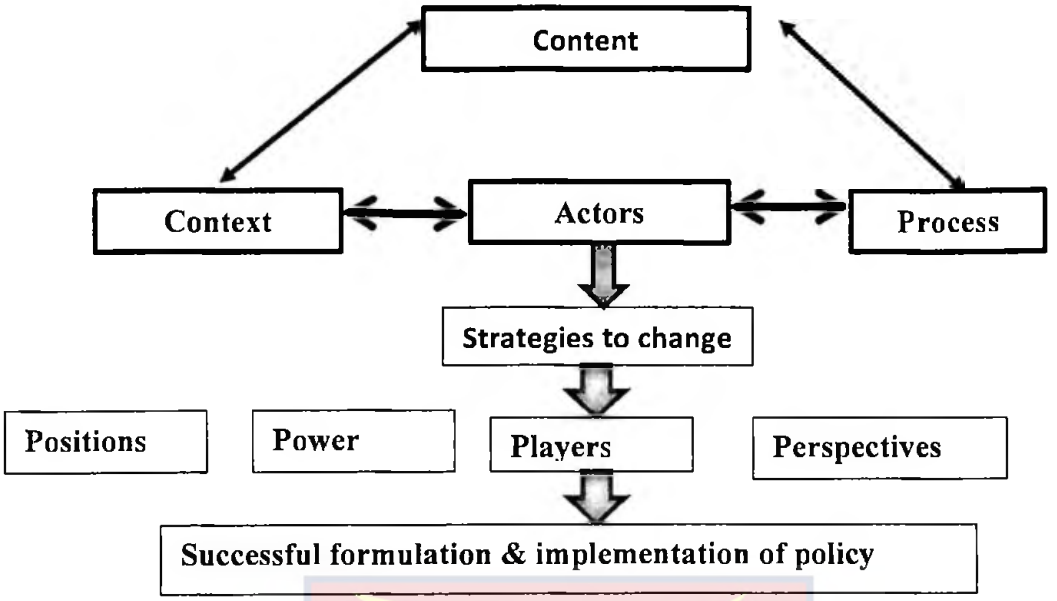

Figure 1: Policy Engagement Framework

Source: Buse, 2008

The policy engagement framework "offers a systematic approach to the on-going collection, analysis and use of political information (e.g. concerning actors, their interests, institutions, ideas, and policy processes and context) that can alter the balance of power between those in support of and those resisting change by enabling pro-reformers to intervene more effectively in the policy process" (Buse, 2008, pp 67-78). This framework, like the political mapping approach of Reich (1996) identifies the key domains of interest in analysing policy prospectively. In addition to these domains developed through the policy sciences traditions, there is increasing focus on the pathways to promote evidence-informed policy-making (Bowens and Zwi, 2005).

During the past decades, the role of government has been steadily changing, with emphasis being placed on getting overall direction through policy and planning, on engaging stakeholders and citizens and sometimes on

empowering stakeholders or partners to deliver programmes and services (Smith, 2003). Since the declaration of the Millennium Development Goals, there has been increasing demand for high calibre managers, policy analysts and planners capable of developing and implementing policies (Smith, 2003).

The policy process has been given further illumination by Walt and Gilson (1994) with the argument that health policy has been wrongly focused on the content of policy or reform and neglected the actors involved in the reform, the processes contingent on the developing and implanting change and the context within the policy is developed . They emphasize the role of various actors and processes in policy making.

Health policy as a relatively new field of endeavour or study can be applied to the health sector or in relation to policies that affect the health status of the population. The processes in the broader public policy making provide some framework within which health policy can be analysed and studied. According to Francis and Souza (2004) a country's health policy is determined by questions such as what kind of society do they want? What are the explicit and implicit goals and whether they are prepared to give priority for the implementation of the goals and provide the necessary human, financial and material resources.

Concept of Sustainability

In 1992, world's leaders adopted the principles of the Rio Declaration and Agenda 21 as the route to sustainable development in the 21st century. Thus, the importance of investing in improvements to people's health and their environment as a prerequisite for sustainable development was recognized at the highest decision-making levels (Seke, 2013; Covalan, 1999). Human

health was highlighted as a central aspect of sustainable development. As stated in Principle 1 of the Rio Declaration; "Human beings are at the centre of concerns for sustainable development. They are entitled to a healthy and productive life in harmony with nature (UN, 1992).

Sustainability concept originates in research on the behaviour of ecological and socio economic systems (Goodland, 1995; Hueting and Reijnders, 1998). Integral to the concept of sustainability is the focus on future needs, where equity, effectiveness and efficiency are central concerns (WECD, 1987; Kemp, 2005). Within the discourse, the essence of a system's sustainability is increasingly being understood as a system's resilience (Fiksel, 2006; Folke, Carpenter and Elmqvist,; Holling, 2001; Gunderston, 2000; Dovers, 1996).

The Concise Oxford Dictionary defines the word "sustain" as "keep up adequately; keep from failing". Sustainability is neologisms drawn from "sustain" which means to supply with sustenance, to make something to be kept up, prolonged or carried on (Concise Oxford English Dictionary).

According to Macbeth (1994), to sustain is to mature, to nourish, to tolerate and to carry on. Aryee (2000) describes policy sustainability as maintenance or survival associates it with the often comments such as the policy failure and termination. Aryee provides possible reasons for policy termination as policy having time span, other having 'sunset' clauses and expire due to statutory specifications, still others caught up in times of financial constraints and are eliminated solely to avoid budgetary expenditure. Associating policy with life can generate and nurture supporters-organizations, people and groups who depend upon the policy for some form of reward or

gratification (money, position power). Viewing policies as life- like entities which can be killed, transformed, reviewed, suspended or allowed to continue provides an important dimension when considering policy success or failure. Smith (1989) argues that regardless of the rating of a policy on other dimensions of success, if a policy can survive and be institutionalized it is a clear success within the policy arena.

Sustainability of an insurance scheme means it has the capacity to keep operating over time (PHR- plus, 2004). A study by Shigayeva and Coker (2014) on sustainability identified common key terms related to the concept as 'sustain', 'resilience', 'viability', 'persistence', 'institutionalization', 'routinization', 'ownership", 'durability', 'stability' and 'continuation'.

A sustainable policy designates the integration of goals and activities of a policy with sustainable development. Therefore sustainability assessment of a policy can be considered as a process that helps policy managers to integrate the objectives of sustainability into policy actions in a given socio-political environment and plan a strategy for policy implementation.

According to Holderen (1995) the word "sustainability" was brought to the policy attention only recently within a couple of decades, and spread not only to environmental scientists but also to other actors like activists, economists, social scientists and policy makers. Discussions on policy have tended to focus on its sustainability and successful implementation. Sustainability of health programmes can be addressed on several levels; institutional, programme, community and health outcomes. The most commonly used notions of sustainability are financial and institutional sustainability. Financial sustainability is the capacity of the system to maintain

an adequate level of funding to continue its activities. Institutional sustainability refers to the capacity of the system to assemble and manage the necessary non-financial resources to successfully carry on its normal activities into the future (Bennet, Gamble and Silvers, 2004). The two notions will be used together in the study. Sustainability, for the purposes of the study is the capacity to keep operating over time that is the ability to continue its normal activities well into the future. The notion of time is central to the concept of sustainability, as to sustain something there is the need to nourish, nurture and keep.

Indicators of Sustainability

Bates, Taegtmeyer, Squire, Ansong, Nhema-Simwaka, Baba and Theobald (2011), provided indicators which can be used to measure sustainability as acceptability, ownership, early engagement of stakeholders, funding, improved resources, institutionalization of activities and innovation.

Shigayeya, Atum, McKee and Coker (2010) provided the following attributes of a sustainable health programmes; first, leadership defined to include the capacity to govern, lead and manage; second, capacity which encompasses resources and capability to plan, implement and evaluate activities; flexibility and adaptability that is ability to adapt, renew or be flexible; interactions which means the capacity to build relationships and interactions in and outside organizations and lastly performance, which is the ability to bring about results or attain the goals. These attributes are useful in evaluating how sustainable a programme or policy can be.

Healthcare Financing

Health financing refers to the methods used to mobilize resources that support basic public health programmes, provide access to basic health services and configure health services delivery system (Sheiber and Maeda, 1997). Among the health-financing methods available are taxation, user fees, donor funding, donations and health insurance. The systems consist of payers, providers and consumers as well as the policies and regulations that govern behaviour as summarized in (Figure 2). It is concerned with questions such as who pays, who gets and who gets paid and under what conditions? Financial barriers to access to care and the rise in out-of-pocket spending, accompanied by a slow growth in prepayment schemes in the form of social and private health insurance, have increased inequities in health care financing, exposing large segments of the population in different countries across different regions to catastrophic health care expenditures (Drechsler and Jutting 2007; McIntyre, Garshong and Mtei, 2008). For people to have access to adequate health services, the health system needs to be financed in an equitable, efficient and sustainable manner (WHO, 2005). Kutzin (2001) identified adequate managerial capacity as a factor for the success of the schemes. This partly justifies the management and review of health financing policies to ensure that they remain appropriate and relevant and continue to deliver their intended outcomes efficiently.

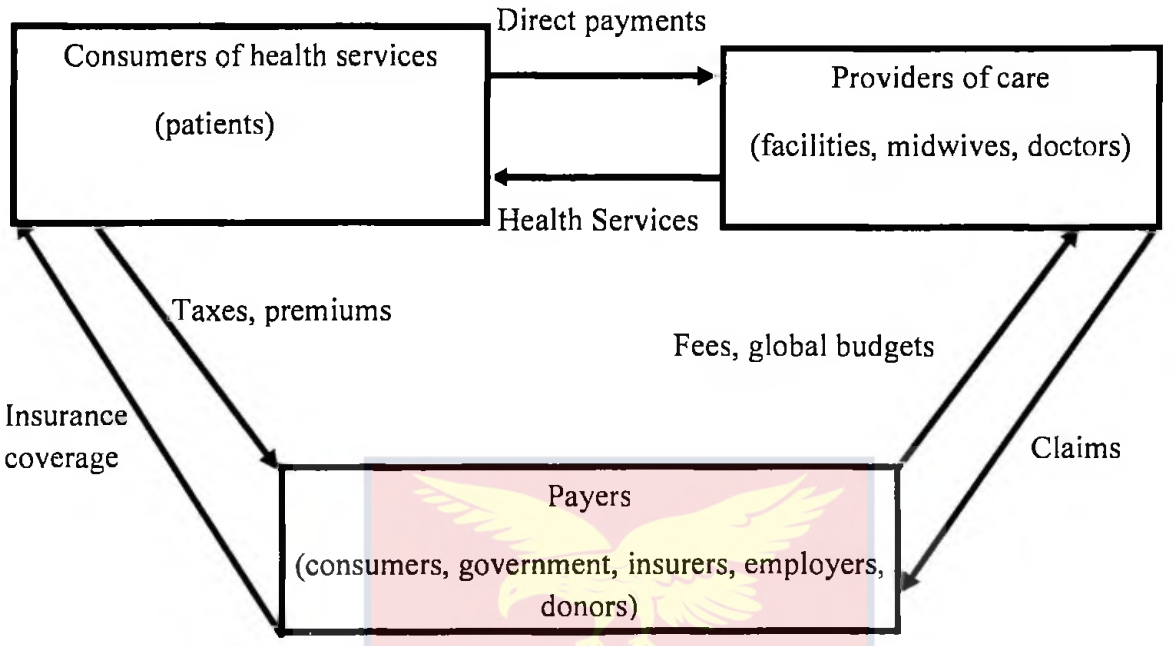

Figure 2: Healthcare Financing Triangle
Source: Sheiber and Maeda, (1997)

Health systems in developing countries are financed through a mix of public, private, and donor sources. Public sources are funds through taxes, fees, donor grants, and loans (Sheiber and Maeda, 1997). Private sources include households and employers who pay fees directly to providers in both public and private sectors, pay insurance premiums (including payroll taxes for social health insurance), and pay into medical savings accounts and to charitable organizations that provide health services (Zellner, O'Hanslon and Chaidani, 2005).

Health Insurance Systems and Mechanisms

Health insurance has become a major focus in health sector financing. The main functions involve collection of revenue, pooling of risks and purchasing of services. Revenue collection is the process by which the health system receives contributions from households, enterprises, government and other organizations including donors. Pooling is the accumulation of and management of these revenues in order to spread the risks among all members of the pool. Purchasing is the process by which these pooled contributions are used to pay providers to deliver a set of specified or unspecified health interventions (WHO, 2000)

A health insurance system is based on risk sharing and involves regular contributions by a large group to a pool which is used to pay for the health services of a small number of people who will require treatment at any point in time. The healthy members of an insurance plan subsidize the sick ones in any given period.

The main objective is to provide protection against the hazards of paying for medical services, which is usually unpredictable and expensive. Insurance systems differ in terms of whether it is compulsory or voluntary, for profit or non- profit,, population cover, geographic areas, occupation and the type of actual or implied contract between the insurer and the insured parties (Hsiao and Shaw, 2007; Largarde and Palmer, 2006; Arhin-Tenkorang, 2001).

Depending on how an insurance system is structured, it can pool the premium payments from the rich and healthy with the poor and sick to improve equity and thus prevent impoverishment by covering medical costs from catastrophic illness or injury.

Normand and Weber (1999) observed that the successful development of social health insurance depends in part on the availability of high quality, appropriate health services for the insured population. Two basic forms of health care provision under social health insurance; the direct method and the indirect method. In the first case, the health fund owns the providers and in the second they enter into contracts with them. Both of them have their strengths and weaknesses. The direct method can lead to quality problems while the indirect method leads to problems of cost control.

In the public sector, social health insurance (SHI) is set up as mandatory insurance systems for workers in the formal sector (Carrin and James, 2005a; Carrin and James, 2005b; Normand and Weber, 1999). Social health insurance contributions, which are typically payroll taxes from both employers and employees, are placed in an independent or quasi-independent fund separate from other government finances. Health insurance contributions may improve equity by mandating larger contributions from higher paid workers (Normand and Weber, 1999). Social health insurance has been successful in Organization for Economic Co-operation and Development countries, which have a large and robust formal sector (Carrin and James, 2005b). Thailand and some countries in Latin America have well-functioning Social Health Insurance systems (Carrin, 2004, Carrin, 2003). SHI systems in countries such as Morocco, Egypt, and Mexico cover populations in which a household member works in the formal sector. SHI systems in low-income countries generally lack the resources to provide wide coverage of quality health services, although some SHI systems have other facilities or contract

with NGOs and commercial providers to expand access. Health insurance schemes are common in both developed and less developed countries.

However, it has been observed that such schemes are generally small and offer a limited contribution towards overall health system goals. Despite some differences across countries, some challenges pertaining to health financing that are common across many countries include poor resource allocation, poor public– private partnerships and a lack of policies for financial sustainability, which are reflected in poor quality (Schieber, Maeda and Klingen, 1998).

A study by Bennett, Creese and Monasch (1998) on sustainability of health insurance schemes argued that financial sustainability and administrative or managerial sustainability are equally important. Some of the factors highlighted to contribute to poor financial viability included the small scale nature of most of the scheme, adverse selection leading to progressively smaller risk pools and higher costs and heavy administrative cost. The main issue was the weak design of the many of the schemes.

Whereas social insurance primarily pools risk across groups, private insurance is based on the distribution of risk between the sick and the well (Normand and Weber, 1994).Unlike social insurance, private insurance is often "risk-rated", meaning that those who are judged more likely to need care pay a higher insurance premium. This arrangement often limits those covered by private insurance to employees – who as a group are lower risk – and benefits do not reach lower income population and those in the informal sector (Normand and Weber, 1994). The performance impact of health insurance on institutional costs has been illustrated in various studies. For example

Schneider and Hanson (2006) analyzed the effect of payment mechanisms for provider behaviour and costs in Rwanda. The link between enrolment and quality of care was investigated by Criel and Watkins (2003); Schneider (2005); Mershed, Busse and Ginceken (2012) tested satisfaction with the National Health Insurance policy in Syria. The study involved the use of qualitative methods to assess views of householders.

A study by Sinha, Ranson, Chatterjee, Acharya and Mills (2005) described the barriers faced in accessing scheme benefits by members of the Community Based Insurance run by the Self-Employed Women Association (SEWA) in India. The study identified factors such as poverty, illiteracy, transport inadequacies, scheme design as barriers in the accessing benefits in a community based insurance scheme.

Yevutsey and Aikins (2010) studied the financial viability of District Health Mutual Insurance Schemes in the Lawra and Sissala districts in the Upper West region of Ghana. The lessons from that study which mainly examined financial documents of the schemes are that adequate revenues and recurrent expenditures can have significant implications for sustainability of the scheme.

Kang, Jang, Lee and Park (2011) demonstrated the sustainability problems of the Korean National Health Insurance Scheme, and identified funding, ageing population, leadership and decline in population growth as the main factors affecting the sustainability of the policy. The study focused on sustainability and recommended a focus on reforms of the operating system of the policy, increased funding and spending.

Similarly, Witter (2007) explored the sustainability of the health insurance scheme in Khartoum, Sudan. One of the major lessons the study provided was the need to continually manage the threats to financial sustainability of the revolving fund.

The sustainability of the Croatian National Health Insurance Scheme was investigated by Vončina (2010) following reforms of the scheme. It was observed that the Croatian social health insurance system faced several long term trends that threatened the economic sustainability of revenue collection. Among them were low percentage of those who actively contributed financially to the Mutual Health Insurance Fund (the employed) compared to the total number of beneficiaries, the aging of the Croatian population caused by long standing decreases in natality and fertility.

Studies by Brugiavini and Pace (2010); Abeka-Nkrumah, Dinklo and Abor (2009); Mensah, Oppong, Bobi-Barima, Frempong and Sabi (2010); Witter and Garshong (2009); NDPC (2008) have reviewed the implementation and examined the effects of the NHIS on utilization of health care including antenatal and institutional deliveries. Some of the outcomes were increased outpatient attendance at the health facilities. The financial protection of the health insurance scheme in Ghana was investigated by Witter, Garshong and Ridde, 2009; Witter, 2007). The studies analyzed routine data, secondary literature, surveys and key informant interviews at national, regional and district levels. The studies made a preliminary assessment of the implementation of the free maternal health care policy and its effect on the NHIS. Among the observations were the threats posed by the absence of co-payments, limited gate keeping, increasing costs and the growing utilization of

members to the sustainability of the NHIS. The sustainability of the free maternal health care policy was also found to be dependent on the sustainability of the NHIS.

A study by Wahab (2008) assessed universal health coverage under the implementation of National Health Insurance Scheme Law in Ghana after a period of implementation. The study examined newspaper reports and interviews. The study concluded that respondents had mixed views about the success of the NHIS but welcomed the introduction and implementation of the NHIS as a timely social protection policy. The focus of the study, however, was not on sustainability but recommended a full and complete evaluation of the success or otherwise of the NHIS.

A study on the NHIS carried out by Apoya and Marriot (2011) generated a heated national debate. The study made scathing comments on reported claims of success of NHIS. Among the comments were the methodology used to determine coverage of the scheme. The report focused on coverage, equity in premium payment, registration among the rich and the poor and inefficiencies. Of significance to this study are the indicators used to assess the success of the scheme.

Accreditation

Accreditation in health care is a formal process by which a recognized body assesses health care institutions to determine whether or not they meet agreed pre-determined standards (NHIA, 2012).The goal is to promote the delivery of quality, safe, efficient and effective health care services to the people. It is a legal requirement that health care facilities be accredited before

they can participate in the NHIS (Act 650 section 70 and the Legislative Instrument (LI) 1809 of 2004 sections 22-36.

Under the legislation establishing the scheme, the NHIC is to secure implementation of the scheme to ensure access to basic health services to all residents. The Council accredits to health care providers and monitors their performance. The National Health Insurance Council (NHIC) is to ensure that health care rendered to the beneficiaries of schemes by accredited health care providers is of high quality (MOH, 2005, p. 46).

To the client, accreditation enables a facility to improve consumer access, choice, quality and service delivery. It increases the pace of adoption of new technology and innovation in standards in health care delivery through manageable facilities, build on the core competency and comparative advantage based on rationalized service provision, ensure health services of minimum standards, provide quality improvements and lastly, it provides value for money, thus strengthening public confidence in the health insurance scheme (GHS,2007).

Under the NHIS, all private and public (mission, private for profit or private self-financing) and quasi-government health institutions that wish to operate under the NHIS must be accredited. The NHIS Accreditation checklist is organized into units/modules and sub-units as follows: range of service, environment and infrastructure; basic equipment, organization, staffing levels relevant to the service, organization and management, safety and quality management and care delivery. The accreditation tools were developed by a multidisciplinary team, piloted and reviewed by broader stakeholders before use (NHIA, 2010).

The process involves an application from a provider or facility to the NHIA and following that The NHIC will arrange for the inspection of the facility. A survey team made up of multidisciplinary, experienced, competent health professionals and trained surveyors in the use of the accreditation tools visit the facility to carry out the accreditation survey. At least a member of the team would be able to speak one major language in the district(s) the team is surveying. Briefing before and after the survey, is done with the management of the facility. The team conducts rounds with a senior member of staff. Records and documents are asked for and examined. The documents examined include nominal roll, organogram, job descriptions for staff, latest annual reports, records of staff appraisal, minutes of recent management meetings, annual plans for current or previous year, financial and audit reports and minutes of operational committees meetings e.g. procurement, quality assurance Team. The team visits the service areas and does a complete assessment and fills in the checklist. The team meets after the rounds to ensure that the checklist has been completely filled in to avoid revisiting the facility to collect missing or uncompleted information.

The team employs various methods for the assessment. These are direct observation, records review, interviews with the facility staff and management and interviews with management where appropriate. Each accredited facility would be issued with a license and the NHIC has the powers to suspend or revoke the license of a health facility. The Council may suspend or revoke an accreditation granted to a health care facility on various grounds. For example a license may be suspended or revoked on the failure to comply with the requirements and conditions of the accreditation, on

conviction of fraud or on any proven case of infraction and misconduct such as submission of fictitious claims and employment of unqualified professional staff.

NHIS accreditation started in 2005 on provisional basis using a minimal set of criteria with no inspection of facilities. A formal accreditation system was developed in 2008 and inspections began in 2009.By the end of 2012, eight (8) batches comprising 4,069 facilities had been inspected, with 3,575 facilities having been accredited (NHIA, 2012).The accreditation results are being used as a proxy of the quality of care being offered in a facility. According to the MOH (2013), the results suggest an urgent need to support health facilities to improve their infrastructure, equipment and staffing in order to improve the quality of health care provided.

In general, the objectives of the accreditation process can be described as worthwhile which has to be encouraged and supported to ensure improved quality of services in the health facilities. Seddoh, Adjei and Nazzar (2011) have reported the benefits to the population in terms of increased access to health care and the direct effect on health system by reorganizing the nature of quality control through facility assessment and accreditation.

The process also provides a further step in promoting quality of care and the work of some of the regulatory bodies in the health sector. For example, in addition to the satisfying of the requirements under the Act 650, health care providers should be approved by the Ministry of Health, comply with the provisions under the Private Hospitals and Maternity Homes Act (1958) and shall be a member of good standing of any national association of

licensed hospitals in the country and shall have a quality assurance programme.

Regulatory and Ethical Mechanisms

A number of mechanisms are provided for to ensure that health insurance schemes are appropriately regulated to prevent abuse, promote efficiency, quality of services and sustainability. Under the Ghana National Health Insurance Scheme such systems and mechanisms can be grouped under legislative, administrative, facility accreditation, professional (bodies) affiliation and the general code of conduct for health care providers in the public sector.

The NHIS Law, Parliamentary Act 650 of 2003 and subsequently reviewed by Act 852 of 2012 which established the NHIS makes provision for the National Health Insurance Council (NHIC) as the body responsible for the NHIS including the authority to register and accredit health insurance schemes in the country. The National Health Insurance Authority (NHIA) is the lead implementing agency. Legislative Instrument (1209) provides interpretation for implementation of Act 650.

One of the major regulating mechanisms in the NHIS is the facility accreditation with the broad objective of ensuring and promoting the provision and delivery of quality, safe, efficient, effective and acceptable health care services to the people of Ghana.

To promote efficiency and ensure that health service provision is done in accordance with standard practices and within the NHIS legal framework, the NHIA conducts periodic clinical audits in the accredited health facilities. Traditionally, the audit defines the process of peer group review of the

diagnosis and treatment patterns employed by a clinician. It is more concerned with the quality of work done and the likely outcome in health terms. It may also include the efficiency of resource use in treating particular types of patients.

One of the mechanisms for regulating the behaviour of prescribers and promoting the rational use of medicines is the NHIS Medicines Drug List which emphasizes standardization in generic medicines for greater effectiveness and efficiency.

Health care delivery requires the services of health care providers and with a multidisciplinary team to work to achieve results and contribute to the achievement of the organizational goals. Services should be delivered with a high sense of professionalism. The monopoly powers exercised by the health care professions due to their low numbers and expertise, ignorance and uncertainty among consumers and asymmetry of knowledge about illness and health care between patients and health care professionals, however, normally create market failures in health and sometimes high cost of specific types of care. Among the mechanisms for ensuring quality, efficiency, effectiveness and discipline which are hallmarks in service delivery are regulation of and promoting high ethical behaviour among health care providers.

Regulation is the formal process by which a recognized body assesses and recognizes that an organization meets applicable predetermined and published standards (McPake, Kumawarana and Normand, 2002). Regulation covers health facilities, health professionals, health products including pharmaceuticals and medical products, and food and non-medicinal products.

Regulatory bodies in Ghana are the Ghana Medical and Dental Council, the Pharmacy Council, the Nurses and Midwives Council, Traditional Medicine Practice Council, Food and Drugs Authority, the Ghana College of Physicians and Surgeons, Private Hospitals and Maternity Homes Board and the National Health Insurance Authority (MOH, 2011). The Statutory Bodies are required to monitor and enforce the ethics and standards of practice of various professional and technical groups within the sector (MOH, 2005).

The NRCD 127 (ACT 91) provided the legal backing for the establishment of the Medical and Dental Council in 1972 to influence the development and implementation of policies relating to the training and standards of duly registered Medical and Dental practitioners. The Ghana Medical and Dental Council regulates the standards of training and practice of medicine and dentistry in the country through a comprehensive documentation system on practising doctors, accreditation of facilities for housemanship training and the development of standards and guidelines for facilities and practitioners to ensure 'fitness to practice' medicine and dentistry (MOH,2010).

The Pharmacy Council of Ghana was set up by the Pharmacy Act 489 of 1994 to develop and implement policies intended to ensure that Pharmacists and Licensed Chemical Sellers operate ethically. The vision of the Council is to secure the highest level of pharmaceutical care by ensuring competent pharmaceutical care providers who practice within agreed standards and are accessible to the whole population. Offences under the Act include operating continually without the supervision of a pharmacist and operating without

renewal of pharmacy license, absence of in appropriate sign board, pharmacy structure or premises and failure to keep up-to-date records and documentation in relation to the pharmacy business.

Parliamentary Decree NRCD 117 of 1972 established the Nurses and Midwives Council in 1972 to handle all affairs relating to the organization of training and the education of nurses and midwives and the maintenance and promotion of standards of professional conduct and efficiency. It regulates nursing and midwifery education and practice. It collaborates with the Ministry of Health to implement policies that aim at ensuring that the general public has access to quality health care delivery by nurses and midwives. Nurses Regulations L.I 683, 1971, also defined the operational requirements for the various categories of nurses and the practice of nursing in the country, the approved training institutions and the standards of education for auxiliary nurses and finally the setting up of supervisory authorities to assist the Board in the execution of its functions.

The Food and Drugs Authority Law, PNDC 305B (1992) sets the guidelines for providers in the food and drugs industry and defined the standards to be met by them, the industry, the licensing of such operations and the penalties to be applied in the event of non- compliance. The National Food Safety Policy was developed by the Food and Drugs Authority to serve as a guide in the promotion of food safety in Ghana (MOH, 2014).

The Ghana College of Physicians and Surgeons promotes specialist education and continuous professional development in medicine, surgery and related disciplines. The College which was established by Act 635 of 2003 and repealed by Act 833 of 2011 seeks to ensure improvement in professional

competencies of doctors, staffing in the district and health care delivery and to contribute to the formulation of policies for sound health and public health in general.

The Private Hospitals and Maternity Homes Board (PHMHB) is mandated to license and regulate practice in the private sector. The Private Hospitals and Maternity Homes Act 1958, sought to raise the standards of health care in private institutions and to have an effective system in the registration of hospitals and maternity homes in the country. The new Health Institutions and Facilities Act, promulgated in 2011 established a regulatory body to license health facilities to provide public and private health care services, promote the establishment and regulation of mortuary facilities and ambulance services. It seeks to repeal the Private Hospitals and Maternity Home Board Act 9 of 1958, Mortuaries and Funeral Facilities Act 563 of 1998 and the St John's Ambulance Services Act of 1979.

Though private sector laboratories and imaging centres are increasing, there was no national institutional framework to regulate their practice (MOH, 2010) until the Ghana Allied Health Professionals Council was set up in 2013 to regulate practice of allied health care service practitioners. The Allied Health Professions Council is the body established by an Act of Parliament (Act 857, 2013) to regulate the training and practice of Allied Health Professions in Ghana. As part of its mandate, the Council is responsible for granting Professional Accreditation for all Allied Health Programmes. The newly created Allied Health Professions Council has started the registration of members as well as developing guidelines for accrediting allied health training institutions and the conduct of professional licensure examinations.

The Traditional and Medicine Practice Act (Act 575) was passed in 2000 to control and regulate traditional medicine practice in Ghana. The Traditional and Medicine Practice Council is to promote, control and regulate traditional and alternative medicine practice through the formulation, implementation, co-ordination, monitoring and evaluation of policies and programmes and thereby contribute to the national development agenda. Among its functions are the development and review of standards for the practice of traditional and alternative medicine and the issuance of certificates of registration to qualified practitioners and license premises for practice. In order to improve the practice of traditional medicine in Ghana, the Traditional Medicine Practice Council has undertaken a number of activities including enforcement in some regions.

The NHIA regulates and supervises health insurance schemes, accredits and monitors health care providers and manages the NHIF (Act 650). In 2010, it sought to inspect and accredit a minimum of 2000 health care facilities in the country (MOH, 2010).

According to the MOH (2014), regulation within the sector continues to improve. A study on the mandates of the regulatory bodies ((MOH, 2000) suggested that ability of the statutory (regulatory) bodies to effectively carry out their responsibilities as detailed in the respective legislations that established them has been hampered by lack of resources. According to the MOH (2014b), the major challenges facing the governance and regulation within the sector include, lack of standards in certain areas service delivery. For example, record keeping and reporting, weak standards especially in the

area of allied health services, increasing spate of non–adherence to agreed standards and weak enforcements of standards.

Regulation in the health sector is aimed at protecting the population by ensuring that competent health care providers practice within agreed standards. The efficient performance of the regulatory bodies can enhance the quality of general health care in the country and go a long way to sustain public confidence in the health sector. There is also the need to manage the regulatory machinery of the sector to ensure that the service delivery is more responsive to the legitimate expectations of clients. Key observations in the health sector performance review report in 2009 (MOH, 2010) indicated that after a 15-year period of aiming at a comprehensive, sector-wide, integrated approach regarding health service organization and health service delivery, a tendency of evolving again to an increasingly fragmented approach in the health sector.

As captured in the 2009 Independent Review Team report (MOH, 2010), this was reflected in several dynamics in the sector, but mainly through: a) an increasing number of health (related) agencies without effective communication between agencies and without performance based / results based financing; b) a greater complexity/variety in health financing mechanisms; with an increasing tendency to earmarking financial and programme resources for district level; and more emphasis on clinical/ curative care through health insurance financing; and c) a loss of focus in the respective Programmes of Work (POW), moving from a theme- based to an agency- based focus. At the same time, the sector was observed to be constrained by some major inefficiency which included: a) the delays in

funding and in reimbursements; b) the high prices for medicines; and c) the learning by doing process of then national health insurance. Fragmentation was said to be enhanced by a weak MOH having some carrots to improve sector and agency performance but no sticks.

Best practice for continuous improvement and attainment of organizational objectives is generally recognized. To this end the Ghana Health Service has developed a code of conduct and Disciplinary Procedures (GHS, 2003) that are general principles or rules of behaviour in the service. The general principles in the Code of Ethics include the principles of legality, primary responsibility, information, usage, principle of confidentiality and the principle of third party contact. The principles in the development of the Code of Ethics relate primarily to general responsibilities with respect to patients, professional practice, communication, decision making and confidentiality.

The implications of Code of Ethics and the Patient Charter developed in 2003 for compliance by managers and staff of the service include the creation of an enabling environment for health personnel to perform satisfactorily through the provision of basic equipment and support, giving fair access across and opportunity for all health personnel to receive requisite training; periodic assessment of the competence of staff.

They are also to promote transparency in management; check and ensure that all health professionals working in the service are duly registered with the appropriate professional bodies; put in proper systems to manage patient information with confidentiality; making health facilities user or patient friendly; establish reward and incentive systems to boost staff morale; staff discipline and the establishment of complaints system (system for

investigating complaints from the public including patients and provision of humane services and ensuring that staff adhere to the patients' charter and code of ethics. For health care providers, they are required to uphold the dignity of their professions, regular update of their knowledge and skills, education of patients on their rights and responsibilities, respect the rights of patients and other colleagues and treat people with dignity.

The performance, motivation and behaviour of health care providers are also influenced by the professional associations they belong to. Some of the associations have developed their code of ethics to primarily promote acceptable or standard comportment of their members. Some of these are embodied in their constitutions. The opinions and advice of the professional associations had in the past been sought by the MOH/Government on several health policies in the country. For example the opinions of the Ghana Medical Association (GMA), the Ghana Registered Nurses Association (GRNA) and the Association of Health Services Administrators (AHSAG) either as professional associations or through their representatives were sought on the establishment of the Ghana Health Service, formulation of the private health sector policy and the introduction of the National Health Insurance Scheme.

One-Time Premium Payment Policy

Universal health coverage is at the centre stage of current efforts to strengthen health systems and improve the level of distribution of health services (Otterson and Norheim, 2014). Attention on universal health coverage is based on the principles of fairness and equity. It is thought that if universal health coverage cannot be attained immediately, then attempts to make progress fairly and equitably makes sense. The One-Time Premium Payment

Policy (OTPPP) arose out of the need to increase universal coverage under the National Health Insurance Scheme (Asenso-Boadi, 2012). The policy was not made explicitly clear in terms of the modalities i.e who is to pay, how much, the mode of payment and collection and the benefits. However, generally, the policy meant that subscribers would pay only the initial (one-time) premium to enable them access health services without the yearly renewals. The NDC as the main opposition party made it a campaign promise to introduce the policy with the view to eliminating the payment of subsequent premium. When it assumed power in 2009, it was envisaged to finalize and disseminate guidelines prior to the implementation of the policy by the end of 2010 (MOH, 2009). The NDC government again indicated its readiness to 'mainstream' the new policy in 2011 (MOH, 2011).

Nketiah (2011) points out that the policy of one time premium payment has the following advantages: first, cheaper collection of premium payment administrative costs over the lifetime of a policyholder and helps to reduce the costs to the policy. Second, there is better persistency or avoidance of non- payment of premiums that helps the National Health Insurance scheme's operations. Third, earned interest on the invested one-time premiums can be used to defray the cost of running the National Health Insurance Scheme. Fourth, a lifetime relief for the policyholders in that regardless of what happens to medical costs, personal finances and health status in the future one is covered. These are considered in the actuarial policy of one time premium payment product, mainly life insurance and or pay out annuities.

Some critics of the proposal claim that it is just not possible to support the scheme with a onetime premium since the sustainability of the scheme

would not be possible if premiums are not paid yearly. First, only a few people have the money to make one-time payment thus the insurer ends in spreading a lot of resources on a small segment of the population. As in some health insurance policies some people would not like to make a one- time payment, since the money would be lost in case of any early death and more so if there are no refunds of projected unused funds at death.

Secondly, because there may not be any refunds after subscribing to the one time premium, the unused portion of the one- time premium cannot be used to satisfy a more pressing financial need, in case the subscriber's financial circumstances change.

Thirdly, there is some difficulty as how to correctly price an ever changing covered sickness/disease or the Diagnostic Related Groups (DRGs) and days (formulary) (Nketiah, 2011). Fourthly, moral hazards come in when a simple disease such as headache will end at a health facility (Nketiah, 2011).

Achieving universal coverage through the introduction of the proposed one time premium policy in Ghana has generated debate. Abiro and Mcintyre (2013) explored the issue and observed a deep confusion in stakeholders' understanding of the policy issue, uncertainties, impact on equity in access to health care, affordability of the policy, financing sources as well as sustainability.

From the above discussion, the proposed OTPPP has implications for the sustainability of the scheme in terms of financing the scheme, issues of fairness and equity, understanding and capacity to implement the policy. Hence there is a need to explore the views of health providers on the policy.

Theoretical and Conceptual Frameworks

Theories and analyses of health policy have blossomed over the decade and continue to evolve. As Surjadjaja and Mayhew (2011), pointed out numerous models and frameworks elaborating the complexities of the policy processes and the stages starting from Easton's linear and mysterious 'black box' of policy making (Easton, 1965) through diffusion theories (Berry, 2007; Mintrom,1997) and 'advocacy coalitions' (Sabatier, 1999) describing more interactive influences and process, to the contemporary consensus that health policy is a complex series of incremental cycles, feedback loops and influences (Buse, Mays and Walt, 2008; Walt, 2004;; Ogden, Walt and Lush 2003. Walt,1994).

Sabatier (1999) critiques the 'stages heuristic' as a tool to understand public policy processes and presents alternative conceptualizations by contemporary scholars of public policy on how policy is made using the criteria of a scientific theory and on a fair amount of empirical testing. The seven frameworks covered in his classic work are:

First, is the stages heuristic which he builds on to categorize actors, actions and interests in public policy. Second, is institutional rational choice which emphasizes how institutional rules alter the behaviour of assumed rational individuals motivated by material self-interest. Third, the multiple streams framework. This holds that the policy process is composed of three autonomous streams (related to problem, policy and politics).If they converge, a 'window of opportunity' is created that may enable policy change. Fourth, is the punctuated equilibrium framework. This framework argues that policymaking is characterized by long periods of incremental change,

punctuated by brief periods of dramatic change when policy entrepreneurs create new 'policy changes'. Fifth, is the advocacy coalition framework. This understanding of the policy process emphasizes competing advocacy coalitions, each with their characteristic belief system, that operate in particular policy sub systems. Policy change occurs with across coalitions or is externally induced. Sixth, the policy diffusion framework which argues that policy change is a product of specific political systems and a variety of diffusion processes. Finally, the funnel of causality framework and other frame works in large comparative studies.

This set of frameworks attempts to explain variations in policy outcomes across comparative and contrasting political systems and social structures. These frameworks are largely based upon and applied to processes in Europe and in the United States. Four such frameworks, also pertinent to health policy development, were identified by Sabatier (1999) as meeting these parameters. These are the event-driven Multiple Streams Theory empirically developed by Kingdon (Kingdon, 2002); the Punctuated Equilibrium framework by Baumgartner and Jones (Baumgartner & Jones, 1993) in which long periods of policy stability are alternated by general shifts in policy perspectives and ambitions; the Advocacy Coalition Framework (Sabatier and Jenkins-Smith, 1993; Sabatier, 1988) that emphasizes the importance of coalition formation of camps of proponents and opponents to new policy directions; and the Policy Domains approach coming from different perspectives on network governance (e.g. Laumann and Knoke, 1987; Borzel,1998).

Other theoretical frameworks that seem applicable, but not extensively validated empirically, are Social Movement theory e.g. (McCarthy and Zald, 1977) arguing that disenchanted people will join social movements to mobilize resources and political opportunity so policy is changed to serve their interests; neo-corporatism e.g. (Olson, 1986)) advocating that (semi-) political organizations in the social environment can play corporate roles to maximize competitiveness, and a host of hybrid approaches that mix these perspectives or address specific processes such as coalition structuring (Breton, Richard, Gagnon, Jacques and Bergeron, 2008).

The study discusses three theoretical frameworks related to the study. These are the Walt and Gilson policy triangle, the Kingdon's multiple streams and the Hogwood and Gunn perfect policy implementation model. These are discussed in turn.

The Walt and Gilson Policy Triangle

The health policy triangle model of Walt and Gilson consists of four elements that are considered essential in process and implementation of health policies (Buse, 2008). The framework consists of context, actors content and processes. The framework suggests that four broad groups of factors influence policy development and outcomes as reflected in (Figure 3). The context factors that influence the nature of policy making in the country, the actors involved in the policy, the processes through which policies are identified, formulated and implemented and the context of the specific reforms (Rajkotia, 2011). The context refers to systemic factors-political, economic and social which may have an effect on health policy.

Other theoretical frameworks that seem applicable, but not extensively validated empirically, are Social Movement theory e.g. (McCarthy and Zald, 1977) arguing that disenchanted people will join social movements to mobilize resources and political opportunity so policy is changed to serve their interests; neo-corporatism e.g. (Olson, 1986)) advocating that (semi-) political organizations in the social environment can play corporate roles to maximize competitiveness, and a host of hybrid approaches that mix these perspectives or address specific processes such as coalition structuring (Breton, Richard, Gagnon, Jacques and Bergeron, 2008).

The study discusses three theoretical frameworks related to the study. These are the Walt and Gilson policy triangle, the Kingdon's multiple streams and the Hogwood and Gunn perfect policy implementation model. These are discussed in turn.

The Walt and Gilson Policy Triangle

The health policy triangle model of Walt and Gilson consists of four elements that are considered essential in process and implementation of health policies (Buse, 2008). The framework consists of context, actors content and processes. The framework suggests that four broad groups of factors influence policy development and outcomes as reflected in (Figure 3). The context factors that influence the nature of policy making in the country, the actors involved in the policy, the processes through which policies are identified, formulated and implemented and the context of the specific reforms (Rajkotia, 2011). The context refers to systemic factors-political, economic and social which may have an effect on health policy.

Actors are individuals, groups (interest or civil society groups) or even an organization or institutions. Processes involve the various stages in policy making. Process refers to the way policies are initiated, developed or formulated, negotiated, communicated, executed and evaluated (Walt & Gilson, 1994). Content embraces the policy objectives, outputs, outcomes, and values/philosophy. Walt and Gilson (1994) have argued that much health policy focuses attention on the content of policy reform and neglects the actors involved in policy reform, the processes contingent on developing and implementing change and the context within which the policy is developed.

Within the health field it has become a popular approach to examining policy is to utilize the 'policy triangle' - an elegant and simple tool which has been used extensively in low and middle income countries and identifies the content of policy, contextual factors, processes and actors as all deserving of attention. Walt and Gilson suggested that these factors are intertwined and need to be systematically considered to achieve a holistic understanding.

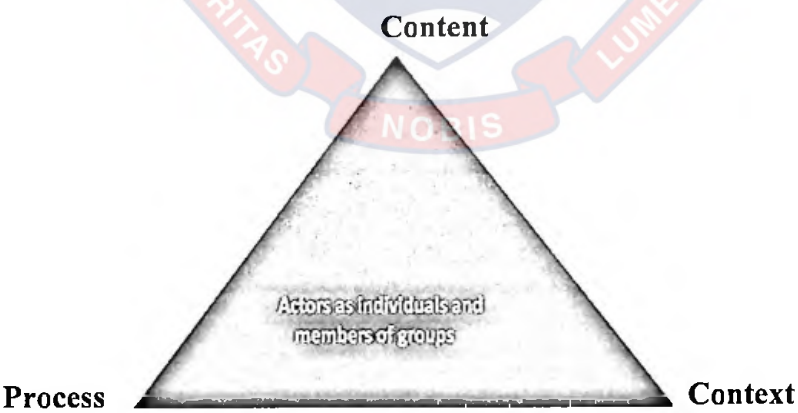

Figure 3: Walt and Gilson Policy Triangle

Source: Walt and Gilson (1994)

The strength of the model is that it deals with the contextual, institutional arrangements, changing circumstances and conflicting values and interests that influence the policy making process. It recognizes power and politics as major factors in policy making and implementation and provides explanations to policy failures. The model of Walt and Gilson (1994) does not reject nor fully support either of the traditional approaches (rationalism and behaviourism). It juxtaposes both the approaches and incorporates their views by arguing the importance of policy content, context, and process.

Furthermore, this model argues to include the role of actors (or interest groups) in analyzing policies. The model has been applied in both developing and developed countries and used to analyze the mental health, tuberculosis, reproductive health and health reforms. For example Green, Gerein, Mirzoev, Bird, Pearson, et al. (2011); Columbini, Ali, Watts and Mayhew (2011) employ the components to examine existing policies and guiding documents on vaccinations in Malaysia. Addai, Addico, Ajayi Askew, Birungi, Jehu-Appiah and Nyarko (2006) used the same framework to investigate priority setting for reproductive health at the district level in the context of health sector reforms in Ghana.

The role of actors in the development of the community health insurance scheme in South Africa was also explored by Thomas and Gilson (2004), using the same framework. The study reviewed the process of actor engagement and management of the policy and focused on the role of actors in sustaining the scheme. Sanneving, Kulane, Iyer and Ahgren (2013) used the framework to examine maternal health policy implementation in the state of Gujarat, India. The study used in-depth interviews and qualitative content

analysis to explore the perceptions of high level stakeholders on the process of implementing maternal health interventions.

The study identified lack of continuity, the complexity of coordination and lack of confidence and underutilization of the monitoring system. The findings suggested that weak coordination and monitoring systems can challenge policy implementation.

The model, however, is considered to be simplistic in approach as it fails to explain the relationship among or association or how the various components affect each other in implementation of policy (Buse, 2008). The policy triangle fails to capture the relationships amongst the actors, context and process. It gives the impression that the four factors can be considered separately. Second, it does not offer readily testable propositions and there is no separation in the policy making process. In practice, however, actors may be influenced as individuals and members of groups and organizations by the context within which they work and context is affected by many factors such as instability and ideological orientation, by culture and the process of policy making. In addition, implementation is not focused as a complex subject in policy making and finally space and time can affect policy outcomes (Buse, 2008).

In spite of the above limitations, it is considered to be one of the most appropriate frameworks for the study in terms of its use, relevance and comprehensiveness in looking at the whole process of initiation, development, formulation and implementation of the National Health Insurance Scheme in Ghana.

Kingdon's Multiple Streams

Kingdon's model involves agenda setting, the implementation frameworks, and the role that different individuals play in policy implementation, and particularly the role health providers play in setting the agenda, implementation and sustainability of a policy (Kingdon, 2002). According to Kingdon (2002), the policy process moves through a number of distinct phases but not in an orderly way.

Kingdon (2002) argued that decision making consists of the coordination of three relatively independent "streams," namely: problems, politics, and policies. This theory considers three streams of agenda building, i.e. the problem stream, a political stream and a policy stream where each stream has its own typical process rather independent from each other.

The multiple streams model views the policy process as consisting of three streams of actors and processes: The problem stream represents the series of conditions requiring public attention. This stream consists of evidence about various problems and the proponents of various problem definitions. In the problem stream, the process is characterized by problem recognition. Various factors focus the attention on a problem or issue of concern and its importance. For example realizations of lack of access to health care among the large segment of the population.

The second stream described as the policy stream involves policy recommendations and proponents of various solutions to policy problems. It includes the presentation of ideas and the development of alternatives. The policy stream represents the series of concrete policy proposals that may address actual or potential problems. Problems and policies are both identified

and championed by participants in the system. It involves the various options and strategies aimed at addressing the problems and issues related to lack of access or barriers to health care. Proposals are selected on the basis of criteria like feasibility, harmonization with dominant norms and susceptibility of politicians.

The third stream is the politics stream which consists of elections and decision-makers where various problems compete for attention. The politics stream then represents the general policy environment and decision opportunities (Sabatier, 2007). In the political stream the process is determined by fluctuations in politics through the influence by people, political parties and ideologies of politicians that can either include or exclude certain issues from the agenda.

For governance assessments it therefore becomes important to link the governance assessment's definitions of governance problems with issues already raised, such as key policy issues. Second, there is the need to provide understanding of the existence, magnitude and depth of governance problems in the problem stream. Third, link the definition of a problem with solutions in the policy stream. In most cases many policy initiatives already exist, and it is important to link with the proponents that support similar policy recommendations to that of the governance assessment. In cases where Government commissions governance assessments as part of reform initiatives, they may nevertheless be important to make these links: assessment conclusions may not correspond with the preferred policy solutions of the entity that commissioned the research.

Fourth, link definitions and solutions with the politics stream. This may include linking to the national mood in a country. The notion of 'national mood 'refers to that a fairly large number of individuals in a given country tend to think along common lines, and that the mood swings from perception that the country's development is hindered by high levels of corruption. Linking to the politics stream may also include linking to pressure group campaigns, in this case, anti-corruption campaigns.

Similarly, the inability of a large proportion of the population to pay for health services and thus making access to quality health care a problem for many in the country and the need to come out with innovative health financing methods to address the problem. time to time. For example, the 'national mood' may be the strength of this model lies in its relation or closeness to reality. In practice, several policies are formulated in response to events such as disasters and in response to felt and imagined needs of the people. Policy makers and politicians take advantage of such events to make electoral promises and secure votes and formulate policies to satisfy the aspirations of the people when in power.

The usefulness of this model hinges on the need for stakeholder participation in policy making and their role in implementation. It gives prominence to the role of the policy elite and highlights the irrationalities of the decision making process Zahariadis (2007), however, described the model as ambiguous. In reality there is separation in the policy making process. The framework cannot be applied mechanistically as different political and geographical variations exist across countries.

Hogwood and Gunn Perfect Implementation Model

The Hogwood and Gunn (1984) model focuses on ways in which organizations and inter organizational phenomena would tend to transform policy. It looks at the factors which will tend to undermine "perfect" implementation and provides a series of prescriptions to policy makers to assist them prevent this occurrence. It is in consonance with the 'top down approach' to implementation referred to by some analysts as legislate first; worry about implementation later (Smithson, Asamoah-Baah and Mills, 1997).The model indicates that there is no sharp divide between formulating policy and implementing that policy, arguing that what happens at the implementation stage will influence the actual policy outcome.

They identified three categories of policy implementation failure as non-implementation, that is a policy is simply not put into effect as intended because of lack of cooperation, obstacles and inefficiency; unsuccessful implementation where policy is carried out in full but policy fails to produce the intended outcomes/effect provide reasons for policy failure or barriers to policy implementation as bad execution, bad policy or bad luck, on co-operation or ineffectiveness of those implementing the policy which result in implementation gap between policy and its effective implementation partly because implementation is the responsibility of local and lower public agencies who may often do not have sufficient resources, with less capacity.

They give the following checklist of conditions which may make perfect implementation unattainable: there may be external constraints, inadequate time and resources, policy implementation may not be based on a valid theory of cause and effect, relationship between cause and effect,

inappropriate resource combination, there may be relationship between cause and effect direct, minimal dependency relationship, there may be lack of understanding and agreement on objectives, lack of coordination and communication and inadequate compliance with authority.

The model as suggested by Hogwood and Gunn is intended to be the ideal type construct but makes assumptions about the conditions conducive to successful implementation. The model is useful in highlighting implementation in the process as very crucial in the attainment of policy objectives. By examining some of the criteria, we can understand the problems that implementation often encounters in practice. The model helps to focus on the conditions and problems which are amenable to solution. It offers an excellent framework or yardstick against which actual implementation process can be measured.

The limitation of the model is that it fails to indicate the weight of each of the conditions to affect implementation. It is unclear whether all the conditions should be present to ensure successful implementation or not. It is criticized on grounds that it fails to interpret the implementation gap.

Principal-Agent Theory

The principal-agent theory is a strand of institutional economics that focuses on the problems dealing with the production and delivery of public goods and services (Miller, 1992; Binger and Hoffman, 1988; Williamson, 1985; Arrow, 1971). The theory focuses on the problems that superiors have in monitoring the behaviour of their subordinates and in creating incentives for the behaviour of subordinates (Gruening, 2001).

According to Jensen (2003), an agency relationship as a contract is where one party, "the principal" engages another "the agent" to perform some service on their behalf that involves delegating some decision making authority to the agents. Turner and Muller (2004), Jensen (2003), Bairney and Hesterly (1996) and Moe (1995) have argued that if the objective of both parties is to maximize their economic interest, then there is good reason to believe that the agent may not always act in the best interest of the principal. Thus, the principal agent theory is employed to explain the potential for conflict of interest that may arise between parties, given that people will not act in the interest of others (i.e. their principals or partners)

In health care delivery, health care providers, for example doctors, could be considered as agents of patients who are the principals. Holland, Goodman and Stano (2010) point out that in the physician-patient relationship, the patient (principal) delegate's authority to the physician (agent) who in many cases also will be the provider of the recommended services. The motive behind this delegation of authority is that the principals recognize that they are relatively uninformed about the most appropriate decisions to be made and that the deficiency is best resolved by having an informed agent. Thus asymmetric information and agency are closely related phenomena. This relationship is significant where health insurance is the financing method. The theory is also important in the area of policy making where managers as agents at the national and regional levels formulate policies.

According to observers the first problematic issue arises from the principle of delegation of decision making. With three ramifications: (i) the interest of principal and agent typically diverge if both are utility maximizes;

(ii) The principal cannot perfectly and costless monitor the actions of the agent and (iii) the principal cannot perfectly monitor and acquire the information available to or possessed by the agent (Jenson, 2000; Barney and Hesterly, 1996).

To minimize the conflict of interests between the parties, principal-agent theorists have suggested the creation of organizational structures (Jenson, 2000). However, that is not without its inherent costs. In project management implementation process, Jensen (2000) discovered four agency costs associated with those 'structures and 'incentives' (i) the costs of creating and structuring contracts between the client and the project manager; (ii)the monitoring of expenditures by the principal; (iii) the bonding of expenditures by the agent; and (iv) a residual loss arising because the manager's decisions not to optimize the project's outcomes for the client either because the manager is behaving opportunistically, or because they do not understand the owner's requirements. A typical principal-agency relationships in health care among patients, health care providers and insurers is illustrated in (Figure 4).

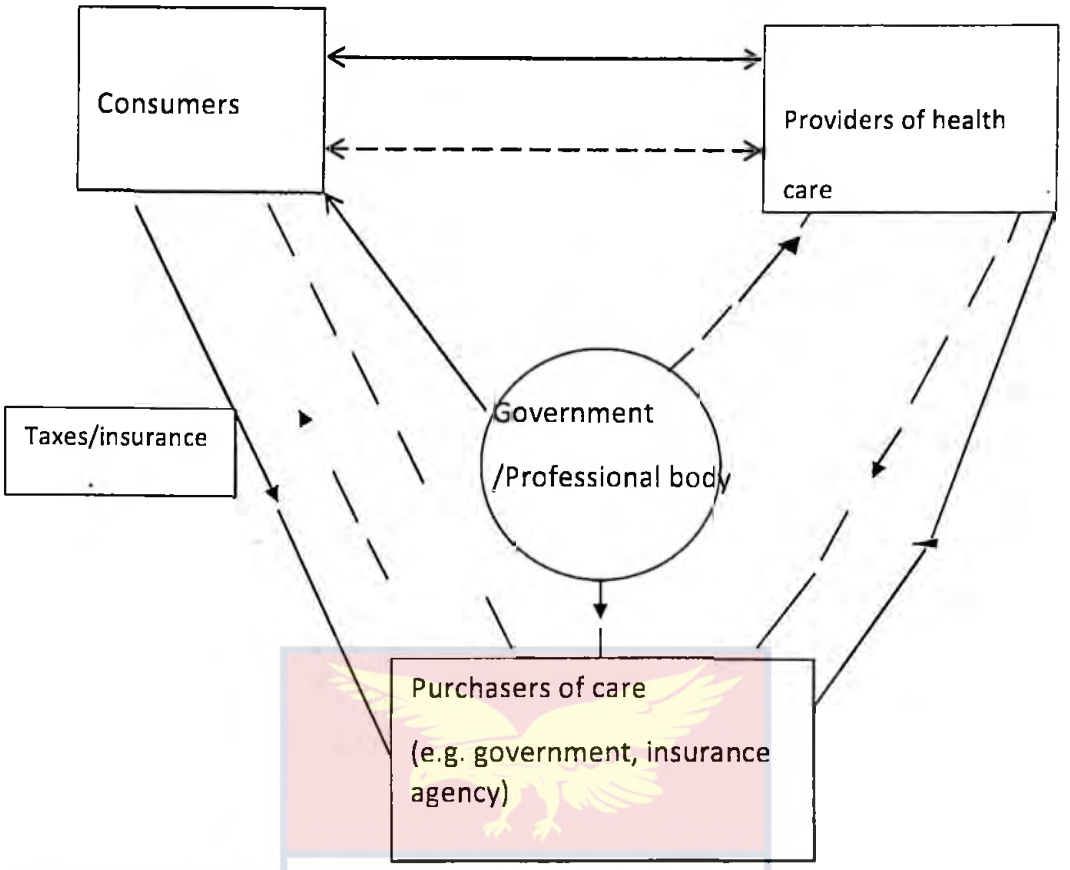

Figure 4: Principal -agent theory

Source: Schieber and Maeda (1997)

The issues raise some kind of tension between the agent and the principal thus resulting in two problems (Moe, 1995). The first of the two problems is 'the adverse selection problem' – where, on projects, for example, the manager as agent knows more about it than the owner as principal. Hence the latter cannot be totally certain about why the former makes the decisions, and whether the right choices are made on behalf of the principal. The second issue of concern is the 'moral hazard problem'- where the personal interest of the manager as agent arises. Hence the manager may do what is best for the owner only if their interests are aligned through contracts designed in a manner that the actions regarded as most appropriate by the principal yield the highest payoff for the agent (Hongoro, 2001; Turner and Muller, 2004; Bergen, 1992; Lane, 1995). Williamson (1985) also

identified some of the typical principal–agent challenges such as behaviour opportunism and information asymmetry which also plague the relationship between politicians on one hand and public employees of various kinds on the other (Lane, 1995). Like all concepts operated in the social spheres, agency theory has its proponents and critics. Barney and Hesterly (2001) have observed the inherent 'investor view only' of agency theory which assumes that humans are principally motivated by financial gains. The public–choice school questions the idea of 'public interest' as the foundation for the principal-agent relationship in the public sector (Buchanan, 1975). Their concern arises out of the egoistic behaviour by special interests groups and institutional failures (Widavasky, 1985; Larkey, Stolp and Winer, 1981) as well as more or less narrow collective interests (Olson, 1982). Walsh (1995) argues that this may be the case because agents also need to be confident that they will not be exploited by the principals. For example by non–fulfillment of their obligations or by the claim that poor work has been done when evaluation is ambiguous (Larbi, 1998).

However, in the context of project/programme management, Turner and Muller (2004) have suggested how some kind of balance can be struck in the four identifiable ways project managers as agents are controlled in their work; (i) self-controlled through the degree of altruistic behaviour of the agent; (ii) Professional control through their codes of ethics, behaviour and professional standards; (iii) Control through the agent's firm, their employer and (iv) Control through the formal and informal efforts by the principal or client to overcome the information asymmetry.

Critical to the functioning of this framework is the effort by the

principal to monitor the agent. In other words, the agents' performance of their tasks will depend partly on the capacity of the principal to monitor and enable agents. The principal- agent theory can be applied to sustainability of health policy of the agent' and the 'principals'.

Guiding Framework for the Study

Sustainability of the insurance scheme will, to a very large extent, depend on the behaviour, competences and attitudes of health care providers and how successful it is implemented. Based on this premise, the study sought to explore the experiences and opinions on the degree of involvement of health care providers in the formulation of the insurance scheme.

The main frameworks which guided the study were the Walt and Gilson policy triangle (1994), the Kingdon multiple streams theory (Kingdon, 2002) and the Hogwood and Gunn perfect implementation model. The Walt &Gilson policy triangle was used when designing the interview guide. Following the model, open ended and probing questions were asked in relation to the *content* of the National Health Insurance Scheme, the *context* in which the scheme was formulated, designed and being implemented, the *actors* involved in the processes of formulation, accreditation and implementation and the structures of the *process*. With regard to the *multiple streams theory*, the literature review sought to give a background to health financing and health policy formulation and the establishment of health insurance in the country.

Lastly, the interview guide was designed to allow the respondents to express their views on role of health care providers and the challenges in the implementation of the NHIS in relation to the Hogwood and Gunn model on

implementation.

The elements in the guiding framework were the factors influencing the sustainability of the scheme, and the role of health care providers in the design, formulation, implementation and sustainability of the scheme. Incorporated in the guiding framework were the involvement of health care providers in the formulation and design processes of the NHIS, and the facility accreditation process, structure, management and organization of the NHIS, funding of the NHIS, the benefit package; and incentives and regulatory mechanisms and the effects of the implementation on the sustainability of the NHIS. It also embodied the accreditation process in relation to the purpose, frequency, involvement of providers, efficiency quality of care and equity; funding specifically the sources, adequacy, efficiency in collection and equity; the structure, organization and management of the scheme, the legal framework, the administrative structures, efficiency, capacity and calibre of insurance scheme staff, relationship among the main actors, reimbursement mechanisms; regulation and motivation of health providers (licensing, registration, ethical mechanisms, provider payment mechanisms, and provider incentive schemes) and the benefit package (disease conditions, range of services and medicines covered, exclusions, cost and equity). In general the study assessed how the factors combined to influence the sustainability of the scheme.

These together sought to explain and further help to understand the influence of power in the design of the scheme, the role of health care providers as actors; context within which the scheme was introduced,

formulated and the implementation and sustainability of the scheme. These factors informed the design of the in-depth interview guide.

Conclusion

This chapter has provided and discussed the picture of the existing body of knowledge on the various theoretical and empirical concepts of and approaches to health policy in both developing and developed countries, the challenges in policy implementation and the policy/programme sustainability nexus. It has attempted to conceptualize and describe policy and the policy process and sustainability and how they relate to the NHIS.A number of policy frameworks and models have been examined. Put together the various elements and variable help to assess the effect or otherwise of the scheme and offer some lessons for the sustainability of scheme it is informed the development of the interview guide

CHAPTER THREE

OVERVIEW OF HEALTH POLICY PLANNING AND FINANCING IN GHANA

Behind every quantity there must lie a quality- Selznick (Undated)

Introduction

The health of Ghanaians has been improving since independence. Infant mortality rate (IMR) fell from 133 deaths per 1, 000 live births in 1957 to 57 deaths per 1,000 live births in 1988, and under-five mortality rate (U5 MR) has decreased from 154 deaths per 1,000 live births in 1957 to 110 deaths per 1,000 live births in 2008 (MOH, 2011; GSS, 2008)). Although improvement has occurred, the rate of change appears to be slow due to factors such as ignorance, cultural beliefs, attitude to health care, limited financial access to health care and inadequate health professionals. The primary causes of preventable deaths in children below five years are malaria, malnutrition, diarrhoea and acute respiratory infections (ARIs) (MOH, 2010).

This chapter provides a context for health policy, planning and financing in Ghana and deals within an overview of the health situation, key health policies and programmes, the structure and organization of the health sector, financing and the progress made to date with the National Health Insurance Scheme (NHIS).

The Health System in Ghana

The development of the health system under the colonial rule dates back to 1491 with European explorers who initially were concerned with mainly curative care for the colonial administrators and later on extended to

the few Africans in the colonial administration (Hansen and Ninson, 1989) The main aim of the medical service was to safeguard the health of European residents through diagnosis and treatment and through their physical separation from the local population. As captured by Simpson (1909, p13) the policy was to provide European quarters in order that the risk of malaria infection from the insanitary conditions of native houses and from infected natives may be reduced.

This policy which was intended to provide health services for the local population was further supported with the provision of pipe borne water, a few other sanitary facilities and the building of urban general and specialized hospitals in the areas and rural dispensaries such as Cape Coast and Tarkwa. The Gold Coast Medical Department now the Ministry of Health was established in 1951 (Hansen and Ninson, 1989).

The period between 1901 and 1957 saw the consolidation and expansion of the colonial health service when efforts were made to extend health services to the middle and northern parts of the country. The 1920s saw the development of basic infrastructural facilities such as roads, harbours, rail network, markets, piped water, descent housing, schools and health centres across the length and breadth of the colony. Under Governor Guggisberg, the highest point of public health delivery was reached with the building of Korle Bu Hospital in 1923. This hospital was meant for Africans and for research into tropical diseases (Hansen and Ninson, 1989).

Successive governments collaborated with missionary institutions such as the Catholic, Methodist and the Presbyterian Churches, the para-government institutions such as the military, police, and a few private

individuals and the mining companies to provide health services (Hanson and Ninson, 1989) during the period between and services were oriented more toward curative care than preventive care.

Following the attainment of internal self-rule in 1951, a ten–year Development plan was launched in that same year. The plan proposed an expenditure of 120 million pounds sterling of which social services (education, health, housing and social welfare) were to take up about 33 per cent. As part of the process, the Ministry of Health was created and a commission was appointed to examine the colony's health system. The commission recommended, among other things, that all public hospitals and health centres be placed under the control of the new ministry; that hospitals fees be abolished and that urban and district councils be made responsible for sanitation. The recommendations had a significant influence on the health policies of the nationalist government after independence particularly. By 1957, when Ghana became independent, the health system had developed certain features. Among them were (Hansen and Ninson, 1989)

- a strong curative and urban bias
- a centralized medical administration
- central government as the largest provider of health services
- subordination of traditional healing systems to bio-medicine
- spatial disparities: rural-urban and north–south

Between 1960 and 1966 about 35 rural health centres and nine rural health posts were established and manned by health centre superintendents, community health nurses and medical auxiliary staff. Traditional medicine practice was encouraged in line with the African personality concept with the

formation of the Ghana Psychic and Traditional Healers Association in 1963.Following the prevailing economic challenges in the country at the time the public health system started deteriorating. Essential medical supplies became scarce and brought discontentment among health personnel (Hansen and Ninson, 1989).

In 1966, following the overthrow of Nkrumah's government, attempts were made to reverse the policy of active state financing of health care by the two immediate successive governments: National Liberation Council (1966-1969) and the Busia Government (1969-1972). Various committees of enquiry such as the Easmon Committee (1969) and later the Konotey-Ahulu Committee (1970) recommended increases in the fees paid at the public health facilities. The policy sought to introduce fees at the public hospitals. This resulted in some public agitations against the increases and led to the suspension of the NLC Decree 360 which mandated the increments.

The period under the National Redemption Council/Supreme Military Council (1972-1979) and the Provisional National Defence Committee (PNDC) junta saw the global health revolution with the promotion of primary health care. Emphasis shifted from curative to preventive and basic health care. In 1985, hospitals fees were increased in the public health facilities.

In 1996, Ghana developed Vision 2020, a long – term vision for growth and development that would move it from a low income to middle income country by 2020. The priority areas identified in the document were (NDPC, 1997)

- Maximizing the healthy and productive lives of Ghanaians
- Ensuring fair distribution of the benefits of development

- Attaining a national economic growth rate of 8 per cent per annum
- Reducing the population growth rate from 3 per cent to 2.75 per cent
- Promoting science and improving technology as tools for growth and development.

Based on the Vision, the MOH developed a Medium– term Health Strategy (MTHS) and a five–year programme of work (1997-2001) to guide health development in Ghana from 1997 to 2001. The programme of work was to achieve the following:

1. Increase geographical and financial access to basic services.
2. Provide better quality of care in all facilities and during outreaches
3. Improve efficiency in the health sector
4. Ensure closer collaboration and partnership between the health sector and communities, other sectors, and private providers both allopathic and traditional
5. Increase overall resources in the health sector, equitably and efficiently distributed.

Its mission statement, which summarized the overall direction of the health sector, is as follows:

> *"As one of the critical sectors in the growth and development of the Ghanaian economy, the mission of the health Ministries, Department and Agencies is to improve the health status of all people living in Ghana through the development and promotion of proactive policies for good health and longevity; the provision of universal access to basic health services, and provision of quality health services which are affordable and accessible. These services will be delivered in*

humane, efficient, and effective manner by well-trained friendly, highly motivated, and client oriented personnel" (MOH, 2003).

Up to the beginning of the 1990s the approach whereby the MOH developed its own policies, implemented and regulated, evaluated its own performance, and developed the human resources needed to run the health service (MOH, 2004) was deemed inefficient. As a result, part, there was a decision to decentralize roles and responsibilities to different agencies as part of institutional reforms. Out of that decision, Act 525 of 1996 was passed to establish the Ghana Health Service (GHS) as the implementing body for public sector health services. Through that, service delivery was hired for the Service, and the policy, regulatory components, resource mobilization, monitoring and evaluation and administrative support for the Minister remained with the MOH. Thus, the Ghana Health Service was established in 2003.The Act also paved the way for the strengthening of regulatory bodies, such as the Food and Drugs Authority, the Nurses and Midwives' Council, the Medical and Dental Council, the Traditional Medicine Board, the Funeral Homes Board, and the Private and Maternity Homes Board.

Under the Act, the health sector comprises the Ministry of Health and seventeen (17) agencies dealing with service delivery as well as various statutory and regulatory agencies. Three major government institutions define the public sector namely (1) the Ministry of Health (policymaking), the Ghana Health Service (GHS) and (3) the teaching hospitals (service delivery). The MOH is responsible for sector- wide policy formulation and monitoring and evaluation of progress in achieving its targets (Markinen, Sealy, Adjei and

Murioz, 2011). The Ministry provides various types of support to the Teaching Hospitals, Statutory Bodies and the Ghana Health Service.

The Ghana Health Service was set up as part of the Health Sector Reforms by the Ghana Health Service and Teaching Hospitals Act 525 of 1996.It is directly responsible for health care delivery in the country as it facilitates planning and management of a decentralized system at the national, regional and district levels with the district having a sub district level which includes community health delivery (MOH, 2011). As part of the decentralized health sector the District Directors have oversight responsibility for private health care providers operating in their respective districts. The operations of the GHS are supervised by a Council that reports to the Minister of Health.

At the tertiary level are the teaching hospitals responsible for service delivery, teaching and research. There are four national referral hospitals with the mandate to provide advanced clinical health services to support the health services provided by the Ghana Health Service, educate and train undergraduate and postgraduate students in the medical profession, conduct research into health issues for the purpose of improving the health conditions of people in the country, carry out specialist outreach programmes and ensure good governance and financial management. Under Act 525 of 1996, the Teaching Hospitals Boards were set up to oversee the administration of the hospitals.

Access, quality and coverage of health information, preventive care, clinical care and emergency services are all important aspects of health delivery. To improve access to health care, the National Health Insurance Act

650 (2003) and LI 1809 (2004) was passed. The aim is to assure equitable and universal access for all residents of Ghana to an acceptable quality package of essential health care services without out of pocket payment being required at the point of use (MOH, 2003).

Health Financing in Ghana

Health financing in Ghana has a long history. Financing of health care in Ghana has gone from free health care, with total cost borne by government, to the present era of a combination of health insurance and direct out–of-pocket payments. In the colonial era, curative services in Ghana were on fee paying basis. A combination of free medical attention and treatment and payment was the practice depending on one's occupation and income. The policy dated back to the 1880s. Chapter VI of the General Orders of the Gold Coast Colony (31st December 1907) contained the following provisions:

"Public officers when ill were entitled to the gratuitous attendance of a Medical Officer. The wives and families of all officials whose salaries did not exceed 300 Ghana pounds per annum are entitled to receive medical attendance free. Officers with salaries above that amount were required to pay for medical attendance on any member of their family other than themselves" (Government of Ghana, 1970, pp.24). A scale of charges for government hospitals, lunatic asylums and dispensaries throughout the country was developed. This specified rates payable by persons not in government service, for government officers in respect of European wards, Native wards and Lunatic Asylums, and Dispensaries. (Government of Ghana, 1970).

This was the situation up to the mid-sixties under the National Liberation Committee regime which set up the Easmon Committee (1968).The Committee recommended increases in hospital fees charged at public health facilities.

In 1969, the Government appointed a committee chaired by Dr. Konotey-Ahulu to examine the payment of fees at public health institutions. Following recommendations from the Committee, hospital fees were introduced by Act 387 of 1971. Though the rationale for instituting the policy was to recover cost, one of the recommendations of the Committee was the introduction of National Health Insurance Scheme in the country. The position of Committee of Enquiry on the introduction of National Health Scheme at the time was captured as follows:

> *The place of a National Health Scheme in a developing country was discussed. We think it is premature, but suggestions are given for limited pilot health security schemes which may be gradually extended over the years* (GOG, 1971p viii).

The implication of that probably informed the commendation for the establishment of health insurance scheme the revised population policy of Ghana of 1994 and the need for pilot schemes in the country the objectives of the population policy were to address some of the challenges in access to quality health care.

In 1985, the fees were increased substantially with the enactment of Legislative Instrument 1313. Full cost recovery started with drugs under what was referred to as the "cash and carry" system. This formed part of the economic recovery and health sector reform programme. The 1985 policy was

intended to generate at least 15 percent of the recurrent expenditures in 1986, 1987 and 1988. (Vogel, 1991). The policy stipulated that;

- Patients pay fully for drugs, except in the case of specified communicable diseases such as tuberculosis, leprosy, meningitis, chicken pox, cholera, and measles.
- Charges be varied according to the level of health facilities used;
- There should be differential charges for adults and children, Ghanaians and non-Ghanaians (L.I, 1313).

In 1986, guidelines were issued by the Ministry of Health as to the revenue retention for part of the fees collected based on the level of health facility. The charges reflected the full cost of drugs without charges for the services of medical personnel as well as the use of equipment and facilities. The increased fees were meant to be used to revamp the health sector that had reached a very low point by 1983 (MOH, 2013).

Though there were improvements in equipment and drug supply after the introduction of fees (Vogel, 1990; 1988) led to a decrease in attendance at public health facilities by a third (Waddington & Enyimayew, 1989). For example, at the Cape Coast Central Hospital the annual outpatient attendance dropped from 84,000 in 1979 to 28,000 in 1985 reflecting the general situation in the health sector.

An exemption policy was introduced in 1986 to assist the poor. The policy was not effective for several reasons including inefficient emergency services, difficulties in identifying the poor, fraudulent practices, and insufficient education on the policy (MOH, 2003). The policy was also not discriminatory enough, difficult to operate and expensive and resulted in

challenges in implementation. This led to attempts to find a more sustainable and humane way of financing health care in Ghana.

Historical Context and Processes of Development of the National Health Insurance Scheme in Ghana

The idea of introducing health insurance in the country dates back to the 1971 with the establishment of the Konatey-Aholu Committee (1969). The Committee did not favour the introduction of the establishment of full implementation of health insurance scheme in the country but recommended a piloting of the scheme in the first instance. Realizing the benefits of the health insurance scheme and as policy measure to improve the health of Ghanaians, it was incorporated in the revised 1994 Population policy (Government of Ghana, 1994).

The first Community Health Insurance (CHI) scheme in Ghana was the Nkoranza Health Insurance Scheme started by the St Theresa's Catholic Mission Hospital in 1992. It initially covered outpatient services and was hospital based (Blanchet, Fink and Osei–Akoto, 2012; Asenso and Wahab, 2012). Though it faced challenges in its implementation, the scheme survived with the support of local and foreign collaborators and the enthusiasm of the management of the hospital.

In 1992, a unit was created in the Ministry of Health (MOH) to establish a National Health Insurance (NHI) as an alternative to 'cash and carry system'. The unit undertook the possibility of establishing a Social Health Insurance (SHI) scheme for the formal sector and organized groups such as cocoa farmers in the Eastern and Western regions. By 1999, the

proposed SHI pilot had not materialized (Agyepong and Adjei, 2008; Osei, Akazili and Asenah, 2007).

The failure have been attributed to lack of leadership, consensus and direction in the MOH as to the way forward, the failure to sufficiently appreciate the difficulties of implementing centralized SHI in a low- income developing country and to carefully listen to the relatively low key dissenting and warning voices that suggested the approach might face difficulties.

Following the failure of the pilot in the Eastern Region, the Social Security and National Insurance Trust (SSNIT) planned for a centralized health insurance scheme to be run by a company called the Ghana Health Insurance Company. Like the pilot in the Eastern Region, it did not succeed. In 1993, the United Nations International Children's Fund (UNICEF) funded an exploratory research on the feasibility of a District -Wide Community Health Insurance (CHI) for the non- formal sector in the Dangme West. The study showed enthusiasm among community members for the concept of the CHI.

After the study, there was an attempt to implement a Community Health Insurance (CMI) in the Dangme West district. For the pilot, the MOH was to finance the design and implementation of the scheme and the European Union (EC) to monitor and evaluate the process. Other actors involved were the District Assembly, the District Health Directorate, the Research Centre and the local communities.

However, the MOH financing was not made available and therefore the EU grant for evaluation was not renewed after the initial installment. Despite the central setbacks, the district health directorate and research centre,

the district assembly (Local Government) and communities continued their collaboration and completed the design of the pilot district CHI scheme. The Dangme District Assembly contributed part of its UNDP poverty reduction fund to support community mobilization and household register development and the World Health Organization (WHO), and Danish International Development Agency (DANIDA) provided start-up funding. Registration of beneficiaries and delivery of benefits started in October 2000. The Ghana Health Service (GHS) and MOH provided financing to continue the implementation and evaluation.

Later on other CHI schemes, popularly called Mutual Health Organizations (MHOs), were established taking diverse forms. The rate of their development accelerated after 2001 following the political and official support. Development partners such as the DANIDA, the Department for International Development (DFID) and PHR-plus, and the United States Agency for International Development (USAID) supported the establishment of the MHIOs. The mission hospitals under the Christian Health Association of Ghana (CHAG) and the various Regional and District Health Directorates were involved in the development of the MHIOs through technical support such as the development of a training manual for administrators and governing bodies and capacity building both in –country and outside the country. For instance the Catholic Diocese of Sunyani initiated a health facility- based health insurance at St Theresa's Hospital, Nkoranza in the Brong Ahafo Region. The Society of Private Medical Practioners, Ghana, also established the first mutual health insurance; the Nationwide Mutual Medical Insurance Scheme in 1993 (Seddoh and Akor, 2012).

When a new government took over in January 2001, a seven- member ministerial health financing task force with membership drawn from the MOH, Ghana Health Service (GHS), Dangme West District Health Directorate and Research Centre and the Trades Union Congress was set up. The Task Force was to support and advise the MOH on the development of a national health insurance scheme, the building of systems and capacity for regulation of health insurance, the development of appropriate Health Insurance Legislation, and the mobilization of extra resources to support national health insurance.

Ghana took the decision to access the Highly Indebted Poor Country (HIPC) Initiative in March 2001 and reached decision point in February 2002 and completion point in July 2004. Under the Initiative, the MOH allocated HIPC funds to support the creation of government sponsored MHOs in all districts where they did not already exist.

Following the implementation and the activities of the Task Force, a draft national insurance health insurance bill was developed in 2002. The general public was invited through public advertisements to submit comments on the bill before Parliament after series of stakeholder meetings. Organized labour, comprising the Civil Servants Association (CSA) and allied groups such as the Ghana National Association of Teachers (GNAT), Ghana Registered Nurses Association, Judicial Service Workers Union and the Trades Union Congress (TUC) showed interest in the NHIS. The CSA in the Ashanti Region converted its civil servants medical refund scheme into MHIO and the Association in Accra and other places had started planning and organizing for similar purposes.

A National Health Insurance Scheme (NHIS) was eventually established under Act 650 of 2003. Sources of funding for the scheme were to be proceeds from the HIPC initiative, sector budget support, 2.5% Social Security National Insurance Trust deductions from workers in the formal sector, 2.5% National Health Insurance Levy (NHIL), insurance premiums by subscribers and returns from investment (MOH, 2003).

A National Health Insurance Council (NHIC) was established to govern the NHIS and supervise the National Health Insurance Authority, the National Health Insurance Fund and the District Health Mutual Organizations. The object of the Council was "to ensure the implementation of a national health insurance scheme that ensures access to basic health care services to all residents" (MOH, 2003 pp2-4). Its responsibilities included registration, licensing and regulation of health insurance schemes, and supervision of their operations. It was also responsible for granting accreditation to health providers, monitoring their performances and ensuring that health care services rendered to beneficiaries were of high quality. A chief executive officer and supporting secretariat were to support the NHIC in the execution of its functions (MOH, 2003).

In 2012, the Act was repealed and replaced by a new law (Act 852).The object of the Authority under Act 852 is to attain universal health insurance coverage in relation to persons resident in Ghana, and non-residents visiting Ghana and to provide access to healthcare services to persons covered by the Scheme. Section 39 of Act 852 establishes the National Health Insurance Fund (NHIF) and gives responsibility of its management to the Board. The object of the Fund is to provide finance to subsidize the cost of

provision of healthcare services to members of the National Health Insurance Scheme.

For the purpose of implementing the object of the Fund, section 40 (2) of Act 852 stipulates that the monies from the Fund shall be expended as follows: to pay for the healthcare costs of members of the National Health Insurance Scheme; to pay for approved administrative expenses in relation to the running of the National Health Insurance Scheme; to facilitate the provision of or access to healthcare services; and to invest in any other facilitating programmes to promote access to health services as may be determined by the Minister in consultation with the Board. The sources of funds to the NHIF are provided under section 41 of the Act as follows:

The National Health Insurance Levy (NHIL) 2.5 percentage points of SSNIT contributions. Such money that may be allocated to the Fund by Parliament; grants, donation, gifts and any other voluntary contributions made to the fund, Interest that accrues to the Fund from investments made by the Authority Fees charged by the Authority in the performance of its functions; contributions made by members of the Scheme; and monies accrued under section 198 of the Insurance Act, 2006 (Act 724).

The Authority earned a total revenue of GH¢773.83 million and incurred total expenditure of GH¢788.32 million resulting in net operating deficit of ¢14.49 million. Claims cost for the period was GH¢616.47 million, representing 78.2% of the total expenditure. National Health Insurance Levy (NHIL) due from Ministry of Finnace at the end of 31st December 2012 was GH¢335.41 million. The Fund's investment portfolio stood at GH¢169.23 million as end of December 2012 (NHIA, 2012).

Government funding/support for district MHOs was not tied to efficiency and policy effectiveness or responsiveness criteria. Again, all MHOs that were not district wide government sponsored (public) were classified as private. Private MHOs, though recognized as not- for- profit solidarity organizations and legally entitled to operate would not receive any financial support from the National Health Insurance Fund or any of the subsidies to cover groups exempt from premium such as the elderly and the poor.

The policy provides for a benefit package of services and defines exclusions. The benefit package includes full OPD treatment, admissions (surgery/medical) and drugs based on NHIS Drug list. The conditions are outpatient services including general and specialist consultations including reviews, investigations including laboratory investigations-rays and ultrasound scanning for general and specialist outpatient services, HIV/AIDS symptomatic treatment for opportunistic infections, outpatient /day surgical operations and outpatient physiotherapy, oral health services, eye care, maternity care (antenatal, deliveries and post-natal) and all emergencies.

Inpatient services are general and specialist care, requested investigations including laboratory X-rays, ultrasound, scanning for inpatient care, medication based on NHI scheme drug list, blood transfusions and surgical operations. Specialist services include oral and eye care, maternal career emergencies. Others are cervical and breast cancer treatment, traditional medicines approved by the Food and Drugs Authority (FDA) and feeding where available.

Free services under special programmes are immunization, family planning, mental health care, tuberculosis, onchocerciasis, buruli ulcer, trachoma and confirmatory HIV test. Exclusions which are services not part of the package under the Scheme include cosmetic and aesthetic services, rehabilitation other than physiotherapy, cash benefits (reimbursement to individuals), appliances and prostheses(optical aids, hearing aids, orthopaedic aids, dentures or dental apparatus) cosmetic surgeries and aesthetic treatment, HIV retroviral drugs, other than symptomatic treatment of opportunistic infections and other AIDS related diseases, artificial insemination, hormone replacement therapy, vasectomy and sterilization, B- Scan photography, dialysis for renal failure, organ transplantation, drugs not on NHIS medicine list, heart surgery, brain surgery, cancer treatment, diagnosis and treatment abroad, medical examinations for purposes other than curative(visa applications, industrial, education, institutional, driving license) over -the counter drugs and officials ward.

Under the scheme, health workers are to provide quality care, negotiate benefit package and tariffs, treatment protocols, improve management capacity, financial management, information system and documentation, patient information, treatment cost and staff development (MOH, 2003).

The principles underlying the Ghana National Insurance Scheme are equity, cross subsidization, risk equalization, solidarity, subscriber/community ownership, partnership, affordability, reinsurance, quality care and sustainability. Under the scheme, services are to be provided by accredited service providers in the public, mission, quasi-government and private health care providers-hospitals and clinics, maternity homes, pharmacies, licensed

chemical shops and diagnostic facilities. Claims are made by the service providers and then submitted to the district schemes for payment using the Diagnosis Related Group (DRG) rates for services rendered and Fee–For Service (FFS) for medicines.

A per capita (capitation) provider payment system for primary care under the NHIS aimed at improving; cost containment, control cost escalation by sharing risk between schemes, providers and subscribers and improving efficiency through more rational use of health resources was piloted in the Ashanti Region (NHIA, 2013).This was met by protests and mixed feelings.

The private health practitioners complained of limited consultations on the introduction of the capitation policy and the low tariffs. So far the report on the evaluation of the policy had not been made public; the policy is still on pilot basis in the Ashanti Region with the intention to extend it to two other regions.

The scheme is currently operational in hundred and fifty-five (155) district offices across the country. It has a total active membership of 8.8 million representing 35% of the population (NHIA, 2012). A total of 3,575 health care facilities have been accredited to provide services to the insured. The total active membership of the scheme increased from 8,227,823 in 2011 to 8,885,757 in 2012 representing an increase of 8% over the previous year.

Out-patient utilization of health care services increased from 0.6 million in 2005 to 25.5 million in 2011. However, in 2012, outpatient utilization decreased to 23.9 million. In-patient utilization increased from 28,906 in 2005 to 1,451,596 in 2011. In 2012, in-patient admissions decreased to 1,428,192. Claims payment is the major cost driver of the Scheme. Claims

payment has increased fromGH¢7.60 million in 2005 to GH¢616.47 million in 2012. (NHIA, 2012)

Summary and Conclusion

The NHIS has been implemented in the country for about 10 years. The NHIA began implementation of Government's free maternal health care policy initiative in July 2008. The NHIS accreditation tools were reviewed in 2008 (MOH, 2009). New tariffs based on the diagnosis related groupings (DRGs) was implemented in the same year and a revised medicines list was also developed. The DRG system involves paying per episode of care, according to disease groups but also differentiated by level of care and sector. Work has also been completed on the development of prescription guidelines. All these have been done with the view to enhancing efficiency in the implementation of the scheme.

Despite all these, the implementation of the NHIS faces challenges which have implications for its long term sustainability. Among them are weak portability, inefficient claims processing and delays in claims payment by the DMHIS and the provisional regime of accreditation (MOH, 2009 pp19). Submission of reports on registered members in the exempt categories by schemes to ensure early release of subsidies and requests for reinsurance continues to be a problem. Another issue was the overcrowding at the various OPDs following the high patronage. According to the NHIA (2012) there are still some challenges militating against the implementation of the scheme. These challenges include financial sustainability of the scheme, identification of the poor and vulnerable, identity card management, quality of care and slowness of the ICT system. The need to continually address the challenges

and sustain the scheme to be able to achieve its objectives is important. This in part provides some justification of the study.

The general observation is that there are challenges facing the health sector and the various health policies and programmes aimed at addressing health financing. There have also been challenges with social and development policies under the various governments and periods on the implementation and sustainability of the various health financing programmes. Among them are weak institutional capacity (inadequate personnel and logistics) and the effects of political changes on the development and implementation of policies in most sectors of the economy and in the health sector.

The theoretical and guiding frameworks were combined to provide a comprehensive approach to better understand the content of the NHIS, the process of formulation and design of the NHIS, the influence of the different actors particularly health care providers in the formulation processes and implementation of the NHIS and how these interact with the contextual factors to affect implementation and sustainability of the NHIS. Thus the content, context, the actors and the processes under which the NHIS was established provide the context within which the findings of the study can be viewed. The NHIS has been touted as a success and received both national and international acclaim and recognition (GNA, 2013; NHIA; 2011).

Recent developments and concerns expressed by stakeholders such as the NHIA, health development partners and Civil Society Organizations, however, show that the NHIS is vulnerable and risks collapse. The implementation and sustainability of the NHIS like other social policies and

the introduction of the one -time premium payment policy has been the subject of debate and criticism and constitutes the focus of this thesis.

CHAPTER FOUR

STUDY DESIGN, SETTING, METHODS OF DATA COLLECTION AND ANALYSIS

I now understand that a person thinks in a given paradigm, a sort of worldview, and the thoughts and ideas one holds are reflections of that paradigm. I now understand that reality is not "one thing out there" that one can "objectively" discover. On the contrary, reality is complex and multiple; it is not fixed, nor can it be grasped fully. Therefore, knowledge is always relative and partial. (Effinger, Maldonallo and McArdle, 2004)

Introduction

One of the central arguments of the thesis is that health care providers constitute an important group of actors in the implementation and sustainability of the National Health Insurance Scheme. To achieve sustainability of the scheme requires an examination of their roles, interests, competences, attitudes as actors involved in the development, management and implementation of the scheme.

The research methodology for the study discusses the overall perspective adopted for this research process (Neville, 2007). Methodology is a way of systematically solving the research problem (Kothari, 2004). This chapter discusses the whole research approach including the underlying philosophy. It further discusses the study population and the modes of inquiry employed in gathering and in analysing data. This includes the research design adopted for the study and the basis for the choice of the particular research approach as well as issues of validity and reliability. It examines three broad issues: the research design, study population and methods of analysis.

Research Scope

Conceptually, Gilbert (1993) suggests that every research must be placed in an appropriate academic or subject matter. The philosophical assumption underlying the research comes from the belief that the views and opinions of health care providers on the NHIS emanate from their interpretations of their individual experiences. This study is within the context of sustainability of the Ghana National Health Insurance Scheme from the perspective of health care providers in the Cape Coast Metropolis as one of the key actors in the formulation and implementation of the Scheme.

The study used a combination of in-depth interviews, observations and analysis of existing data sets including those from the NHIA and reports. In-depth interviews offer the potential for capturing experiences in great depth. According to Bernstein (2004) people will always provide much more information on a one on one discussion than they will be in a public forum. Although interviews cannot be a substitute for public forms of participation, they often provide information that can be detailed enough. In-depth insights into health care providers 'views provide a basis to inform the broader debate on how to sustain the scheme. It was to offer a means of understanding the authentic perceptions, sentiments and emotions of health care providers on the NHIS in a more holistic manner.

Research Strategy

The qualitative research method was thought to be the relevant approach for the study as it sought to describe, explain and understand a phenomenon. According to Rasmussen, Osterguard and Beckman (2006, p.93) the approach focuses on the significance of meaning derived from the data.

Henning (2004) proposes that such research should be guided by the interpretative approach which emphasizes personal experience and interpretation. The interpretative paradigm which is adopted is informed by the philosophical thought which aims at achieving depth rather than breadth of the views of one of the major stakeholders in the National Health Insurance Scheme (Flick, 2002; Ezzy, 2002). The research was designed as a qualitative study. The study adopted the intepretivist philosophy which maintains that research is to interpret human actions within the context of culturally specific meaningful arrangements (Audi, 1995).

Within the variants of the intepretivist philosophies, the constructivist philosophy that humans are reliant upon a cultural "matrix" in order that they can reduce the mass of possible events to manageable amounts at any given time and space (Foucault, 1991; Luhmann, 1998) informs this study. This "matrix" is what gives order to the world and is dependent on history. The elements of a cultural "matrix" emerge in a given context, and they could have denoted something else in a different time or place. People experience reality in very different ways–according to the historical and regional context in which they exist. Therefore, reality is never objective and it is observed through a socially constructed perspective that has been handed down to people and that gives order to their world. These cultural perspectives can never be taken off because without them people do not have the ability to see (Draube, 2007).

The methodology acknowledges the possibility of multiple interpretations of similar phenomena. The qualitative research design is amenable to this philosophy. Yin (2011) discusses the greater flexibility

offered by qualitative research in selecting topics of interest because it is not constrained by such issues as the inability of the researcher to establish an ideal research condition or the inadequacy of data series.

The qualitative research design allows the kind of close interaction between the researcher and the researched so that the realities constructed by the researched and the meanings attached to these can be extracted. The reality, from the perspective of the respondent is most important and given the subjective nature of this approach and the importance of language (Eriksson and Kovalainen 2008), the qualitative data definition, gathering and analyses was found most appropriate.

The approach was chosen with the aim of understanding the research participants' world and that can be attained as they explain and describe different phenomena in their own words.

Study Design

The study sought to ascertain, through in-depth interviews and observation the opinions, views and experiences of key health care providers on the sustainability of the National Health Insurance Scheme using officers in the Cape Coast Metropolis. The issue of the sustainability of the NHIS is of national concern. This implies that the study should have covered the whole country but it was not possible to involve all health care providers because of constraints of time and finance. The choice of Cape Coast was influenced by the fact that the metropolis has a relatively large number and diverse health institutions. There are the Ankaful Leprosy and the Psychiatric Hospitals, University of Cape Coast Hospital, the Christian (Anglican) Eye Clinic, a Regional Hospital which is in the process of being up graded into a teaching

hospital, a district hospital and the two urban health centres which make Cape Coast unique. The area is thus relatively endowed in terms of health facilities as indicated in Table 2. A review of the literature also indicates that to date, no similar study has been done in the area.

Study Area

The Cape Coast Metropolis is one of the seventeen political and administrative districts in the Central Region. As the capital area of the Central Region it covers a land area of 122 km². It is principally urban and the most urbanized (12.6%) in the region (GSS, 2012) and shares borders with the Komenda Edina Eguafo Abirem (west), Abura Asebu Kwamankese (east) and Twifo Hemang Lower Denkyira (north) districts. It is bounded on the south by the Gulf of Guinea. The location of health facilities where the study was conducted is indicated in (Figure 4).

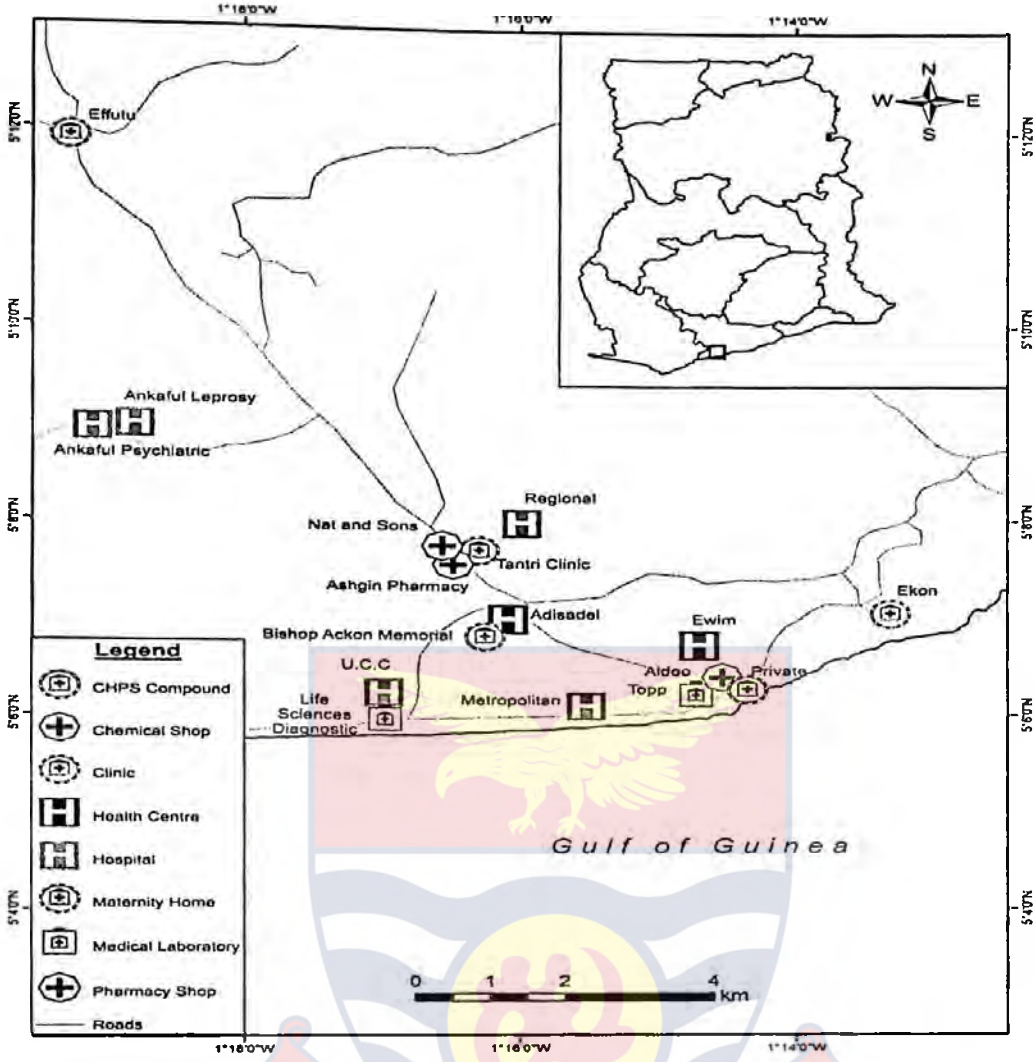

Figure 5: Map of the study Area

Source: Cartographic Unit, Department of Geography and Regional Planning, UCC

With a population of 148, 441 in 2010 and a growth rate of 3.1% (Ghana Statistical Service, 2012) there are 102 communities in the Metropolis and these are divided into five (5) health sub-districts: Ewim, Adisadel, Efutu, Cape Coast RCH central and University. The facilities in the Metropolis are Regional Hospital, District Hospital, University of Cape Coast Hospital, Baiden Ghartey Memorial Hospital (private), and Urban Health Centres

(2), Rural Clinic, Private Maternity Home, Private Clinic, Regional Police Clinic, Mission Clinic, PPAG and five (5) functional CHPS Zones at Ekon. (Table 1)

Table 1-*Population of Cape Coast Metropolis in 2010*

Sub-district	Population
Reproductive Child Health Central	37,110
Adisadel	47,501
Ewim	29,689
University of Cape Coast	22,266
Efutu	11,875
Total	148,441

Source: Metro Health Directorate Annual Report (2012)

Health services delivery in the metropolis reflects the pluralist nature of health care services in the country: a mixture of public and private institutions structured along the three-tier system of the primary health care strategy. At the community level, services are delivered through outreach programmes and the services of TBAs, chemical sellers, traditional healers and private clinics and maternity homes. At the second tier are the five sub-district health facilities namely, Cape Coast Central, the Reproductive and Child Health Centre, Ewim, Adisadel, Efutu and the University of Cape Coast. At the 3rd tier are the Regional Hospital, Ankaful Psychiatric Hospital, Bishop Ackon Memorial Christian Eye Centre, Ankaful Leprosarium, the Cape Coast Municipal Hospital and the University of Cape Coast Hospital. Categories of health professionals in the metropolis are doctors, specialists, nurses, pharmacists, biomedical scientists, hospital administrators and midwives etc.

It was therefore easier to gain access to them. Implementation of the National Health Insurance Scheme formally started in the metropolis in 2000 before the establishment of the National Health Insurance Scheme. Known as the ***Oguaa Mansin Apomuden Kuw***, it was one of the pilot schemes in the country before the national implementation of the scheme. The objectives of the *Oguaa Mansin Apomuden Kuw* were to pool resources together as a risk sharing venture to cater for the health care needs of the people of Cape Coast, to make curative care more accessible and affordable to the people of Cape Coast and to reduce the financial burden on the people of Cape Coast at the point of service (Nuertey, 2009, Personal communication)

In the Cape Coast metropolis, records at the Oguaa Mansin Health Insurance office indicate that attendance at the various health institutions increased from 57 in 2005 to 409,221 in 2013.Facility utilization (OPD) in 2013, recorded a per capita attendance of 2.2 after a steady increase from 1.6 in 2009. Admissions increased from 15,684 to 15 936 at the end of 2013.The insured patients represented 81.6% and 18.4 as non- insured as compared to 79.2% and 20.8 respectively in 2012 (Metro Health Directorate, 2012). Overall, as Markinen et al. (2011) report, the institution of the NHIS since 2005 has indeed changed the financing landscape of the health sector in Ghana.

Table 2 provides a list of health care providers in the metropolis and the top ten causes of OPD attendance, admissions and deaths in 2010 and 2011 respectively some indication about the prevailing conditions and access to health care in the area and its implications for the benefit package.

Table 2- *List of Health Providers in the Cape Coast Metropolis*

Category/Facility	Hospital	Health Centre	Pharmacy	Laboratory	Maternity home	Clinic	Chemical shop	CHPS	Total
Medical Admin	6	1	-	-	-	1	-	-	8
Clinical Specialist	11	-	-	-	-	1	-	-	12
General Medical Officer	43	-	-	-	-	-	-	-	43
Hospital Admin	5	-	-	-	-	1	-	-	6
Nurse Manager	5	-	-	-	-	-	-	-	5
Nurse	151	14	-	-	-	5	-	-	170
Midwife	10	6	-	-	1		-	-	17
Pharmacist	7	-	7	-	-	-	-	-	14
Medical Assistant	8	2	-	-	-	1	-	-	11
Accountant	6		-	-	-	-	-	-	6
Optician	-	-	-	-	-	1	-	-	-

Table 2 continued.

Physiotherapist	1	-	-	-	-	-	-	-	1
Dietician	1	-	-	-	-	-	-	-	-
Biostatistician	10	-	-	-	-	-	-	-	10
Radiographer	4								4
CHO/CHW	-	-	-	-	-	-	-	4	4
Laboratory				8					8
Chemical seller	-	-	-	-	-	-	80	-	80
Clinical	1	-	-	-	-	-	-	-	1
Psychologist									
Nurse Anaesthetist	5	-	-	-	-	-	-	-	5
Total	276	23	7	8	1	10	80	4	407

Source: Central Regional Health Directorate Cape Coast, (2009)

Table 3-*Ten Top Causes of Admissions, Deaths and OPD attendance in the Cape Coast Metropolis*

Case	Admissions			Deaths			OPD Attendance	
	2010	2011		2010	2011		2010	2011
Malaria	1552	1460	Malaria	84	58	Malaria	122948	135564
Pregnancy related Complications	678	518	Anaemia	49	35	Other Acute Respiratory Infections	41867	54058
Anaemia	384	263	Hypertension	23	27	Hypertension	17797	24539
Hypertension	225	288	Tuberculosis	30	35	Skin Diseases & Ulcer	14644	17444
Gastro enteritis	169	260	Neonatal sepsis	18	27	Diarrhoea Diseases	13204	13605
URTI	84	117	AIDS	11	11	Rheumatism and Joint	8906	11982
Tuberculosis	80	102	Gastro enteritis	8	6	Acute Eye Infection	7555	11661
Pneumonia	78	107	Pneumonia	13	9	Anaemia	10061	11307
Hernia	78	11	Typhoid	3	3	Acute Urinary Tract	5582	11159
Other diarrhoea diseases	2	124	CVA	15	15	Diabetes Mellitus	5857	8618
						Others	136803	137525
Total	**3290**	**3126**		**239**	**211**		**385224**	**437,462**

Source: Metro Health Directorate Annual Report (2012)

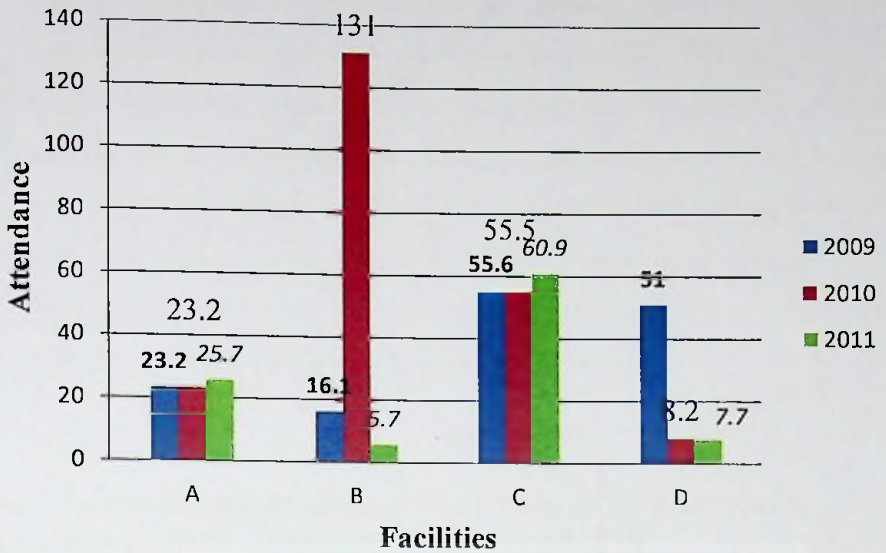

Figure 6: OPD Attendance by Facility Ownership

Source: Metro Health Directorate Annual Report 2012

The government facilities continued to record the highest attendance followed by the quasi-government facilities, private facilities and the mission facilities. In 2011, the private facilities recorded an increase of 16.1% over that of 2010 (13.1%). Out Patient Department visit per-capita was 1.6 visits per capita in 2009, 1.82 visits per capita in 2010 and 1.73 visits in 2011 (Figure). This means that every person in the Cape Coast Metropolis visited the health facilities once or twice in the year 2011.

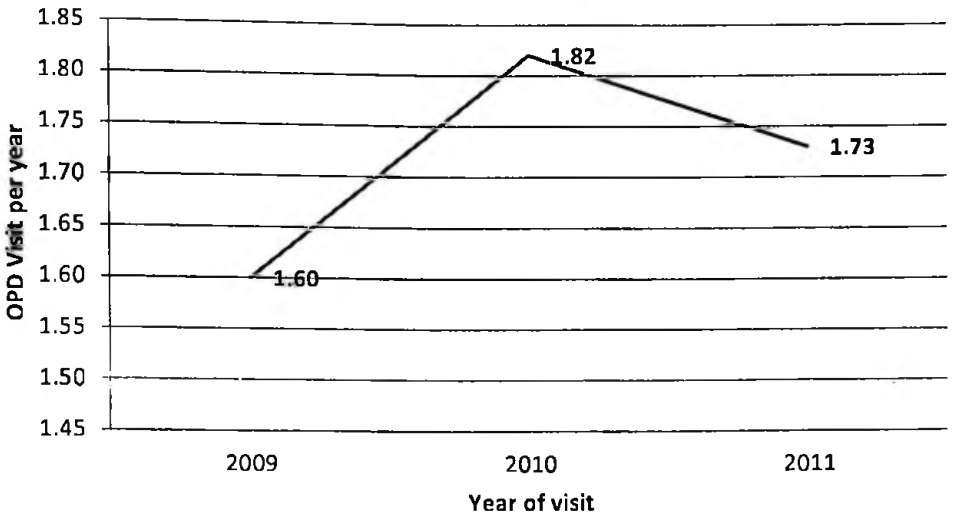

Figure 7: Out-Patient Attendance Per Capita in the Metropolis,
Source: Metro Health Directorate Annual Report 2012

Table 4-*Bed Complement Analysis in the Cape Coast Metropolis*

Indicator	2009	2010	2011
Admissions	8,957	7,972	8,182
Discharges	7,479	7,339	7,655
Deaths	823	440	373
Death rate	9.9	5.7	4.6
Patient days	26,432	29,377	27,745
No. of beds	174	183	200
Average length of stay	3.1	3.7	3.4
Turnover interval	4.46	4.8	5.6
Average daily occupancy	72.4	80.4	76
% Bed occupancy	41.6	43.9	38
Turnover per bed	47.7	42.5	40.1

Source: MHD Annual Report (2012)

Table 5-*Surgical operations performed in the Metropolis 2009 – 2011*

Indicator	2009	2010	2011
Major	2,865 (76)	2,429 (66%)	2,476 (64%)
Minor	905 (24%)	1,262 (34%)	3,871 (36%)

Source: MHD Annual Report (2012)

Study population

The target population for the study was health care providers and managers working in the health facilities-public, mission, quasi-government and private sectors in the Cape Coast Metropolis. These were heads and officers of hospitals, health centres, clinics, pharmacies, maternity homes, chemical shops, and medical laboratories and Community-Based Health Planning and Services (CHPS) compounds; (see Table). Administratively, the Psychiatric and the Leprosy Hospitals are located in the Komenda Edina Eguafo Abirem Municipality but they are included in the study on account of the availability of some specialist personnel such as a psychiatrist, clinical psychologist and skin specialist in the two facilities. Individual health care providers constituted the unit of analysis.

Sample and Sampling Technique

The health sector utilizes a hierarchical structure with jobs classified across several grades. The sample was purposively selected for the study. Respondents were selected to ensure that the various categories of staff (health professionals and managers) were covered. Forty (40) health care providers working in 19 health facilities were interviewed. Table shows the list of health facilities by type and ownership in the Metropolis and those

selected for the study. Table 6 shows the categories of health care providers in the type of facility ownership selected for the study.

Table 6-*Health Facilities by Type and Ownership in the Cape Coast Metropolis*

Type/Ownership	Gov't	Quasi Gov't	Private	Mission	Total selected
Hospital	4 (4)	1	1 (1)	-	6(5)
Health centre	2 (2)	-	-	-	2(2)
Maternity Home	-	-	1 (1)	-	1(1)
Pharmacy	-	-	8 (2)	-	8(2)
Clinic	2 (2)	1	1 (1)	1 (1)	5(4)
Laboratory	-	-	2 (2)	-	2(2)
Chemical Shop	-	-	80 (1)	-	80(1)
CHPS	4 (2)	-	-	-	4(2)
Total	12(10)	1	93(8)	1	107 (19)

Source: Regional Health Directorate, Central Region, (2009)

(In brackets are number of selected facilities in each category

Table 7-*Category of respondents interviewed by type of health facility ownership*

Category	Public	Private	Mission	Quazi Govt.	Total
Medical Supt/CEO	3	2	-	-	5
Hosp. Admin	3	-	1	1	5
Nurse Manager	1	-	-	1	2
Clinical Specialist	2	-	-	-	2
Medical Officer	1	-	-	-	1
Pharmacist	1	2	-	-	3
Accountant	1	-	1	-	2
Physiotherapist	1	-	-	-	1
Staff Nurse	1	2	-	-	3
Midwife	1	1	-	-	2
CHN/CHO	2	-	-	-	2
Biomedical Scientist	1	1	-	-	2
Anaesthetist	1	-	-	-	1
Clinical Psychologist	1	-	-	-	1
Dietician	1	-	-	-	1
Optometrist	1	-	-	-	1
Medical Assistant	2	-	-	-	2
Medical Records officer	1	-	-	-	1
Technical Officer	-	-	1	-	1
Chemical seller	-	1	-	-	1
Radiographer	-	-	-	1	1
Total	25	9	3	3	40

Source: Field work, Owusu- Boampong (2012)

Research methods

The views of health care providers on the sustainability of the NHIS was the focus of the study. Consequent upon the nature of the research problem and the objectives, the study the study adopted a mixture of methods (triangulation) to provide a broader perspective on the

phenomenon of sustainability which the study sought to explore and to enhance data collection and analysis. Three main approaches or methods were employed in the study. These were the in-depth interviews, observation and documentary evidence.

In-depth Interview

In-depth interview was used because it allows for intensive and systematic discussion of issues which the study sought to achieve. Information gathered were the demographic and work profile of respondents; involvement in the formulation of the national health insurance policy; facility accreditation; funding of the scheme; the structure, organization and management of the scheme; benefit package; incentive systems, regulation, and ethics; implementation of the policy; effects/impact of the introduction and implementation of the policy; sustainability of the scheme and the one-time premium payment policy (Appendix 2).

Observation

An important part of the data collection process was to observe and record the various components and themes such as the mood and gestures of respondents and the physical settings of the facilities such as OPDs, consulting rooms, wards and offices, patients waiting time, patient-staff relationships, staff – scheme managers' relationships and claims processes.

The purpose of adding observations was to situate responses in the physical, human and interactional settings (Morison, 1993; Cohen, Manion & Morison, 2000).These included respondents' questions, comments and non-verbal communications e.g. laughter's and/or anxieties (Appendix 2 and 3).

At the OPDs, consulting rooms and dispensaries, large numbers of patients were seen waiting to be seen by health workers or to be served. Some of these are captured in the images (plates). Frustrations and anxieties were seen on the faces of some of the patients at the crowded OPDs. Privacy in some of the consulting rooms was compromised. At one of the pharmacies where the interview was conducted, the interviewee had to pause the interview and attend to clients on several occasions and this prolonged the interview. Staff in the claims section in some of the hospitals, were also seen to be busy processing papers and patients for submission. Relationship among staff and between the patients was found to be cordial.

The field notes also captured some of the observations made by the researcher. In all the observation was useful since it allowed the researcher to fully appreciate the health care delivery environment in respect of the claims of increased workload better and allegations of unethical behavior of health care providers.

Documentary sources

The third source consisted of facility records, and financial and administrative documents. Information collected included outpatient attendance, inpatient admissions and revenue generated. Earlier studies and reports carried out on programme and policy sustainability, the NHIS, and other health insurance schemes elsewhere were reviewed. Other sources which informed the study were contributions to and reports of policy debates, and conference proceedings, hospital and municipal health directorate annual reports (2009-2012), the Health Insurance Law (Act 650 of 2003); Health Sector Programmes of Work,(1996-2001, 2002-2006,

2007-2013); MOH Independent Health Sector Performance Review Reports (2004-2013), Policy Framework for the Implementation of the NHIS (2003); Operational Reports of the NHIA (2009-2012), The Ghana Poverty Reduction Strategy documents (I & II),Ghana Shared Growth and Development Agenda document (2010-2013); the Ghana National Population Policy(1994); and Legislative Instrument 1809 of 2003. The document review was to further analyze, understand and to plot trends and patterns to corroborate key informant views.

Pretesting of the Instrument

The interview guide was pretested in the Sekondi-Takoradi Metropolis between 24th and 27th August 2011. Sekondi–Takoradi was chosen because it has almost the same characteristics as Cape Coast in terms of health facilities, health providers, geographical features and political status. Five respondents made up of a Medical Director, Clinical Specialist, Nurse Manager, Pharmacist, Administrator, and a Midwife were interviewed. The rationale was to check for the validity and reliability of the instrument, wording and ordering, identify key missing and emerging themes, estimate duration of interviews and identify challenges, if any. The average duration of each interview was 50 minutes. Some of the distractions during the interviews included patients and telephone calls.

Among the observations from the pretest was the enthusiasm of respondents to be part of the study. Others included the large number of patients seeking treatment at the public hospitals and the private pharmacy shops. Some respondents felt the interview was an opportunity to voice out

their concerns about the challenges facing them. After the pretest a report was written and submitted to the supervisor for his comments. Among the lessons learnt were the needs to establish rapport with respondents to gain confidence and cooperation and proper scheduling of interviews with respondents. It was also observed that careful selection of setting for pretesting was important.

Field Work

The fieldwork was conducted between 12th October 2011 and 30th January 2012. To gain access to the facilities and respondents, a letter of introduction was obtained from the department to the facilities for permission to undertake the study. In most cases, the respective heads assisted in the identification of the respondents to be interviewed. The heads and the respondents were briefed on the objectives of the study. Written consents were obtained from the respondents. Some of the respondents did not want to complete the consent forms for various reasons including lack of time and that fact that some of respondents were known the researcher.

The interviews were done in the consulting room, office or ward as was deemed convenient for the respondent. On the average, each interview lasted for 60 minutes. Where there seemed to be a difficulty in the interpretation of any section of the guide, effort was made to fully explain it to them. All the interviews were conducted in English Language since all the respondents were literate in written and spoken English.

Field notes were also taken during the interviews. The interviews were audio taped and each of them transcribed. Two persons assisted the researcher while the main supervisor sat in some of the interview sessions.

Experiences from the Fieldwork

Among the experiences from the field were in the scheduling of interviews and challenges with interviews. The first was due, in part to the busy schedule of their work of some of the respondents. Due to the busy schedules of the respondents, the interviews suffered some distractions including telephone calls, medical emergencies, visitors and staff. Most of the interviews were thus conducted at their convenience. Secondly, the study was originally expected to include respondents from the Police and Prisons Clinics and two chemical sellers. However, it was not possible to interview respondents from those facilities due to the procedures in obtaining permission from their headquarters. Only one chemical shop owner could be interviewed, as several of them who were approached were reluctant to participate in the study.

Thirdly, a few respondents had some challenges in understanding the section on motivation, regulation and ethics. This section became a bit difficult to complete. Some of the respondents found the instrument to be lengthy. These combined to prolong the duration of the interviews and caused some distress to a few of them.

The interview guide was considered to be quite comprehensive and therefore interviewing forty respondents made the study a huge task with implications for the analysis of the data in terms of time. Feedback from

respondents indicated that the in-depth interview guide was somehow long.

The respondents were willing and cooperative. Some of them felt that the study might help address some of the challenges they were facing in the implementation of the scheme. Others felt that they needed to assist in the research on moral grounds.

On the other hand, only a few agreed to sign the consent forms. While some of them felt it was not necessary others did not want to commit themselves. In spite of the foregoing, acquaintance and familiarity with most of the respondents provided some goodwill, respect and credibility which facilitated the study.

Feedback from the supervisor after sitting in some of the interview sessions also helped to refine and improve the style and flow of questioning and interviewing in the subsequent interviews. It also improved the understanding and skills of the researcher in undertaking research especially using the qualitative approach. The data gathered and the responses were found to be generally useful and informative.

Together with the interviews, the observation enabled the researcher to identify the personal feelings of health care providers arising during the questioning, develop a greater appreciation for the challenge of sharing all one knows about the NHIS. A lot more was also learnt about the value of patience in the interview process. It also helped to gain an appreciation of feeling of being and also not been heard in the policy formulation process in the health sector. Finally, it helped to identify priory assumptions about the participants.

Data Analysis

Qualitative content analysis was the main approach adopted (Hsien and Shannon, 2005). This involves a subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns. The data were analyzed using the inductive framework approach (Ritchie, Spencer & O'Connor (2003) and by directive content analysis (Barbie, 2005). The approach means that the use of preconceived categories was avoided and that the codes and categories are derived directly from the text rather than being based on in a specific theory. The focus here was on "who said what, to whom, why, to what extent and with what effect (Laswell, 1998).Interviews and discussions were transcribed verbatim from recorded tapes to facilitate the breakdown, examination, comparison, conceptualization and categorization of the data collected. The analysis involved the familiarization with the data which entailed transcribing, identification of recurrent themes, identification of codes, grouping into main themes, mapping and interpretation of data and identification of key themes, grouping of recurrent themes. Significant responses from the interviews were quoted verbatim to buttress key concepts of the study.

The data were divided into simpler text units for coding which is an interpretative technique that both organizes the data and provides a means to introduce the interpretations of it into certain quantitative methods that was entered into a data base Nvivo 7 software package. This was used to scan and sort large set of qualitative data including count of words, phrases or coincidence of tokens within the data. It allowed for reflection, resolution of

differences in interpretation later.

The responses shared by most respondents were further plotted on a spread sheet to enable the development of themes from which an analysis could be made. The responses were then analyzed thus helping the researcher to identify patterns. Analyzed data were presented including an indication of where those findings lead to. This was done with the use of narrative reports, quotes and tables taking into consideration the modules, formulation and design, implementation and sustainability of the scheme. An integration of the research findings from both the literature review and empirical studies was provided in response to the problem statement. A discussion of the findings which comprise a summary, contextualization and interpretation of the findings was done leading to the conclusions and recommendations.

Ethical Issues

Ethical permission was given by the University of Cape Coast Ethical Review Board. Permission was given by the heads of facilities for the study to be conducted in their respective facilities. Respondents were assured of confidentiality of the information provided and that no name would be recorded on tapes, forms and transcripts maintaining that the information will be stored on computer and that the results would be anonymized. Respondents were told that the study was solely conducted as part of research degree and not for official use and they voluntarily consented to participate in the study without any coercion or threat of victimization (Blaikie, 2000).

Steps were taken to minimize discomfort and stress to the respondents resulting from long period of interview by providing them with some

refreshments and giving them some idea of the expected duration of the interviews.

Validity and Reliability of the Study

In a qualitative study, validity and reliability are conceptualized as trustworthiness, rigour and quality (Golafshani, 2003). This approach enables the mitigation and possible elimination of the researcher's bias, which is often experienced in qualitative research. Although the traditional criteria for examining rigour in qualitative and quantitative research has been internal and external validity, reliability and objectivity (Punch, 2005) these do not adequately satisfy the rudiments of qualitative approach because of differences in the underlying philosophies (Wolcott, 1999).

Credibility of the study was ensured through the application of triangulation of data (Scaife, 2004; Mays and Pope, 2000; Cohen et al., 1994) (Punch, 2005; Bush, 2002; Cohen et al., 2000) using in-depth interviews, communication with officials, personal observations and insights, and documentary review, all within the remit of qualitative paradigm.

Secondly, the responses provided by the interviewees were repeated by the researcher for them to confirm or modify. This ensured that they understood the issues well and their responses were not misrepresented by explaining the sticky points to them.

Thirdly, responses of participants were captured as they were presented during the interviews and were checked immediately after to ensure that they followed the proper procedures regarding the questions.

The presence of the supervisor who had considerable experience in

qualitative research during the interviews, discussions and sessions helped improved the quality of the interviews. He only observed the sessions and discussed the issues with me after the interviews. The regular discussions with the supervisors also helped to enhance the quality of the study.

The pretesting of the interview guide ensured that most of the deficiencies were adjusted. From experience, there was no major barrier with the use of English language.

Member checking was also applied to improve on the trustworthiness of the findings. This was done at an interactive meeting with some of the respondents and district and hospital managers. The preliminary findings were presented and feedback from the participants was used to clarify some of the views expressed during the interviews.

The rapport between the researcher as a senior management staff and the respondents enhanced the credibility of the study. A good number of participants were forthcoming with insightful responses without any fear of intimidation. The problem of positionality as an employee of the Ghana Health Service and a professional colleague was considered to be minimal as some of lower cadres of the health care providers were not well known to the researcher. I tried to disregard my own experience and perceptions of the scheme and the behavior, positions and attitudes of the respondents. My influence, if any, was thus minimal.

Conclusion

Selecting, scheduling and interviewing of respondents were the main challenges in conducting the study considering the number and range of

health care providers. The length of time spent on the interviews was also influenced by the interview guide and distractions in the consulting rooms and offices of respondents. The analysis of the data required some diligence in view of the large volume of data gathered. The co-operation from the respondents was encouraging. The study on the whole, offered a useful learning experience for the respondents and the researcher as well taking into consideration the fresh insights and ideas gained with respect to the implementation of health insurance in general

CHAPTER FIVE

VIEWS AND EXPERIENCES OF HEALTH CARE PROVIDERS ON THE FORMULATION PROCESSES OF THE SCHEME

We follow the view that the social construction of reality is personal, experienced by individuals and between individuals-in facts the interactions which connect us are the building blocks of reality, and there is so much meaning in the space between individuals (Slawomir, 2009).

Introduction

In the service and health organizations, the various clinical, management, technical and other personnel are the principal inputs for the performance of most interventions. They diagnose problems and determine which services will be provided and how (Pan African Health Organization, 2001). Health interventions are knowledge-based and the providers are guardians of this knowledge. This suggests that seeking the views of health care providers in the process of the NHIS as major health policy initiative is therefore important. The formulation process involved all the mechanisms through which the NHIS was designed, how the interactions with the policy communities' particularly health care providers and professionals were conducted and how the content was developed. This chapter presents the background characteristics of the respondents, as well as their observations, opinions and general views on the processes involved in the formulation of the scheme including accreditation arrangements.

The chapter further discusses their level of involvement, the strategies used to elicit their views and participation in the processes. The views and opinions of respondents on their involvement or participation in the

formulation and development of the National Health Insurance Scheme are also discussed.

Background Characteristics of Respondents

Working in a type and /or ownership of health facility, for example a regional hospital, health centre or university hospital can influence the level of participation in the formulation process and hence their views on the process.

The views and opinions of health care providers on policies can also be influenced by gender, age, training and educational background, length of service and/or experience and licensing or registration.

Background characteristics also determine the extent of involvement in the decision making/policy making process at both the sector and facility levels. Licensing and registration status have implications for regulation, accreditation, efficiency and quality of care. Table 8 shows the number, ownership of facilities and health care providers interviewed.

Of the forty (40) people interviewed, twenty two (22) respondents were aged between 40 and 59 years. Twenty seven of them were males and half (21) had spent 10 or more years within the service and had been licensed or registered by the various regulatory bodies such as Ghana Medical and Dental Council (GMDC), Nurses and Midwives Council (NMC) the Pharmacy Council the Ghana Biomedical Association, Ghana Medical Association (GMA), Association of Health Services Administrators (Ghana) (AHSAG). Twenty one (21) had university education (As Table 8)

Table 8-*Background Characteristics of Respondents*

Characteristic	No
Age	
20-29	5
30-39	8
40-49	10
50-59	12
60+	5
Sex	
Male	27
Female	13
Working Experience	
Less than 5 years	13
6-10 years	6
More than 10 years	21
Licensing/Registration status	
Yes	31
No	9
Education	
Graduate/University	21
Post-Secondary(Nursing Technical grades)	12
Secondary/SSS	7
Total	**40**

Source: Field work, Owusu- Boampong (2012)

Involvement in the processes of formulation of the NHIS

Involvement of key stakeholders in the design of policy is part of policy making process. Walt (1994) observed that peoples' participation in the formulation of health care policies ensures their meaningful support during the implementation phase. Participation is seen as a political principle or practice and also a right. It facilitates the involvement of those potentially

affected by or interested in a decision (Smith, 2003). The principle of public participation holds that those who are affected by a decision have a right to be involved in the decision-making process and should be able to influence the decision (Co- Intelligence Institute (CIPol), 2008).

Participation is viewed as a tool, intended to inform planning, organizing or funding of activities and may be used to measure attainable objectives, evaluate impact and identify lessons for future practice. As Abel-Smith (1994) noted the success of policy depends on public acceptance and participation. Others argue that public participation can sustain productive and durable change. The International Association for Public Participation core values (IAPP, 2008) among others mentions influence, sustainability, information and communication as the benefits of participation. Greene (2003) also demonstrated how the health system in Cuba has seen significant transformation through effective community participation.

Involvement in formulation

Of the 40 people interviewed, two main categories of respondents were identified. The first category was respondents who were not involved and the second were those who were involved in the formulation process of the scheme. For the health care providers who were not involved in the process, three main reasons were given: either in school, out of the country or were employed but were not involved. As indicated:

No, I was not involved though I was working in the hospital as a staff. They selected some people from the region; one from the region and one from the district. (Staff Midwife, 42 years)

No I was not involved. I was practicing outside the country. I was not in the country then. (Specialist, 62 years)

Another remarked:

*No I was not involved and I don't know the reason. Perhaps it involved only politicians (*Nurse Manager, 56 years).

Another noted:

No. I was not involved as I was in school then. (Community Health Nurse, 25years).

The Community Health Nurse was about 15 years old when the Scheme was introduced about ten years ago. She was not yet in training as a nurse and could not have been involved in the process as a student.

Those who were involved in the policy were mainly those who occupied management positions such as district and hospital managers, facility proprietors, district directors, medical superintendents, administrators and nurse managers. They were selected based on their roles and training. The following remarks attest to the assertion:

I was directly involved first as prescriber and also attended to registered patients. (Medical Superintendent, 53 years)

I was involved as District Director of Health Services. It was piloted in my district and I was involved in the sensitization of the people, recruitment of staff, i.e. scheme managers. (Medical Specialist, 55 years)

Nature of Involvement

The involvement of health care providers took various forms. The mode or nature of involvement was either personal (direct) or through

membership of professional association or employer (indirect) or both. The Involvement was based on their role either as an individual health care professional e.g. medical doctor, pharmacist, and nurse or as a member or representing a professional association/organization such as Ghana Medical Association, GNRA, the PSG or the CHAG as indicated in the following quotes:

I was not involved in my individual capacity but as a staff of CHAG and the Christian Council of Ghana. I provided inputs in respect of attendance, service providers, charges, medical items/inputs e.g. consumables, broad discussions on content of services to be provided. (Administrator, 48 years)

Another remarked as follows:

I participated indirectly as part of the Ghana Medical Association and sent in suggestions. (Medical Superintendent, 52)

I participated as an individual and part of a system .I attended meetings on the formulation of the policy organized by the MOH.I attended several seminars/meetings and was a member of one of the university advisory committee which was responsible for write ups and position papers. (Administrator, 45 years)

The above observations suggest that respondents who were doctors and other health care providers in administrative positions were much more involved in the formulation process than other health care providers. As expected, heads of facilities were considered to be key actors in the

Implementation of the scheme and therefore their views and opinions were deemed to be important and were thus selected to participate in the

process.

The technical, political and social nature of the NHIS affected the processes of formulation. The NHIS was considered a novel health policy which required some expertise in its design and implementation. It was seen as an innovative approach to health financing to assure equitable universal access to quality basic package of health services to all residents in Ghana.

Benefits of Involvement of HealthCare Providers in Policy Making

Almost all the respondents including those involved and those not involved attested to the importance of involving health care providers in the design and formulation and development of health policies such as the NHIS. Among the reasons given were improved commitment, ownership and a better understanding of the policy. These were expressed in various forms some of which are the following statements:

I think if people are involved and they understand and own the policy, they become more acquainted with it and once they appreciate what they are talking and understand it, they uphold it and then it is better with them. (Community Health Nurse, 29 years)

Both the policy formulators and implementers must work together but if somebody sits somewhere and plans for someone to implement, commitment may not be there for the latter. No matter how brilliant the ideas may be, if they are not properly translated to the person implementing it, implementation can be a failure. (Medical Director, 58 years)

Respondents who were involved felt that they learnt and contributed to policy making and stressed the importance of involving key stakeholders in the policy process. To them their involvement enhanced their attitude to the

implementation process.

Suggestions to Improve Policy Making

Respondents were asked to make suggestions as to how to improve public policy formulation. One of the suggestions that emerged from the survey was the need for greater involvement of health care providers as key actors in implementation and in service delivery. Others suggested that the process should be devoid of party politics in the selection of participants to be consulted stressing the importance of inclusiveness. For example:

The policy process should seek the views from those involved. It should involve most workers like us because we take care of the patients, because there are certain things we may know. The process of formulation of policies should be depoliticized. (Clinical Specialist/ Public Health Physician, 52 years)

Another stated:

It should have been piloted first because of the fact that there are problems in catering for all children; aged. This would have helped in paying for the claims. It is restricted to age, those in WIFA e.g. 23 years are delivering the third time, This creates single mothers between 15 -18 years. We should be consulted in policy formulation because we are at the grassroots. (Midwife, 61 years)

There should have been an identification of stakeholders. There were disagreements because of the tendency to omit certain individuals. No need to miss out on them. A pretesting of the proposals before mainstreaming them to find out how workable they are could have helped. Some policies need to be tested for their uniqueness and peculiarities (Administrator, 42 years).

The general limited involvement of respondents in the formulation process could probably explain their opinions on the implementation and sustainability of the scheme since some of them felt that their views were not considered in the design. Several lessons can be gleaned from the responses. Actor involvement in formulation processes, careful selection of actors at all levels and backgrounds and the need for piloting new policies can promote the implementation and sustainability of policies.

Facility Accreditation Process

The objective of facility accreditation is to ensure that facilities are in position to provide appropriate health care. Provisional accreditation by the NHIA facilitates NHIS's reimbursement and forms an integral part of the implementation of the NHIS.

Two major categories of respondents were identified: those who were not involved and those who were involved in the accreditation process. There were also facilities which had not been accredited. Various reasons were given. The main reasons assigned were that they were either in school or did not participate in the process. For example:

No. I was not involved. It was done by the former accountant and the administrator. I was then not employed in the health sector. (Accountant, 43 years)

For the health insurance, I will say no because we were not actually part of it when they came down to collect their information. (Physiotherapist, 47 years)

I was not involved and I cannot give any reason for that though it is helping. (Staff Nurse, 30 years)

Respondents who were involved were mainly in the management positions and therefore had adequate understanding and knowledge of the procedures involved in the accreditation process. For example:

I was involved. They went round with me to inspect what they wanted to see, equipment etc. They came with tools for the accreditation and assessed us on the tools. Prior information was given to us to prepare. It involved the university authorities. (Nurse Manager, 56 years)

I was involved in the process as a team leader, and member of a technical team which developed the accreditation tools. I was deeply involved from day one as I was the focal person for management of personnel for the various sections. I partnered others to look at the tools by organizing personnel. I took unit heads through the tools and prepared the facility for the process by way of training (Administrator, 45 years).

Those who were involved in the process acknowledged the fact that the process was useful and necessary and cited improvements in quality of care and in the provision of additional equipment following the accreditation. Among the improvements were in equipment situation and also led to staff training and acquisition of new skills and sharing of ideas through peer review. It had enhanced their understanding of accreditation and the National Health Insurance Scheme. For example:

It was useful because without accreditation one cannot in the first place have the authority or mandate to render health care services to the public (those with NHIS).It is necessary. It legalizes the relationship or contractual agreement between the NHIA itself and the health care provider

or facility. I have learnt more about accreditation (Medical Assistant 46 years)

As another put it:

It identifies you as a service provider and also offers the facility an opportunity to render quality health care. The NHIS was explained to me (Midwife, 61 years).

On the lesson learnt from the process, respondents mentioned that it promoted integrity but it required adequate preparation to put things in place. It led to monitoring and proper documentation. The findings also showed that though most respondents generally acknowledged the importance and benefits of accreditation, they also mentioned the negative aspects of the process. According to them, it was time consuming. For example

It is a long process and expensive. Like I said initially, you will be given the guidelines and put a few things in place and given temporary accreditation, You go through all process again and finally come for the accreditation before providing services. When you pass they give you the certificate. (Administrator, 50 years)

The tools were quite a lot, too many. Some are not applicable to our institution. It takes two years to get accreditation but, I think it can be done in five (5) weeks. (CEO, 56 years)

As another put it:

The process was really challenging and time consuming. The problem was that the preparation towards the accreditation was not easy. Thus, purchases, supply and putting up structures.(Laboratory Technologist, 57 years)

Among the suggestions made in respect of improvements in the accreditation process were the need to refine the accreditation tools, improve team work, consensus, involvement and a reduction in the accreditation fees paid by the private health providers. For example:

The N.H.I.A should involve those at the facility level in the development of the modules. Only the relevant areas must be covered for the various categories of facilities. (Nurse Manager, 56 years).

Accreditation is needed to indicate ability to provide services and so the process need to be done by top notch professionals to ensure proper and quality care. Those who will facilitate the accreditation must be paid well to do proper work. For now most of them have been complaining that is the scavengers. We realize that all the doctors and administrators who were trained because of the small amount of money that were given to them they have all left. They brought in new people which do not allow consistency in the system (Accountant, 56 years).

There is the need for teamwork and consensus. All the minds should meet. Others not consulted e.g. psychologists are behaviourists who help people to understand themselves so that they can understand others. They need to be involved. Involvement is vital, we need to be briefed as what is happening and offer our comments. We are also stakeholders. There should not be one -man show. The ideation stage and feedback are very important. (Clinical Psychologist, 52 years)

It should be done annually so as to put health facilities in check. I think a separate agency should be responsible for accreditation. We have

three (3) parties looking for the same thing and finally charge their own fees for the accreditation process. (Medical Director, 57years).

The foregoing indicates that respondents considered the accreditation process to be useful and if properly implemented it would help to improve the existing physical facilities and staffing and generally improve quality of care in the hospitals. It could also enhance smooth implementation and sustainability in terms of service provider motivation and regulation and public confidence in the service delivery

Discussion

Evidence in the literature shows that participation in health programmes can empower communities, create a sense of ownership and foster accountability (Ashford, Gwatkin and Yazbeck, 2006). Participation, whether individual or community can also lead to equity and sustainability if the process empowers diverse members of communities especially the most disadvantaged to advocate changes for improvement. It can also be a key to avoiding pitfalls through representation. Participation in the formulation and development of the scheme by health care providers took various forms: It was either direct or indirectly through discussions at meetings, seminars, submission of memoranda and issue of conference communiqués.

The involvement of health providers either as individual staff members or as members of professional associations was crucial for the formulation of the scheme. The involvement of other professional associations of health providers such as the Biomedical Scientists Association, the Public Health Technical Officers Group, the Health Accountants Association, provided opportunities for a wider involvement in

the design and formulation of policies.

While there is a strong and reasonable evidence of limited engagement of some health care providers (respondents) in the formulation process, it is argued that the process at the time was influenced by factors such as urgency and the nature of the NHIS. The technical nature of the NHIS also meant that only a few with some knowledge and experience in health insurance could have been involved in its design and formulation. However, being a new policy also required wider and sustained consultation among stakeholders.

Wider participation in a process leads to increased understanding, appreciation, acceptability, consensus building, enrolment, improved implementation and sustainability (Khawaja, 2013; IAPP, 2008; Smith, 2003). Participation and involvement of health care providers can improve their understanding of the scheme and their roles and attitude towards the implementation.

Accreditation is a form of regulation and formed part of the National Health Insurance Scheme. In order to provide the basic package of services, the NHIS covers both the public and private health care providers at all levels of the health system, subject to their accreditation by the NHIA. This was seen as a positive development which ensures that the NHIS can be accessed at a facility with minimum standards. Thus the objective of accreditation is to ensure that facilities are in a position to provide appropriate health care and that the facilities have the necessary infrastructure, equipment and staff. The study showed that accreditation gave renewed legitimacy to the institutional quality structures and programmes being implemented in facilities under the

Ghana Health Service.

The results showed that some of the respondents outside management were not involved in the accreditation process though they acknowledged its usefulness. Those in the private sector appear to have some reservations about the process with respect to late notification, the high level of fees payable and the perceived lack of avenues to seek redress for their grievances. To them the process put a lot of pressure on them.

A challenge with the accreditation process is the inability to consider ill- equipped health facilities in rural areas. This means that the pattern of accreditation will remain inequitable as accreditation follows where facilities are sited (Seddoh, et al. 2011).

Finally, the accreditation process focused on facilities instead of practitioners. The level of accreditation assigned is equivalent to the endowment of the facility. This has created a situation which is detrimental to small health facilities. For instance, an experienced doctor working at a rural or small facility or a health centre which has not been accredited may not be able to prescribe drugs but a newly qualified doctor at a tertiary institution can do so. This anomaly can undermine task shifting and the policy to redistribute health professionals to rural areas since some doctors would not like to work in the small facilities which are not accredited. However, the accreditation process was found useful to validate and to ensure that services and facilities were of certain quality.

Conclusion

The involvement of stakeholders in the formulation of the National Health Insurance Scheme and the accreditation process was found to be useful. The results are consistent with the observation (Kwaraja, 2013) that the level of involvement in the policy formulation process can influence the success or failure of policy implementation.

Despite the inherent benefits and advantages in public participation in both decision and policy making, the process of formulation and development of the NHIS has been criticized on grounds of exclusion (Witter, Garshong and Ridde, 2013; Agyepong and Adjei, 2009. The design of the scheme showed that it combined the characteristics of both social health insurance and community based health insurance and therefore the expectation was that people in the community/district levels would be involved in the management and implementation of the schemes.

Finally, the findings suggest that while there were some consultations with some identified persons and recognized institutions, involvement of health care providers of the scheme formulation processes involved mostly people who were in management positions and those who were in the Ghana Health Service.

CHAPTER SIX

VIEWS ON THE IMPLEMENTATION OF THE NATIONAL HEALTH INSURANCE SCHEME

Policy theorists recognize that implementation involves coordinating action across multiple organizational actors and implementers (O'Toole, 2000)

Introduction

One of the key propositions of the study is that sustainability of any health insurance scheme is contingent on its efficient implementation. Grindle and Thomas (1990) observed that policy implementation is an on-going, non-linear process that must be managed and requires consensus building, participation of key stakeholders, conflict resolution, compromising, contingency planning, resource mobilization and adoption.

According to some observers, the stages of implementation in the policy process have been overlooked on the assumption that the policy design was more important (Kamuzora and Gilson, 2006; Palumbo and Calista, 1990). Some researchers have also pointed out inconsistencies in implementation of policies in developing countries since independence (Aryee, 2001; Crichton, 2008). According to Cairney (2012), the study of implementation derives from the notion that decisions taken by policy makers may not be carried out as intended.

The NHIS Act (Act 650) was passed in 2003 and implementation began in the third quarter of 2005. A policy framework (MOH, 2003) was developed to provide the general direction for the implementation of the scheme. As captured in the policy frame work of the NHIS (MOH, 2003), the

vision of the National Health Insurance Scheme was to assure equitable universal access to quality package of health services of all residents in Ghana without being required to pay out of pocket at the point of consumption of service.

The short, medium and long term objectives of the NHIS were set in the policy framework as follows: in the short term, that is within the first 5 years, the necessary bodies would have been created, awareness raising and consensus building carried out, the needed legislation passed and the enabling environment developed to ensure the realization of the medium and long term policy goals of government. In the medium term the objective was to ensure that within the 5 to 10 years at least 50-60 % of residents would belong to a health insurance scheme that adequately covers them against the need to pay out of pocket at point of service use to obtain access to a defined package of adequate quality needed health services.

In the long term the objective was to ensure that every resident of Ghana would belong to a health insurance scheme that adequately covers him or her against the need to pay out of pocket at point of service use to obtain access to a defined package of acceptable quality needed health services.

As part of the implementation of the scheme, a National Health Insurance Council (NHIC) was established to register, license, regulate, supervise operations, grant accreditation to health care providers and monitor their performance. Discussions of the implementation revolved around the design, funding, benefit package, enrollment, utilization, implementation, and quality of care (Witter and Garshong, 2011).

The chapter deals with the views of health care providers as key actors on the implementation process of the scheme and their observations on the progress made and the challenges associated with its implementation Suggestions made by respondents to improve the implementation of the scheme are also discussed.

Views on the Implementation Process

Respondents were asked to describe the process of implementation of the NHIS, how it has been operating, those involved and their respective roles and the challenges facing the Scheme. Respondents were also asked for their observations on whether the Scheme had achieved its intended objectives or not, and to give suggestions to improve the process of implementation.

The findings of the study on implementation of the scheme indicated diverse opinions. The implementation process was described variously as smooth, good and challenging. Those who deemed implementation as smooth felt that there were enough evidence to show that progress had been made in establishing the structures and systems while a lot of people are also benefiting from the scheme. To them the defects in the process of implementation were normal and should be expected as a new policy. They felt that the positive aspects far outweighed the negatives. For example a respondent put it:

The implementation of the NHIS so far has been smooth. People are benefiting from the scheme despite the few challenges. (Community Health Nurse, 29 years).

Others felt that implementation had been good given the achievements made since the introduction of the scheme. They considered it to be good considering the fact that almost the required structures such as the NHIA, regional and district scheme offices had been put in place but said there were problems facing the scheme. As a respondent remarked:

The implementation is so far good but I think the mode of payment to the service providers is where something should be done about it. This is a private institution and as private persons, they actually pay their workers from what they get. The mode of payment should be reviewed so it can be earlier than what is coming. (Medical Laboratory Scientist, 57 years)

The respondents who rated implementation as challenging felt that it had been bumpy looking at the challenges facing the scheme.

The implementation of the Scheme has been challenging because all these stakeholders or the clients from my perspective refuse to renew his/her premium, then the insurance do not have adequate funding, then the providers too are not paid, delays from the insurance office, district assemblies too are also stakeholders, all these cumbersome process come together to make the implementation of the scheme challenging. (Nurse Anaesthetist, 34 years)

An assessment of the implementation of NHIS, from the perspective of the respondents revealed that some achievements had been made in terms of increased utilization and the establishment of structures, while others considered the fact that there were challenges.

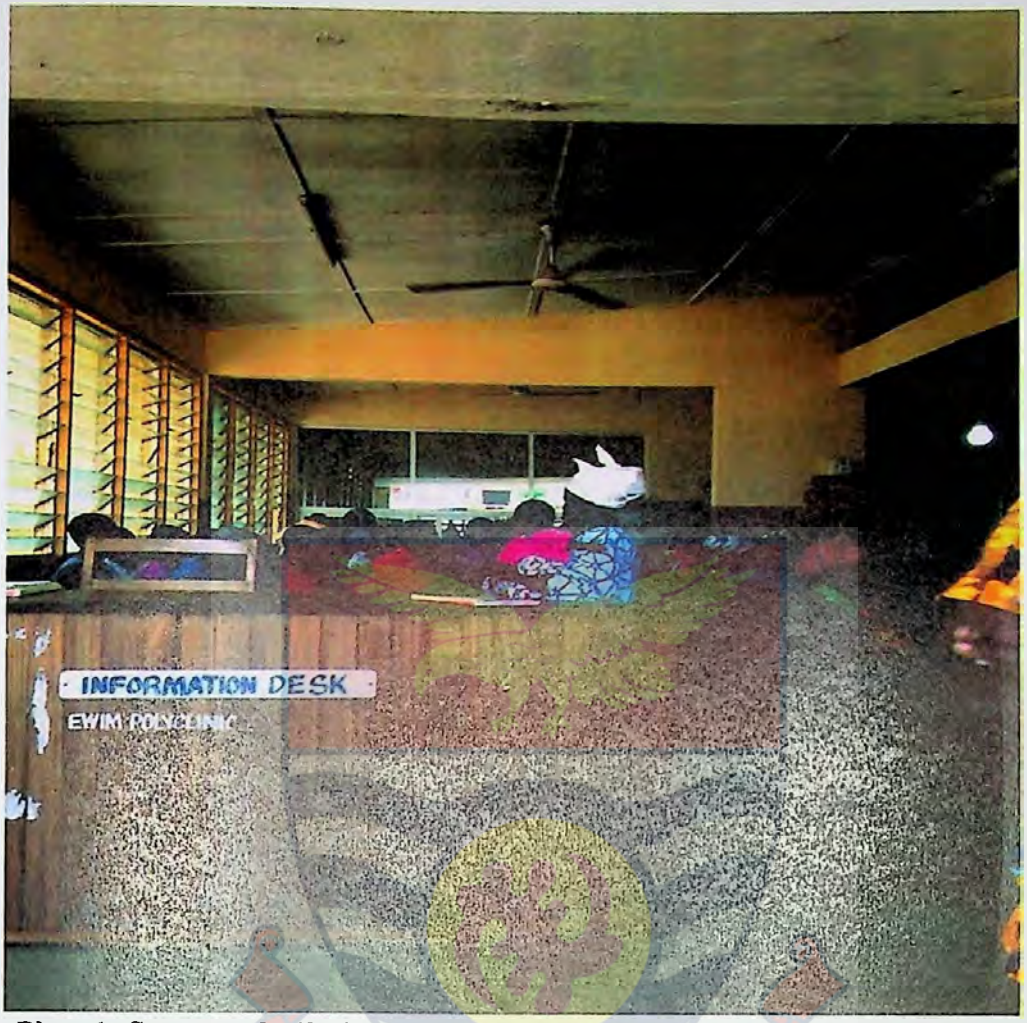

Plate 1: Scene at the Ewim Health Centre

Source: Field Work, 2012

Actors and their respective roles in the implementation of the scheme

The major actors mentioned can be grouped into two major categories, namely; institutional and individual actors. The institutional actors involved in the implementation of the scheme are the NHIA, MOH, Ghana Health Service, Teaching Hospitals, Ministry of Finance, SSNIT, District Assemblies, Development Partners. The individual actors are health professionals (public and private) health care providers- doctors, nurses, pharmacists, registered cardholders (clients).

Table 9-*Summary of Roles of Key Actors in NHIS formulation and implementation processes*

Category			Roles
Actors	**Institutional**	**Local:** MOH, NHIA, SSNIT, District Assemblies, CSO, Mass Media, Policy Think Tanks/ Academia	• Facilitation, • Support • Regulation • Implementation
		International: Development Partners (DANIDA, ILO, DFID, WHO, WB etc)	• Support, • Legitimacy • Recognition • Capacity building
	Individuals	Health care providers, Registered NHIS clients	• Service provision • Patronage and accountability in service provision and management of the NHIS

Source: Author's construct, Owusu- Boampong (2012)

The views of respondents on the respective roles of institutional and individual stakeholders are summarized in the Tables 9 and 10

Table 10- *Key Institutional actors and their roles in the implementation of the scheme*

Actor	Expected role(s) in implementation	Role(s) Played	Remarks/Recommendations
MOH	• Policy design and development • Regulatory mechanisms	• Key role in formulation and design of the scheme- ministerial oversight responsibility. • Coordination and supervision of activities • Resource mobilization	• Policy Framework provided basis for NHIS implementation • Role in facilitating release of funds to the NHIA and health care providers can be improved. • The MOH should play a more moderating role between the NHIA and the health care providers
Ghana Health Service	• Facilitate accreditation of public health facilities • Staff sensitization and development • Costing of services • Facilitate establishment of DMHOs • Corporate membership on NHIC	• As umbrella service provider/key implementer • Service provision • Scheme design and implementation	• Ensure the enforcement of its Code of conduct for its staff • Improve quality of care in its facilities • Can play a strong advocacy role in facilitating early reimbursement of claims
NHIC/NHIA	• Regulation of schemes • Supervision of schemes	• Implementation of the free maternal health policy and	• Additional roles/initiatives have further enhanced

Table 10 continued

	• Accreditation of facilities • Reimbursement of claims • Development of tariff operational manual for service providers • Setting up and operationalization of insurance schemes • Public education and sensitization	establishment of the over 145 schemes • Additional roles being performed such as Clinical audits, establishment of call centre, claims, processing centre and Consolidated Premium Account (CPA) • Lead implementing agency • Purchaser	sustainability • Delay in reimbursing health care providers remains a source of concern • Should improve its engagement with key stakeholders

Source: Author's construct, Owusu- Boampong (2012)

Table 11-*Key individual actors and their roles in the implementation of the scheme*

Actor	Expected role in implementation	Role(s) played	Remarks/recommendations
Pharmacist	• Preparation and dispensing of medicines • Patient education on drug use • Patient education on the NHIS	• Advice to NHIA on Drug Tariff setting and DRGs • Accreditation surveyors • Public sensitization on the benefits of NHIS • Scaling up and operationalization of mutual insurance schemes • Development of manual for service providers and subsequent reviews(NHIS Medicines Tariffs, Medicine List Prices and NHIS prescription forms • Tools for accreditation of hospitals, health centres and maternity homes, pharmacies, licensed chemical shops	• Improvements needed in quality service provision particularly in medicine safety, rational use and prescription monitoring. • Key role in the sustainability of the scheme in terms of cost effective formulary, medicine safety and accreditation of health facilities including pharmacies
Nurses	• Provision of nursing services • Public education and	• Service provision • Accreditation in pre-auditing and monitoring for adherence to	Continued adherence to service protocols

Table 11 continued

	sensitization on NHIS.	standards	
Facility Managers(Medical Directors, Nurse, Managers, Administrators, Accountants)	• Provision of incentives to staff. • Supervision of staff • Prompt submission of claims • Provision of supplies	• Supervision of staff • Provision of enabling environment for staff	• Key stakeholder in implementation • Inefficiencies and limitations in service provision e.g lack of essential supplies
Individual Registered clients	• Provision of supplies and equipment • Facilitate facility accreditation • Payment of premium • Regular renewal of membership	• Payment of premiums • Registration of membership • Patronage of services • Renewal of subscriptions	• Concerns with quality of care and inability of some clients in renewing membership • Their ability to seek quality of care is however, is weak for lack of information
Doctor	• Provision of medical services • Patient education on the NHIS	Service provision	Role and attitudes are critical as leaders of the health team, as administrators and they constitute a powerful stakeholder collectively as

Table 11 continued

			members of the GMA. Continued adherence to clinical protocols, NHIA standards and provision of quality services The frequent strike actions by doctors, numbers and their distribution have been a source of concern. Continuing engagement with the NHIA is necessary
Other healthcare providers	• Provision of services • Patient education on NHIS	Service provision	The frequent strike actions by health care providers and their attitudes have been a source of concern. The NHIA should constantly engage them through their professional association

Source: Author's Construct, Owusu- Boampong (2012)

The first group of institutional actors were the development partners such as the Department for International Development (DFID), the United Nations International Children's Fund (UNICEF), International Labour Organization (ILO) and the Danish International Development Agency (DANIDA). They provided technical assistance in the development of the scheme, capacity building and monitoring as part of the implementation of health sector reform programme (Witter & Garshong, 2009, Appiah-Denkyira & Preker, 2005). The development partners have for some time been part of the independent review processes in the health sector. They have reviewed the implementation of the NHIS and provided useful insights for improvements (MOH, 2009-2014; MOH, 2003; MOH, 2006, MOH, 2005).

The second groups of actors mentioned were health facilities such as the hospitals, health centres, clinics, pharmacies, medical laboratories, and maternity homes. Their roles were mainly service provision and education of clients/patients on the procedures and the need to register with the scheme

The International Labour Organization (ILO), known for its long standing record of technical cooperation in the field of social protection, provided policy and technical advice on the determination of the financial feasibility of extending coverage to the poor (ILO, 2007; Leger, 2006). The ILO model demonstrated that the financial sustainability of the NHIS was not assured while the study by Leger focused on cash flow analysis of the NHIS in 2006 and; it predicted a deficit in 2007 with an increase in coverage. Part of the initial funding of the scheme was provided through the HIPC Initiative which was mainly supported by the development partners, for example the DFID which provided financial and logistic support for the public

sensitization programmes, studies on NHIS and the establishment of District Mutual Health schemes. As observed by Witter, Garshong and Riddle (2013) the role of donors appeared to be catalytic in kick -starting the scheme.

At the local level, institutional actors involved in the formulation and implementation of the NHIS were the Ministry of Health, Ghana Health Service, and the National Health Insurance Authority and the registered clients. The Ministry of Health as the supervisory authority for the health sector was responsible for overall policy framework for the NHIS. It developed the policy framework to guide the implementation of the scheme.

The Ghana Health Service as one of the agencies of the Ministry of Health is responsible for service delivery at the sub-district, district, regional and national levels. As a major public sector provider and a facilitator for the establishment of schemes especially Mutual Health Organizations (MHIOs), it was expected to sensitize the staff, provide data for costing of services and ensure quality of service at the various health facilities. A respondent indicated:

It is on the ground to implement the policy. For instance, for an institution to qualify for accreditation, they need to meet the standard. Ghana Health Service has provided equipment such as Lab, x-ray and the maintenance of such equipment and supervision in given fund generated by the health institution (Optometrist, 49 years).

The NHIA is the main implementing agency for the NHIS. It is mandated by the NHIS law to accredit health facilities, regulate the establishment of schemes and ensure the reimbursement of the health care providers. As the lead implementing agency for the NHIS, the NHIA has

fairly played its role as the regulator. The accreditation process, clinical audits and the application of sanctions on defaulting facilities and health care providers have promoted quality of the health care and ensured a degree of efficiency in service provision and improved provider behaviour. The NHIA has also instituted an Awards Scheme to recognize excellence in service provision and corporate partnership. Thus NHIA has injected some efficiency in the accreditation process and in its operations in general in order to maintain trust and confidence in the scheme.

Registered clients are the beneficiaries of the services provided by accredited providers under the scheme. They are in categories- those in the formal sector (SSNIT contributors), the informal sector and those in the exempt category. These specified the mode of contribution or payment of premium to access health care under the scheme.

The scheme managers are the regular employees of the NHIA, who work at the various levels of implementation of activities of the NHIS- national, regional and the district. The staff includes marketing officers, ICT personnel, regional and district managers, accounts and public relations officers. The role played by the staff include public sensitization on the NHIS registration of clients, issuance of membership cards, renewal of membership, collection of premiums and liaison with service providers. Their roles are mainly administrative in nature. A respondent summed up the various roles as follows:

The major stakeholders in the implementation of the scheme are the managers, health care providers and the beneficiaries. The role of the health care providers is that they are the implementers of the scheme policies. The

*role of the scheme managers basically to collect premiums pay claims and do the disbursement of fund either from central Government or from local sources. The role of the beneficiaries is to pay their contributions in terms of the payment of the scheme either in premium or also to access the service they want. (*Physician Assistant, 43 years)

According to some of the respondents, the roles of the actors ranged from provision of technical assistance, provision of medical services, public sensitization and education, funding and provision of infrastructure for offices for the scheme operations. These findings corroborate the observations made by earlier studies on the role of various stakeholders in the implementation of the scheme (Rajkotia, 2011; Witter and Garshong, 2009).

The roles can be summarized as facilitation of the scheme, service provision and regulation. For example, the role of the Ministry of Health in the design and establishment of the NHIS was considered to be the basis for implementation of the scheme. The Ministry provided leadership in the policy processes and mobilization of public support and resources for the efficient functioning of the NHIA.

Services provided by health care providers constitute the benefits of the NHIS which translate to a greater extent in to the core of the NHIS. The quality of the services can influence public acceptability of the scheme. The role of the registered clients is in paying the premiums and renewing their membership. For example respondents made the following observations such as:

They need to pay up the premiums regularly and renew their membership with the NHIS (Medical Director, 52 years).

The clients should also renew their cards timely and not to wait till they are sick. They should only report to the health facility when necessary and come with their cards. (Biostatistician, 55 years)

Registered clients should comply with treatments. They should not abuse the system by going from facility to facility. They should also patronize services and pay the right premium as stated in the policy. (Pharmacist, 47 years)

Clients, in addition to the payment of premiums, are expected to take their personal health care seriously and participate fully in discussions aimed at improving the implementation of the scheme both at the local and national levels.

The roles of the institutions such as the media, local opinion leaders, civil society organizations, the Metropolitan/ Municipal/District Assemblies, the Ministry of Finance, SSNIT, development partners, political parties, policy think thanks have been to provide activities such as public sensitization, technical support, funding, staff capacity building, suggestions and research.

Observed effects of the introduction and implementation of the scheme

The effects of the introduction and implementation of the policy were seen as being positive and negative as well. Among the positive effects was improved health seeking behaviour of members, increased hospital utilization and reduction in medical complications. As some respondents mentioned:

On the positive side, I can say people are not scared when they are sick. It has lessened the financial problems for health. (Staff Nurse, 30 years)

I think OPD attendance at the hospitals has increased and since the attendance has increased, in effect, the emergency cases are minimal because the people come to the hospital early because of the health insurance. (Medical officer, 30 years)

Some studies have reported the positive impact of the scheme in respect to equity of premium, utilization and enrolment, access to health care, benefit incidence and progress towards universal health coverage (Dalinjong and Laar 2012; Mills, Ally, Goudge, Gyapong and Mtei, 2012; NHIA, 2012; Blanchet, Fink and Osei-Akoto, 2012; Brugiavini and Pace, 2010; NDPC, 2008). Health Sector Independent Review reports and annual reports of health facilities also indicate the positive development especially on the demand side.

It is also argued that the reported increased utilization at the various health facilities is a positive phenomenon which means a general acceptance of the introduction of the scheme and improved access to health care. It also indicates a growing confidence in the scheme, mobilization of additional financial resources, reasonable justification for further investments and improvements in health infrastructure and increased solidarity among the registered clients which can help sustain the scheme.

The negative consequences mentioned were increased staff workload at the health facilities which has led to reduced quality of care in terms of patient waiting time, poor health provider attitude and misconceptions about the scheme. According to one respondent:

The effect is, now that people are patronizing the facilities (hospitals), you go to the hospitals and they are choked with people because they are not paying directly as it used to be. (Medical Superintendent, 59 years).

It puts stress on the facility as people attend hospital more often. Some clients even come when they are not sick. (Medical Assistant, 42 years).

Plate 2: Patients in a queue at the OPD at the Cape Coast Metro Hospital

Source: Field Survey 2012

Achievement of Objectives the Scheme

The objectives of the NHIS were set in the context of time and coverage providing for the short, medium and long term perspectives. This

was probably meant to provide a basis for assessment of progress in implementation and sustainability of the scheme. Respondents were asked to indicate whether the scheme has achieved its objectives or not. Responses were mixed with regard to the achievement of the objectives of the scheme.

Yes, in all, the policy has achieved its objectives because previously without the National Health Insurance Scheme, it was a headache when one was sick, but because of the insurance, people are not afraid to go and seek health care. (Accountant, 56 years)

The policy has achieved its intended objective which was to eliminate cash and carry. Now people with insurance can now have access to a health facility. (Medical Records officer, 52 years)

Another noted:

I will say moderately. Yes in a way. A policy takes time to achieve its objectives. It needs about 10 years. (Medical Superintendent, 52 years)

Another remarked as follows:

Not really. It has not achieved its objectives. Actually there are some challenges. (Physiotherapist, 46 years)

Main challenges facing the Scheme

Respondents were asked to express their views on the challenges facing the scheme. The challenges mentioned ranged from increased patient attendance leading to over utilization, delayed payment to providers, poor communication among stakeholders and resource constraints.

The findings showed that respondents in senior management positions mentioned delayed reimbursements as the main challenge. Those in the

junior and middle level management grades complained of increased workload as result of the increased utilization. Others felt that inadequate funding and lack of comprehensiveness of the benefit package constituted major challenges.

The opinions given by respondents reflected their training, position and experience with the implementation of the scheme. Generally the late reimbursement was mentioned as the most worrying issue by most respondents. According to them it affected their efficiency and motivation as health professionals.

Some of the diseases and services were not included in the benefit package such as cancers and family planning but were thought to be important to the attainment of the MDGs. Some diseases were also considered to be expensive and thus not affordable to the poor and expensive to treat. For example as one respondent posited:

The benefit package is not comprehensive. It defeats the purpose of the scheme if not all the conditions are included. (Physiotherapist, 46 years)

Others felt that the long waiting time in obtaining a membership card could lead to frustration on the part of clients and possible denial of service in any emergency. As a respondent remarked:

The waiting time for obtaining membership card is long. If the service is needed urgently and care is delayed, it can lead to complications. (Staff Nurse, 29 years)

Others were of the opinion that the increased workload arising from the increased utilization at the facilities could put the health care providers

under severe stress which could lead to further frustrations, inefficiencies, low staff morale, unethical practices and poor quality of care. For example: *There is increased staff workload which can lead to mistakes on the part of us the health providers.* (Physician Assistant, 43 years)

Others attributed the inability of the NHIA to reimburse health care providers on time to the operational management inefficiencies such as lack of prioritization. The NHIL is collected by the Revenue Authority and put in the Consolidated Fund. Release of the earmarked funds to the NHIA for disbursement to the providers takes time and involves long processes. As mentioned:

The scheme is not being efficiently managed by the NHIA. There is no efficiency in the operation of the scheme. The facilities are not reimbursed on time but you find funds being used for other things such as buying old ambulances. Meanwhile the NHIA owe the facilities. I don't see the sense in this (Nurse Manager, 56 years).

Some respondents also felt that the Diagnostic Related Groups (DRG) system of payment does not facilitate full costing of services. They want the full cost of all the services provided in a facility to be reimbursed to enable them use it to improve the quality of services. To some respondents, the payment system does not place much premium on those services provided by specialists. For example:

The facilities are not allowed to charge for some services such as dietary services. They are not included the services charged but to me they should be paid for. We can use the fees to improve the quality of services (Dietician, 31years).

The tendency of some patients or registered clients often moving from one facility to another was cited as a major challenge facing the scheme. To them, it contributes to the increased workload and a waste of essential and scarce medical supplies on the patients. Some of the respondents felt it was either due to ignorance or deliberate practice. As illustrated in the following quote:

Some of the clients do not understand the insurance system. For every ailment they come to the hospital. They move from one facility to another to collect drugs. There is abuse of the system by clients because everything is free now. This is creating shortages of drugs and increased workload on us. (Community Health Nurse, 26 years)

Delayed reimbursement of claims and the increased attendance at the health facilities were the main challenges since it has implications for the smooth running of the facilities. Independent review reports and annual facility reports have also corroborated the issue of delayed reimbursements (MOH, 2009; Witter and Garshong, 2009).

Two major observations made during visits to the facilities were the long queues at the OPDs especially at the hospitals; and also health care providers were seen busy and complained of increased workload in the midst of limited or little incentives. The increased utilization, however, meant a reported growth in revenue for health care providers which were reported to have resulted in some improvements in some of the facilities (Witter, Garshong and Ridde, 2013).

The ability of the facilities to provide the needed inputs to render quality services motivate their staff and have the potential to collapse the

health centres through. The attitude and ethical behaviour of health care providers are likely to be affected by the increased workload. These observations are generally consistent with results from earlier studies on the NHIS and elsewhere. In a study on factors influencing the implementation of the Community Health Fund in Tanzania, Kamuzora and Gilson (2001) observed that district health managers were also confronted with low enrolment through the inability of members to make contributions, low quality care and lack of trust in some scheme managers. They further argued that it is important to focus attention on the policy implementers who are capable of reshaping policy during its implementation with consequences for policy outcomes.

The argument that patients make unnecessary use of services assumes that people can always tell whether use is necessary or not (Abel-Smith, 1994). Many do not know whether the symptoms are serious or not. The allegation that some patients move from one facility to another on the same day or within the same week may probably be due to the perceived poor quality of care provided in some of the facilities. It can be explained that because people could not afford the cost of health care then, they accepted any service –be of quality or poor. Now with the introduction of the NHIS, they would naturally shop to get better services. The extent of the problem however, needs further exploration as to the magnitude and the reasons. This is because the practice has the potential of collapsing the scheme.

Suggestions to Improve Implementation of the NHIS

Respondents were asked to make suggestions to improve the implementation of the scheme. The first suggestion was in respect of timely release of the portion of the VAT from the Ministry of Finance to the NHIA to enable it reimburse service providers on time. As at the time of the study, it was observed that the NHIA was in arrears of six months in reimbursing providers.

Respondents advocated for improving the environment-based diseases. Preventable diseases such as Malaria, HIV/AIDS, TB and high maternal mortality dominate Ghana's health system and that investment has been made in controlling them. Though some progress has been made to reduce the prevalence of such diseases, their continued coverage under the scheme needs to be revisited. Some co-payment is recommended for malaria to reduce its pressure on the scheme.

Respondents were unanimous in advocating for increased motivation and incentives to enable health workers cope with the increased volume of volume arising from increased patient utilization. This is to be expected, as they are likely to benefit from the improved incentives. It is also realistic since lack of incentives can create opportunities for negative staff behaviour. During the interviews, it was found out that some private health facilities had instituted some form of cash incentives for their staff in addition to the establishment of non-monetary incentives such as recognition of high performing individuals and corporate service provisioning.

Discussion

The NHIS was introduced in 2003 and the NHIS law was passed in the same year but its full scale implementation started in 2005.The main components of implementation can be grouped under legislative instruments, governance, administration, membership, service provision and financing. The main legal frameworks guiding the implementation of the National Health Insurance Scheme have been the Act 650 of 2003 and Legislative Instrument 1809 had been passed. The law was passed after public discussions and some protestations. Given the political environment at the time, the commitment to fulfil its manifesto by the then ruling NPP and the support from the development partners to build and implement an aspiration and promise of a national health system free at the point of delivery for all as a right and need were critical factors towards the implementation of the scheme.

To date the various structures are in place with the NHIC as the governing body, the NHIA as the secretarial and DMHIS constituting the administrative agencies under the scheme. The Ministries of Health and Finance, and the Parliament of Ghana have oversight responsibility over the NHIS. The NHIA has taken a number of initiatives to improve the performance of the NHIS. These include but not limited to the establishment of 145 autonomous schemes in 2003 and further expansions as new districts were created. In 2008 Free Maternal Care Programme was introduced, and led to the review of Act 650 and eventually the passage of Act 852. The establishment of Claims Processing Centre (CPC) in 2010, implementation of a Clinical Audit in 2010 and the establishment of the NHIS Call Centre in 2012 are positive developments.

The scheme, according to the NHIA (2014), has grown over the years from an initial membership of 1.5 million in 2003 to a subscriber base of 10.5 million as at December 2014. Moreover, 29 million attendances at health care facilities were made on account of the NHIS. Currently, 69% of the NHIS registered subscribers are exempted from paying premiums. These are SSNIT contributors and pensioners, persons under 18 years, persons 70 years old and above, pregnant women, indigents (the core poor), persons with mental health conditions, categories of disabled persons designated by the Minister responsible for Social Welfare and Protection as well as beneficiaries of the Livelihood Empowerment Against Poverty Programme.

The introduction of the scheme has created additional fiscal space for resource reallocation such as to preventive health care and capital investments to increase access. With the introduction of NHIS, there has been standardization of services and payment mechanisms across the health sector-private and public

Another positive effect has been the accreditation of facilities, which has to some, extent, improved quality of services at the various health facilities. The clinical audits instituted by the NHIA coupled with the monitoring and evaluation mechanisms have also promoted professionalism in service provision, accountability and reduced the unethical practices in the health sector (Hor, 2013).

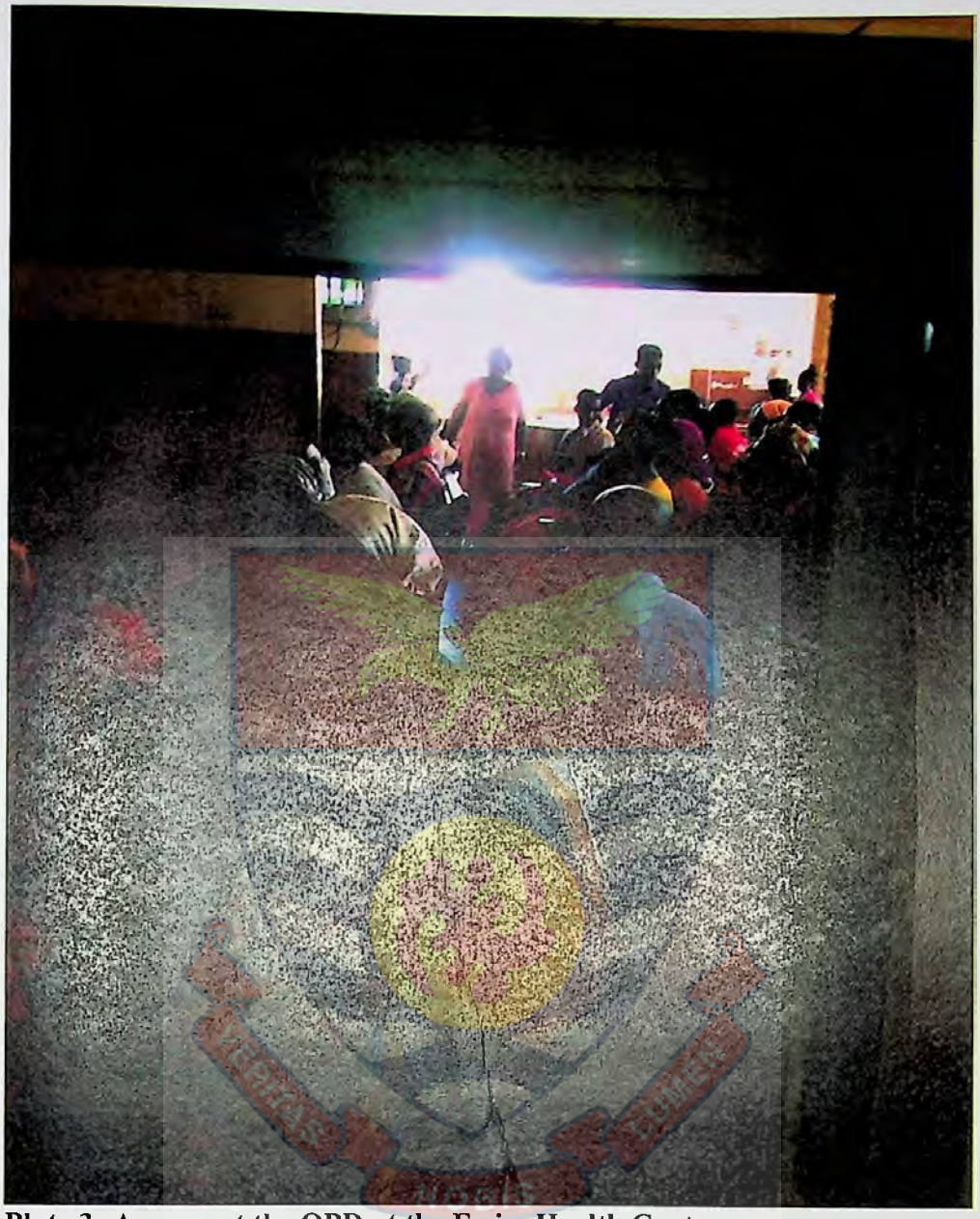

Plate 3: A scene at the OPD at the Ewim Health Centre,

Source: Field work (2012)

Conclusion

The results of the study suggest diverse views on the implementation process of the scheme. The challenges in the implementation of the scheme included delays in reimbursement and increased utilization of facilities and increase in the workload of medical personnel.

It was observed that the threats and actual suspension of services by private providers and the mission health institutions to clients for non-reimbursement of claims by the NHIA would have implications for the sustainability of the scheme. As Lipsky (2010) noted in an environment commonly characterized by resource uncertainties, policy implementers adopt coping behaviours to manage the high demands and time pressures that they face and through these behaviours they re-interpret and reshape policy in unexpected ways.

Hill (1997) categorized these coping behaviours as rule breaking or careless rule interpretation, officious rule enforcement which make it difficult for the public to secure entitlements, failing to give information about entitlements, and slow work practices which impose implicit rationing through delays. There have been reports of informal payments at some of the facilities such as charging for services out of hours, asking patients to pay for drugs which are not to be in stock and asking patients to pay for "superior" drugs which are not provided under the NHIS (Witter and Garshong, 2009). Policy being effectively re- translated and recreated through by apparently powerless implementers through their practices (Kaler and Watkins, 2001; Hill, 1997; Walt and Gilson, 1994).

The roles and level of influence of the respective actors in the implementation process varied among them and were largely determined by factors such as economic and technical knowledge. The values and behaviour of the actors also differed and were influenced by their commitment, interest and positions as agents and principals. Health care providers were

responsible for aspects of such as referrals, prescription practices and facility accreditation.

CHAPTER SEVEN

VIEWS ON SUSTAINABILITY OF THE SCHEME AND THE ONE-TIME PREMIUM PAYMENT POLICY

Introduction

The goals of the National Health Insurance Scheme are to attain a financially sustainable health insurance scheme, achieve universal financial access to basic health care services and to secure stakeholder satisfaction (NHIA, 2012). Financial sustainability of the scheme remains a challenge to the MOH, NHIA, health care providers and registered clients given the general acceptance of health insurance and its consequential increase in health care service utilization, demand and supply side moral hazards, non-adherence to the gate keeper system and efficiency (NHIA, 2012).

One of the objectives of the study was to find out the views of health care providers on the factors including the introduction of the one- time premium policy on the sustainability of the scheme. As a new policy, the proposed one-time premium payment policy appeared to affect the sustainability of the scheme. This chapter presents the views of health care providers on their understanding of sustainability of the scheme, factors affecting the scheme, the one-time premium payment policy and suggestions to sustain the scheme.

Views on the Sustainability of the Scheme

Policy sustainability is frequently debated. The debate becomes fair, if it is accompanied by a clear idea of what it means to be sustainable. How to assess sustainability and what the policy implications are. There is clarity about the meaning of sustainability in terms of ability to adequately finance a

scheme in the face of growing cost pressure, utilization, consumer and provider expectations, coverage and quality of service (Thompson, Foubister, Figueras, Kutzin, Permanand, et al., 2009).

When asked, respondents had different interpretations of sustainability of the scheme. Among them was sustainability in terms of within time or period, broad acceptability, ability of the scheme to pay claims promptly, ability to achieve its intended objectives and provide the expected benefits. The following are some of the definitions that emerged:

Being able to go on. It should hold on its own. It is its ability to stand the test of time. (Medical Officer, 34 years)

As health care providers, they appreciated the need for the scheme to be sustained and that appropriate measures would need to be put in place to secure the efficient implementation of the scheme. The definitions provided were in support of the financial and managerial sustainability of the scheme.

Factors Influencing the Sustainability of the Scheme

The NHIS was designed to be a mandatory health insurance system, with risk pooling across district schemes, funded from members' contribution and a levy on the value-added tax (VAT) charged on goods and services, from which a broad minimum package of care could be funded. Respondents were asked to mention factors which affect the sustainability of the NHIS. From the discussions, the main factors identified to affect sustainability were the involvement of health care providers in the process of formulation and design of the scheme, facility accreditation, structure and management including the

design of the NHIS, funding, benefit package and ethical and regulatory mechanisms. The factors are discussed as follows:

Formulation process and design of scheme

Respondents who were involved in the formulation design and the accreditation processes expressed optimism and confidence in the sustainability of the scheme. A possible reason for this is that they generally felt that their involvement in the design and formulation of the policy had enhanced their understanding and appreciation of the scheme and ownership. Involving people in the process of formulation can improve their sense of renewal of commitment and belonging to the process. It can mean a sense of recognition of effort, a feeling of pride and a source of motivation.

Facility Accreditation Process

The NHIS covers both public and private health care providers at all levels of the health system, subject only to their accreditation by the NHIA. Accrediting facilities is meant to ensure the provision of quality services through well-trained and qualified personnel, availability of appropriate, well-maintained medical/hospital equipment and infrastructure. Respondents were asked for their views on the accreditation process and how it affects the sustainability of the scheme. The general view was that accreditation has improved quality of service in some facilities through availability of qualified staff, medical equipment and supplies and infrastructure which can enhance public confidence in service delivery and in turn help to sustain the scheme. For example:

I think accreditation is related to sustainability in one way. Accreditation helps to bring standards up and by bringing up standards; it makes for good care to clients. They do not come back with the same ailment. (Optician, 54 years)

The argument is that accreditation process can contribute to the sustainability of the scheme since it ensures that appropriately trained health service providers are available as well as adequate and safe medical equipment and properly maintained infrastructure. These factors can affect the sustainability of the scheme. An increase in accredited providers widens access which is positive but has an impact on cash flow as the tariff for private health care providers is higher and subscribers in urban areas have price disincentive to patronize them and can lead to increase in cost of care.

Structure, Organization and Management of the Scheme

The study sought to ascertain views on the structure and management of the scheme towards its sustainability. The structure and management of the scheme is broadly defined to include the legislative framework, management of the scheme, existing organizational structures, management of the insurance funds, registration of clients, reimbursement procedures, calibre of the scheme managers and the working relationships between the scheme managers and the health care providers. Respondents felt that the existing structure and organization of the scheme was too centralized making local involvement and supervision ineffective. Others expressed concern about the lack of autonomy of the district mutual schemes as provided in the Act 650. As pointed out by one respondent:

The structure of the NHIA is too centralized. Everything is in Accra. For example the district management boards are not independent to take initiatives to address problems and challenges at the local level though it is supposed to be community based. (Laboratory Scientist, 57 years)

The NHIA is the regulator and implementer at the same time so who is monitoring whom? If the management structure is weak, it means the system can collapse. It has effect on the efficiency and credibility of the NHIA. (Administrator, 47 years)

If the structure is not well developed it can affect sustainability. Now we don't know whether the mutual schemes report to the regional scheme managers or headquarters or to the Boards. There is a problem (Medical Director, 58 years).

Other respondents, however, contended that the structure was appropriate and well organized. With the three-tier structure at district, regional and national level, it allowed for control and efficiency. The headquarters is responsible for policy and resource mobilization, the regional offices for co-ordination of the activities of district schemes while the district offices were responsible for daily activities of the scheme including claims vetting, issue of ID cards, serve as mediatory link between the providers, clients and the NHIA.

It is well structured. We have the national, regional and district levels operating efficiently. (Staff Nurse, 34years)

Opinions were mixed on the calibre, competence and background of scheme managers. They were variously described as inadequate, and have

limited training and experience in the management of health insurance schemes.

Respondents were of the view that poor calibre and inefficient scheme managers constitute a threat to the sustainability of the scheme. For example:

The scheme lacks areas of expertise in claims management. They should have staff with technical background. It can affect the sustainability of the scheme where there is no transparency on both sides will open up during vetting it could be exposed. Facilities must know what went into it. There should be transparency on both sides. (Administrator, 41 years)

On subscriber enrolment, some respondents reported that increased subscriber enrolment has implications for the sustainability of the scheme since it increases the workload of health care providers. The increased workload can lead to agitations for better remuneration which can affect premium payment. The increased workload has serious implications for quality of care. The other implication is that cash flow is affected. Increased utilization though is positive, the increased membership, does not necessarily translate into increased revenue or income since the bulk of income is from SSNIT and the VAT levy. The more people are enrolled in terms of coverage, the greater the risk of financial difficulties. Patterns of care can also be distorted by provider interests and unequal access by different groups. Others, however, mentioned that it is positive as it can to lead to the employment of additional staff to address the shortfalls in staff. It can also be interpreted to mean a growing confidence in the scheme.

Funding mechanisms

Respondents were asked to share their views on the funding mechanisms and how they affect the sustainability of the scheme. Respondents were generally of the view that the sources of funding and level of contributions were adequate and equitable. To them the NHIL provided equitable sources of funding since it enables everybody including foreigners to contribute to the funding of the scheme. Some argued that the system ensured that the rich contributed more and this upheld the cross subsidization principle underlying the scheme (Rajkotia, 2007).

A few, however, felt that it was unfair to SSNIT contributors for being asked to pay again for the NHIS levy For example:

I think it's not fair. Some pay more than the others and then for the VAT, I think VAT is not every registered store that a charge VAT so there is also not fairness there because some may escape paying VAT. (Medical Director, 56 years)

Some respondents also felt that the level of premium was low and could not fund the scheme. For example as a respondent noted:

The premium is low and need to be increased but for some people especially the poor I have a problem with that. There should be fairness. (Medical Director, 52 years)

Respondents were of the view that funding was very crucial for sustainability since it ensured adequate resources to pay providers improve their motivation and provided resources for recurrent expenditure.

As some respondents noted:

The main reason for the inability of NHIA to reimburse providers promptly and adequately is lack of funds. Funding is therefore very important and so other sources should be explored to generate more funds or it can affect the operations of the scheme (Administrator, 48 years)

Many facilities and providers threatened to and even suspended services to clients for not been paid for services rendered on the basis of no money syndrome (Medical Officer, 35 years).

Funding was considered important as it affected the ability of the facilities to provide essential medical supplies and the provision of quality care to patients. Respondents also reported that adequate funding enhances the motivation of service providers.

I think it's not fair. Some pay more than the others and then for the VAT, I think VAT is not every registered store that a charge VAT so there is also not fairness there because some may escape paying VAT. (Medical Director, 56 years)

Reimbursement

On the issue of reimbursement, respondents especially those in private medical practice stated that regular/prompt reimbursement of claims was their biggest motivation. It ensures the smooth running of the facility as the insurance scheme has become the major source of revenue to the hospital. However, respondents expressed concerns about the insufficient clarity about reimbursement such as late reimbursement of funds.

Some respondents, however, mentioned that late reimbursement of claims was a major source of concern to health care providers. Some cited the inability of the management to reimburse promptly making the health

facilities unable to deliver efficient services. These have resulted in shortage of medicines and other essential supplies, indebtedness and threats to suspend services to registered clients (Ghanaian Chronicle, 2014).

In 2013 and 2014, CHAG threatened that its 183 members would stop accepting NHIS cards if payment was not received for outstanding claims. Since 2014 service providers under the scheme have been threatening to return to cash and carry system due to huge sums of arrears due them. In 2015, even the public health facilities also issued notices to that effect. For instance one pointed out:

In most cases items used in most hospitals are on credit basis, so it means they are supplied on credit to be paid for later but it takes about 3 to 5 months to be paid. And when payments are made they are not in full. At time it comes at 50%, 60% or 70%. It is only on a few occasions that they make full payment. (Accountant 38 years)

This assertion is also evidenced in institutional (hospital and GHS) annual reports and in the media. Lack of financial stability leads to mistrust as some districts that had exhausted their funds were forced to begin charging clients again. The implication, here is an ear return to the 'cash and carry' era and a reduced confidence in the scheme among the stakeholders.

Benefit package and exclusions

Health services covered by social protection policies are essential for protecting people from severe financial loss. Of critical concern in any social protection policy such as the NHIS is the benefit package. A comprehensive benefit package includes services and cost sharing mechanisms such as co-payments.

Some respondents were aware of the benefit package under the scheme and its significance. To some of the respondents, it is the core of the policy since the range of services is an indicator of quality of care, promotes confidence in the scheme as clients can present their medical conditions for treatment.

While some respondents considered the benefit package and exclusions to be satisfactory as it covered most of the common disease conditions in the country namely malaria and anaemia. Others, however, felt that services such as family planning which are considered key in the efforts to reduce maternal deaths in the country should have been included.

To some respondents, the large number of diseases covered under the scheme without any co-payments can collapse the scheme. Similarly, some disease conditions if included could have negative effects on the scheme since they are expensive to manage; for example cancers.

The benefit package is the foundation of the scheme. If the benefit package is made too wide, it can collapse the scheme because people may need to undergo surgery that will cost GHC 20,000 and when everybody is put on board, it will collapse the scheme. They should start with the minimum package. (Clinical Psychologist, 52 years)

The range of disease conditions covered under the scheme such as malaria, other infectious and communicable diseases are preventable. Therefore controlling and reducing the incidence of malaria and other preventable diseases can bring the cost to the scheme down making resources available for other services.

Incentives, Regulations and ethical mechanisms

Hospitals have no incentives for cost control under an environment of maximum profit seeking (Li, Wu, Xu, Legge, Hao, Gao, Ning and Wan, 2012). Incentives, regulations and ethical mechanisms under the scheme are meant to improve quality of care, as well as improve code of conduct, provider attitude and behaviour.

Among the provider incentives and regulatory systems are staff vehicle revolving scheme, progressively improved salary levels, free accommodation for senior management staff and provision of refreshment for staff on night duty. The regulatory mechanisms include the GHS Code of Conduct and Disciplinary Procedures, rules of regulatory bodies such as the Ghana Medical and Dental Council, Nurses and Midwives Council, the Pharmacy Council and the NHIS Law and regulations. Respondents said that though there were staff incentives, they were not directly related to the introduction of the National Health Insurance Scheme since they were instituted before the introduction of the NHIS.

It was reported that in some of the private health facilities, incentives had been instituted to address the challenges associated with increased workload. It was also found that in some public health facilities there were incentives such as in place but were mainly for the senior management staff. Respondents were also of the view that the available incentives were insufficient relative to the increased workload associated with the introduction and implementation of the scheme.

Provider incentives, regulations and ethical mechanisms can affect provider morale and that prompt and adequate reimbursement can boost confidence in the scheme. As mentioned:

If workers are motivated, they give of their best. With regards to regulations, if they are strictly adhered to, work will go on smoothly. (Physiotherapist, 43 years)

There were divergent views on the question as to whether the scheme can be sustained. While some respondents felt it was sustainable, others were sceptical.

Various reasons were offered to support the position that the scheme could be sustained. First, the scheme was considered to be a laudable pro-poor policy intended to address the lack of access to quality health services and therefore had the support of Ghanaians. Second, the scheme, since its inception, had improved attendance at the health centres and changed the financing architecture of hospitals. Moreover, the scheme has in-built mechanisms such as the inclusions, controls and regulations to sustain it. For example one respondent noted that:

Yes it can be sustained because it is a good thing. Everybody says it is a good policy in view of the benefits which is clearly evident. People are now coming to the hospital early unlike previously. In the past patients were being detained for their inability to pay. There were unpaid hospital bills which had to be written off. It is big relief to all. (Nurse Manager, 56 years)

Nevertheless, some held a contrary view. Respondents in this category argued that the scheme faces challenges such as delays in reimbursement, lack

of logistics, malpractices, increased workload, inadequate funding and low tariffs. As pointed out by one of the respondents:

No. It takes too much time to reimburse the health facilities. As things stand now and by hindsight, it cannot be sustained (Pharmacist, 36 years)

The results showed that nearly all respondents stressed the need for the scheme to be sustained. This is on account of the observed benefits of the scheme and its role in promoting health of the poor. As noted by some respondents:

The health insurance is a good thing that has come to stay and has saved lives and improved people's health conditions in general. In general it is good policy that we must protect and keep it up and it will help us a lot regardless of all the challenges. (Medical Director, 56 years)

I think it is the best social policy to be developed since independence. It is a major policy which cannot be toyed with. It is a lifeline for human life. (Administrator, 47 years)

The views expressed showed that several factors could affect the sustainability of the scheme in varying degrees. For example, funding and ethical behaviour were considered to be the most critical. Nevertheless, most of the respondents supported the introduction of the NHIS as a bold social protection policy in view of the observed benefits and achievements made since its inception.

Views on the Proposed One-time Premium Payment Policy and Implications for Sustainability of the Scheme

One-time premium payment (OTPPP) refers to the payment of a single premium which entitles a member to have a life time health care. The policy is

considered as one of the options to achieve universal health coverage and is intended to confer life membership (presumably for the informal sector workers alone) for those who appeared to have challenges in renewing their membership. The one- time premium payment policy was proposed as part of the 2008 electoral campaign of the National Democratic Congress (NDC). On assumption of power in 2009, the National Democratic Congress (NDC) expressed the intention to implement the policy. Debate on the policy emerged and was focused on its feasibility, affordability, funding and sustainability.

As a proposed policy, the study sought to find out the views of health care providers on their understanding of the policy and how it would affect the sustainability of the NHIS. As a policy, the one-time premium payment policy has both advantages and disadvantages.

First, the policy seeks to make health care delivery universally, accessible and affordable to many people through the elimination or reduction in the burden of having to pay premium every year.

Secondly, it is meant to reduce the tendency of not renewing membership and as a result help to keep more people in the scheme. It would also ensure that more funds would be mobilized initially which can be further invested into productive ventures to keep the scheme running. It was also argued that it is possible to sustain the scheme under single premium payment because at present contributors to the scheme constitute only ten percent of the beneficiaries of the scheme. Finally the component of the revenue from the premium paid by members even though considered to be relatively small, can be used to provide at least some logistics to enhance the operations of the scheme

Some respondents, however, were of the opinion that the OTPP could work provided that enough funds are made available. This would enable the scheme absorb the costs involved in providing care to the registered clients. According to an administrator:

It is possible if we are able to introduce more taxes or incomes to cover the entire financing package. Government knows what one - time in terms of period is. (Administrator, 47years)

The disadvantages are that the one- time payment would mean that the premium should be high enough to make up for the shortfalls in funding in the subsequent years. Given the size and the growth of the Ghanaian population, sustaining the one- time payment policy would be a challenge. In countries where health insurance is being implemented, members do not pay a single premium even though Ghana would have been the first in the world to implement such a policy. Fourth, the introduction of the policy would have definitely necessarily involved some subsidy from the government and this would be a another challenge given the state of the economy

Another argument against the introduction of the one-time payment policy is the envisaged problem of pegging the single premium. It is feared that if the current premium is maintained then the scheme would suffer financial leakage and can collapse the scheme. Any upward adjustment would deny many prospective members access to the scheme since it would make it unaffordable because with the current premium which is considered fairly moderate, many Ghanaians still find it unaffordable.

Generally, respondents were of the view that the proposed one-time premium policy was not clear and expressed doubts about its implementation

and sustainability. The concerns were about its specific objectives, capacity to successfully implement it, how much to pay, mode of payment and procedures for collection. As a respondent remarked:

The one time premium would never work. The insurance system is about money to run it every day and since prices are not static, if you fix price today, tomorrow it will double and the people will continue to be sick, so in the long run.(it takes today, tomorrow it may affect it) so it is not sustainable. (CEO/Medical Director, 64 years)

Among the observations were that respondents felt the absence of specific proposals and details made the policy unclear. As has been the experience with new policies, its implementation and sustainability were in question since modalities for implementation were not clear in terms of how much to pay, how payment would be made, the mode of collection and the benefit package were not specified.

Given the arguments for and against the introduction of the one-time payment policy, and the views expressed by the respondents, the policy is likely to run into financial challenges. The introduction of the policy though was well -intentioned, it is not likely to work. Already, the current system is facing challenges. It would be important to address the challenges to make it efficient before considering the introduction of a relatively untested policy.

The one-time premium payment policy appears to have been dropped by the ruling government and in its place a capitation policy is being piloted for nation-wide implementation.

Suggestions to sustain the scheme

Respondents were asked to suggest ways to sustain the scheme. Irrespective of the views held, several suggestions on how to sustain the NHIS were made. The suggestions which focused mainly on the roles of the various key actors, centred on the funding mechanisms, the structure and management of the scheme and the benefit package.

First, it was proposed that additional sources of funding should be explored to cushion the scheme. Among them were the introduction of a separate pension scheme, the use of a proportion of oil revenue (one per cent is suggested) to be paid into the NHIF, increase in the rate of the premium and the introduction of co-payments. These, were felt would raise additional resources to sustain the scheme. For example a respondent said:

*The NHIA should be able to mobilize additional resources to enable them reimburse the service providers on regular basis (*Medical Director, 52 years).

They (Government) should inject or generate more funds into the scheme to sustain it (Community Health Nurse, 27years)

The Government must seek additional funding to keep the system going (Administrator, 57 years)

The second set of suggestions was that there should be prompt payment of claims through timely release of funds from the Ministry of Finance to the NHIA to disburse them to the providers. The Ministry of Health should liaise with the Ministry of Finance to ensure prompt reimbursement to health care providers. On its part the NHIA should promptly reimburse health care providers for all legitimate claims submitted. Health

care facilities should ensure that claims are diligently processed and submitted on time to facilitate prompt payment to procure medical supplies and pay their staff. As a respondent suggested:

The NHIA should see to it that the reimbursement is done early enough and in an orderly manner (Clinical Specialist, 59 years).

The scheme managers should pay claims as early as possible (Medical Assistant, 46 years)

The Scheme Managers (NHIA) should make payments to the facilities on time to enable the hospital mangers to purchase the necessary materials and equipment for the service providers to work with (Anaesthetist, 38 years).

Third, there should be continued public education by the NHIA and health care professionals on the benefits of the scheme, the responsibilities of registered clients and how to maintain healthy lives. This is likely to rekindle interest in the scheme.

The NHIA must educate both registered clients and the providers on the insurance scheme to promote understanding and co-operation among us (Medical Records Officer, 52 years).

Health professionals should educate the public on the usefulness of the scheme and make patients feel at home (Radiographer, 64 years).

Health care professionals should be ethical because people are abusing the system (Pharmacist, 48 years).

Fourth, health care professionals especially the prescribers should prescribe within the NHIS Essential Drug List. Prescribing outside the drug list can lend to increase in the cost of drugs for patients and thus can affect confidence in the scheme. They also advised that health care professionals

should adhere to clinical protocols especially in treatment and also demonstrate positive attitude towards patients.

Health care professionals should assess clients well, and diagnose well to avoid fraud (Dietician, 39 years).

We (health care professionals) must be honest and efficient in claims management (Health Services Administrator, 49 years).

The NHIA should also reprimand scheme managers found to be involved in any fraudulent practice, such as fraudulent claims, inflating claims and collusion with health care providers.

The NHIA and the MOH should deal with people who embezzle funds and inflate claims otherwise they can collapse the scheme (Nurse Manager, 56 years).

Respondents suggested that health facility managers should ensure the availability of essential medical supplies, including drugs, exercise supervision of staff and provide incentives and motivation. This will help to enhance the quality of health care.

We must be prudent in the use of resources and then institute effective controls to reduce waste and ensure accountability (Accountant, 37 years).

They should provide us with our needs like the materials used for health insurance like stationery and data collection tools (Biostatistician, 52 years).

Some respondents called for regular consultation between health care providers and the scheme managers at national, regional and district and sub district levels. This was because there seemed to be a lack of understanding

between providers and the NHIA and concerns with accreditation, clinical audits, claims payment and the level and frequency of review of the tariffs.

The NHIA must ensure good relationship with health workers and also do in-service training for service providers (Community Health Officer, 29 years)

Respondents suggested that the NHIA and the MOH should organize regular training programmes in claims processing for the scheme managers and health care providers to improve on the efficiency and avoid delays and bottlenecks in the submission of claims and payment.

The NHIA must liaise with the authorities (MOH) to give regular training to health care providers on new ideas coming out of the NHIS implementation to sustain the scheme (Physiotherapist,43years)

Respondents also suggested that additional health personnel such as doctors, midwives, nurses, pharmacists, accounting and other support staff should be engaged and deployed to the health facilities to ease the workload and enhance quality patient care.

The MOH should employ more hands. We are overloaded with work but no incentives (Staff Nurse, 32 years).

The NHIA should recruit more competent people to vet the claims promptly to avoid the delays in reimbursement (Pharmacist, 36 years).

Discussion and Conclusion

Sustainability is one of the principles of any insurance scheme and continues to be debated. Sustainability has several dimensions and these are efficiency, integration, resources, health staff's acceptance (attitudes),

effectiveness, community ownership, supervision, political commitment, training and funding.

Sustainability is viewed in several ways by several people-technical sustainability, political sustainability, financial and managerial sustainability. Sustainability in the context of the NHIS should be considered within the perspectives of registered clients (services), health care providers (reimbursement) and the scheme managers (organizational effectiveness). The interests and commitment of both donor partners and the government in relation to the provision and judicious use of resources are also very important.

Scherer (2005), identified three dimensions of sustainability: (i) continuing to deliver beneficial services (outcomes) to clients (an individual level of analysis) (ii) maintaining the programme and /or its activities in an identifiable form, even if modified (an organizational level of analysis) and (iii) Maintaining the capacity of a community to deliver programme activities after an initial programme created a community coalition or similar structure

Responses were consistent with two of the dimensions suggested by Scherer. For example, respondents mentioned capacity of the scheme to continue to provide benefits to the registered clients and ability of the scheme to reimburse service providers on time and efficiency in its operations. However, responses regarding the capacity of community and involvement in sustaining the scheme were lacking. As health care providers, the responses focused mainly on benefits and prompt reimbursement of claims. This however, will depend on the wilkingness and ability of the registered clients to regularly pay their premiums and renew their membership.

The skills and attitudes of scheme managers in providing prompt, courteous services to both subscribers and service providers were found to be a factor in building the confidence of people in the scheme. The results are consistent with evidence from studies on similar schemes which indicated that they were prevalent (Carrin, Waelken and Criel, 2005; Atuguba, 2009; Abel-Smith, 1994).

Adequate flow of funds was found to be critical for sustainability. Adequate funds to pay for the services provided to registered clients is important in any health insurance scheme since health care providers require funds to be able to procure essential medical supplies and equipment and pay their staff regularly. The inability of the management of the health facilities to provide these can lead to dire consequences in terms of quality of care, staff attitude and performance and ultimately the sustainability of the scheme.

The benefit package was seen as a major factor in the sustainability of the scheme as it influences the confidence and satisfaction of patients with the scheme. The existing package covers about 80-90% of the basic ailments in the country was found to be satisfactory because it is able to protect the poor. Its overall package should be to protect the poor and vulnerable against catastrophic health cost. This is unlike the Kenyan National Social Insurance Fund (NSHIF) which covers only inpatient services making it ineffective in providing care to its members. The package should include inpatient services (Carrin, James, Adelhardt, Doetinchem, Eriki, Hassan, et al., 2007). With no limit to consumption and no co-payments, however, the benefit package has serious implications for the NHIS.

The proposal to introduce one time premium payment policy was received with mixed feelings as many people could have challenges in paying the premiums while others felt it could eliminate the further payment of subscriptions. A one-off-premium payment model would change the character of NHIS from an insurance scheme to a form of general taxation and certainly far removed from the notion of insurance. The implication is that subscribers would, at some time in their lives, pay a prescribed sum and afterwards be entitled to free healthcare for the rest of their lives.

The use of insurance to support the intent of universal access to health proceeds on three main principles: resource pooling, risk equalization and cross- subsidization (Macintyre, 2012, Carrin, Evans and Xu, 2007). The "premium" in the risk market plays the same role that the "price" plays in the commodity market. It provides signals (information) that allow efficient allocation of resources by the participants in the scheme. Similarly, it responds to behaviour of the parties and susceptible to ambient market conditions. Given the high rates of inflation typical of the economy, a one-off premium would lead to shrinking pool of private contributions to offset future inflation.

A key feature of insurance is its ability to invest today's funds to service tomorrow's claims. In the initial stages, the quality of care will actually improve, since it is highly likely that: (a) there will be a surge in early subscription to the scheme and (b) the transition to a one-off payment model will involve an increase in the nominal level of the premium rate but in the long run the system will not have much infusion of new funds..

Diseases such as hypertension, diabetes, cardiac weakness etc. - are more expensive to treat than the "disease of the poor"- malaria, diarrhoea,

cholera. Therefore, attention should focus on the environment-based diseases which continue to contribute to disease burden. This will help to reduce cost of health care.

Attempts at sustaining the scheme should start with an appreciation of the underlying drivers which include increase in membership, increase in utilization, increase in accreditation of providers, sufficient revenue to cover claims, prompt reimbursement to health care providers, efficient service delivery and ethical and financial regularities. Ensuring these will, to a greater extent, promote the sustainability of the scheme.

CHAPTER EIGHT

SUMMARY, CONCLUSIONS AND POLICY RECOMMENDATIONS

There will be little or no progress in achieving Universal Health Coverage unless countries implement reforms to raise and use domestic prepayment funds in an equitable, efficient and sustainable way (Macintyre, 2013 p 2).

Introduction

The National Health Insurance Scheme remains one of the positive social interventions in the health sector since independence. To that extent, most of the public discourses on the subject have largely focused on mechanisms that will guarantee its sustainability. This study was conducted in the Cape Coast Metropolis to explore some of the nuances associated with its sustainability.

Summary

Given the nationwide debate on the sustainability of the NHIS, arising out of the current challenges facing the implementation of the scheme and the lessons from the implementation of similar policies in the country, the study sought to assess the views of health care providers on the sustainability of the scheme in the Cape Coast Metropolis.

The study was based on some major assumptions. First, the behaviour, attitude, performance and motivation of health care providers were considered to be crucial for the sustainability of the NHIS. Secondly, sustainability of the

scheme is closely related to how it is implemented and finally sustainability of policies has not been given sufficient attention.

An interpretative orientation was adopted for this study and was intended to provide respondents the space to provide their views concerning issues such as the design, implementation of the National Health Insurance Scheme and how these could influence its sustainability.

A purposive sampling technique was employed to select 40 participants working in 19 health facilities in public, quasi–government mission and private sectors in the Cape Coast Metropolis. The sample consisted of medical superintendents, medical officers, administrators, pharmacists, nurses, midwives and other health care providers. Discourse analysis was the main method used to analyse the data.

Summary of Key Findings

The main objective of the study was to assess the views and opinions of health care providers in Cape Coast Metropolis on the sustainability of the NHIS. Specifically, the objectives were to examine the views of healthcare on the processes of formulation and design of the NHIS, assess their views on the implementation of the NHIS and discuss the factors affecting the sustainability of the scheme. The key findings from the study, presented in three chapters, are outlined as follows:

A few of the respondents were involved in the process of formulation of the NHIS. This was because most of the respondents were either in school, not employed in the service at the initial stages or outside the country. Respondents who were involved were mainly higher level employees such as

doctors and those in management positions at the time. Some of them were involved in either their personal capacities or as members of professional associations.

The results also showed that respondents had some understanding of the operations of the scheme. Most respondents interviewed acknowledged the role of various actors in the formulation, implementation and the sustainability of the NHIS. Respondents also had a good appreciation of the factors that could undermine or promote the sustainability of the scheme.

Involvement of health care providers in the accreditation process at all levels was found to be minimal since it involved mainly those in management positions. Respondents, however, generally acknowledged the importance of the accreditation process. To them, it led to improvements in the quality of care through the provision of additional medical equipment and staff in some of the facilities. Nevertheless, some of the respondents expressed reservations about the process. Among them being the high cost involved, perceived lack of fairness and lack of feedback to the facilities.

The introduction of the NHIS was deemed to be one of the best pro poor social policies initiated in the country since independence. It had led to improvement in access to health care and increased utilization at both OPD and in admissions. This confirms the earlier findings in studies on the NHIS that the introduction and implementation of the NHIS has improved access and coverage in health services (Seddoh et al., 2011; Witter & Garshong, 2009).

The achievements are expected to have a positive impact on the attainment of the MDGs e.g. poverty, maternal health and general morbidity

and mortality trends in the country. Although the country has not been able to achieve the health targets in the MDGs, the NHIS could be described to have contributed to the modest gains achieved in the area of health (UNDP, 2015).

The challenges identified included delayed reimbursement of health care providers, lack of provider incentives, inadequate funding, fraudulent practices and increased workload at the health facilities. The most recurring challenge mentioned was the delay in reimbursement of claims, and was seen to be a major threat to the sustainability of the scheme. This, if not properly managed, could affect the scheme through aspects such as the behaviour and attitude and performance of health care providers, as well as ability to pay for medical supplies and pay the salaries of the staff.

Respondents were divided on what sustainability of the scheme meant. Some respondents interpreted it as being sustainable, partially sustainable and not sustainable. The three strands could be attributed to their experiences with implementation of the scheme and other previous policies. It could also be due to the numerous challenges facing the scheme and also some hope in the fact that the measures being taken could address them. The three views identified could be grouped into optimism and pessimism. Those who were optimistic of the future of the scheme pointed to its broad acceptance, the benefits and the achievements made to date. For example improved access to health, which hitherto was a challenge to many people. Those who were pessimistic felt that it could be not sustained with the present such as its approach to facility accreditation, structure, organization and management of the scheme, inflow of funds, benefit package and incentives, regulation and ethical mechanisms.

In general, respondents identified inadequate funding as the biggest factor that could affect the sustainability of the scheme.

There were doubts about the introduction of the proposed one-time premium payment policy with regards to its definition and scope. To some it can negatively affect the sustainability of the scheme in terms of affordability and reduce enrolment. Most respondents indicated that they were not clear about the modalities for the proposed one-time premium payment policy and questioned its ability to sustain the scheme.

Respondents were of the view that the scheme needs to be sustained and that the collective role of all the actors- health care providers, NHIA (scheme managers), registered clients, the MOH/GHS, MOF and the government will be crucial for the sustenance of the scheme.

Conclusion

There is a broad agreement and consensus on the introduction of the NHIS as a forward-looking pro-poor policy initiative. There appears to be no controversy among stakeholders as to its appropriateness as a social protection strategy. As one respondent put it, the policy has improved financial access to health care since its introduction in terms of OPD attendance, admissions, reduced death rates and improved revenue mobilization at health facilities.

The overall results of the study suggest that sustainability of the national health insurance scheme could be affected by but not limited to six broad factors, namely the design of the policy, management and organization of the scheme, funding, benefit package and the motivation, ethical behaviour of service providers and scheme managers as well. As Polonsky, Balabanova,

McPake and Poleti (2003) observed, local management, accountability and monitoring are important in implementing equitable and accountable community health financial schemes.

The development of social protection policies such as the NHIS involves a number of actors with diverse roles and interests in the policy conceptualization stage. The involvement of stakeholders in the formulation of policies is essential in promoting ownership, understanding, implementation and the sustainability of the NHIS. The roles include service provision, support, facilitation and implementation. Careful identification, selection and management of stakeholders is therefore important. The experience in Ghana has been the tendency to involve only a few people, mostly the urban elite and more powerful leaving out those in the rural areas and marginalized in policy making. In the health sector the focus has been largely on doctors than the voices of other health care providers. This can lead to a feeling of frustration and disillusionment.

Secondly, political commitment to implementation of policies is necessary. Community health insurance had long been implemented in some parts of the country, between 1989 and 1993 However, by 1998; the scheme had collapsed as a result of delayed reimbursement, inadequate premiums and fraudulent claims. Some district schemes also emerged sponsored by some development partners at Damongo, Drobo, Duayaw Nkwanta, Berekum and Dangbe West districts. However, he the strong political support for pre-payment health care financing in 2001 with the announcement of the introduction of a national health insurance to replace the cash and cash system or user fees at the point of service and the legislation in 2003 was very crucial.

Moreover the position taken by the Trades Union Congress (TUC) over fears of using Social Security and National Insurance Trust (SSNIT) contributions to fund the NHIS and the stand taken by the then opposition NDC party could have changed the course of events had the then government been swayed by the protests and criticisms of some aspects of the NHIS. Indeed the commitment and goodwill demonstrated by the two political parties, namely the New Patriotic Party (NPP) and the National Democratic Congress (NDC) now in power to implement and sustain the NHIS have been commendable.

Similarly the role of academic research has helped to shape the design and implementation of the NHIS. Research to provide evidence to support implementation is helpful. Various studies on feasibility, ability and willingness to pay for insurance premiums both in-country and elsewhere have provided insights and into the design and implementation of the NHIS (Asenso-Okyere, et al, 1997; Waddington & Enyimayew, 1989) provided some lessons for the design and implementation of the NHIS.

The accreditation process has been useful in highlighting some of the systemic flaws in service provision in the country. It has brought to the fore the need to improve quality of care in the government, mission and private health care facilities. Quality of care has been a source of concern for most people in the country and therefore accreditation should be made to go beyond satisfying the requirements of the NHIS.

The NHIS has made incremental progress in the financing and access to health care through affordable prepayment fees (Hor, 2013). As a new policy initiative, the legal framework enhanced transparency, accountability

and implementation. The success of any policy can be assessed within a time frame. It is therefore essential that policies are allowed reasonable time to evolve for are realistic assessment of their impact.

A related issue of multiple stakeholders is the complexity in coordination of the diverse roles and responsibilities. The traditional roles of the scheme managers or third party insurers, service providers and registered clients in addition to the involvement of tax agencies, Ministry of Finance, SSNIT, health regulatory agencies, development partners, academia and NGOs were brought to bear on the implementation of the scheme. These contributed to ensuring that the scheme took off well.

The implementation of pro-poor policies involves the provision of benefits to the poor and the vulnerable. This involves cost. Prior costing budgeting of the policies and careful policy planning are crucial while adequate resources should be provided to ensure efficient implementation and sustainability

Conceptualization of sustainability of policies can be looked at in the context of the following: First, the policy should have some consensus among policy makers and interest groups in terms of participation and acceptability. The enthusiasm shown by the communities and the District Assemblies in embracing and supporting the introduction of the NHIS was positive factor in its implementation. This is likely to promote greater understanding of the policy's content and processes, accountability, responsiveness to policy change, ownership and sustainability.

To achieve policy sustainability, efforts should be made to ensure that stakeholders-policy makers, those involved in its implementation and the

intended beneficiaries are part of any review processes. In particular the various professional associations in health, finance and management should be seen as key stakeholders. Attempts should therefore be made to involve as many as possible through the various health professional associations. This can be done through representation of those groups on relevant sub committees and regular consultations.

Any policy should have the potential to achieve its intended goals, objectives, and outputs outcomes and at the same time be able to deal with the unintended outcomes and challenges. The trade-offs in the achievement of policy objectives and efficiencies through monitoring of data on utilization, benefits, costs, beneficiaries and their contributions.

The delays in the reimbursement of health care providers can seriously limit their ability to provide quality services, erode confidence in the scheme and also affect their behaviour. These can pose serious threats to the sustainability of the insurance scheme. It is therefore necessary for policy makers and scheme managers to consider most appropriate ways of paying health care providers and on time.

Policy implementation remains a big challenge. Among the issue and challenges are lack of capacity, resource constraints, lack of accurate data, corrupt practices and political interference.

Policy Implications

The findings and conclusions have a number of implications for policy. Among them are: First, the involvement of frontline health staff in policy formulation deemed to be important in policy implementation and sustainability (Kwaraja, 2013; Agyepong and Adjei, 2009). Therefore, in any

subsequent reviews of the processes, there should be consultation at various levels – frontline staff through district to regional and national levels.

Second, policies are formulated within a political, economic, cultural context, and they are formulated to address issues of concern and with some urgency. Under such situations, a number of pertinent points may be ignored or escape scrutiny which may result in unintended outcomes. Thus the views of some respondents who advocated piloting of the scheme to enable some of the current challenges could have been managed better appear to have been vindicated. The increased utilization, the staff workload and large exemptions are examples. As a result, regular reviews are necessary and useful to ensure that challenges are addressed with dispatch. Years after the introduction of the scheme, there is the need for a review of some aspects of the scheme.

Third, implementing a new policy to ensure access to essential health care such as NHIS in a developing country like Ghana is a complex task which requires clear assignment, specification and understanding of responsibilities and roles of institutions and stakeholders both within the health sector, political commitment and determination. Therefore there should be adequate stakeholder sensitization and capacity building.

The findings also have potential policy implications for the Ministry of Health and its agencies-the Ghana Health Service, CHAG, the Teaching Hospitals and regulatory bodies. For example the accreditation process has brought to fore issues of quality of care in the various health facilities. Other concerns such as the motivation, efficiency of and ethical behaviour of health care providers are therefore critical for the sustainability of the scheme.

For the NHIS, delays in reimbursements emerged as a major concern which could affect the sustainability of the scheme. This has been widely reported in the media leading to some providers refusing to offer services to some insured clients unless they were ready to make payments upfront(Ghana News Agency, 2010). The delays in reimbursement might account for the differences in behaviour of providing among the insured and the non- insured. This certainly requires urgent action by the NHIA, the Ministry of Health and the Ministry of Finance to address the issue by streamlining the procedures for reimbursements in order to maintain confidence of health care providers and to promote the sustainability of the scheme. It will be useful for the MOH and the Ghana Health Service to monitor the time it takes to reimburse claims. Initially reimbursements to health care providers were to be made within days not months but have been changed. There is the need for a review of the legal arrangements concerning the release of funds from the Ministry of Finance.

A common result of the introduction of DRG systems is tariff creep shifting to diagnoses which attract a higher tariff. This can affect the sustainability of the NHIS since more funds are needed to pay for medical care. A more appropriate method of paying health care providers should be considered by NHIA. The move to introduce the capitation provider payment method which involves the advance payment to service providers is recommended as a measure which can enhance service planning, efficiency and reduce delays in reimbursements to service providers. According to the NHIA (2012), capitation is a provider payment method under which a *predetermined fixed rate* is paid in advance to health care providers to provide

a *defined set of services* for each *individual enrolled* with the Preferred Primary Provider (PPP) for a *fixed period of time*.

Theoretically, the capitation provider method offers some hope but should be properly planned to involve long stakeholder engagement, efficient health facility mapping to determine facilities which meet the basic requirement to provide the package of services under capitation and proximity of Preferred Primary Providers (PPPs). Governance and leadership role of the Ministry of Health will be very necessary in reframing the funding arrangement under the capitation payment method.

The issue of funding has been identified as crucial for the sustainability of the NHIS. Among the areas is the large category of exempted persons under the scheme, generous benefit package, the inability of a number of people to renew their membership, inadequate budgetary resources. To sustain the NHIS, other sources of funding should be explored. It is recommended that a proportion of revenues from the oil and gas industry and part of the communication tax should be allocated to the NHIA. As part of strategies to sustain the scheme, co-payments can be considered. The large exempt groups have the tendency to increase the cost of operations and should be revisited.

A major concern expressed by many respondents was limited involvement in the processes of formulation and design of the scheme. Given the dynamic nature and history of implementation of various health policies, the Ministry of Health and NHIA should constantly review key aspects of the scheme such as the benefit package, premiums, exemptions and the NHIS medicine tariffs. This should always involve the various stakeholders. Such

regular reviews and contributions will help to identify issues which should be addressed to ensure sustainability such as public confidence in the scheme, quality of care, coverage, accountability and efficiency.

Respondents also identified the roles of several actors in the implementation of the scheme. Regular engagement with the key stakeholders–the Ministry of Health, Ministry of Finance, Ghana Health Service, health care providers, registered clients and scheme managers at all levels is critical. A high level and sustained formal dialogue is important to extend the scope of consultation and consensus building on the approaches for achieving the objectives of the Scheme in a manner that captures the concerns of health care providers. It will further promote trust, confidence and transparency in the implementation of the scheme.

A number of respondents acknowledged the negative effects of fraudulent practices and unethical behaviour on the sustainability of the scheme. A number of health care providers and scheme managers had been reported to be involved in fraud, unprofessional and unethical practices. There is the need for the Ministry of Health, Ghana Health Service, health regulatory bodies and various professional associations to enforce their disciplinary codes. It is also important for the NHIA to strengthen its clinical audit mechanisms.

The findings in the study showed that the structure, organization and management systems can affect the efficiency in operations and therefore the sustainability of the scheme. The role of the NHIA as a regulator and implementer at the same time has implications for its effectiveness as lead implementing agency of the scheme. Concerns were expressed by respondents

regarding its "overbearing" posturing which can affect the behaviour of health care providers. For example there are no sanctions for not paying claims on time. This can trigger mistrust.

As specified in the LI 1809, accreditation may be denied, suspended or revoked based on a number of reasons. A major challenge however, is the difficulty in applying the denial, suspension or revocation to government health facilities. To promote quality of care at the facilities and enhance confidence and transparency the NHIA should ensure that the accreditation process is efficiently and fairly conducted. The study sought to understand the views, perspectives, attitudes, opinions and experiences of health providers and facility managers on the sustainability of the National Health Insurance scheme. The findings emerging from the study reinforce the theoretical concepts and frameworks that demonstrate that the implementation of a scheme should involve the different actors to ensure buy-in.

The limited involvement of health care providers in the formulation process did not ensure total buy in. The power dimension between the political elite and technocrats at the Ministry of Health during the formulation and implementation stages of the NHIS led to some members not to be involved. Studies by Seddoh and Akor (2012); Agyepong and Adjei (2008) similarly observed that the formulation process involved a few politically connected technocrats

In relation to the Gill Walt's Policy triangle, the study examined the content of the NHIS-the design of the scheme, the goals, underlying values and principles, objectives, the benefit package, exemption categories, funding mechanisms, outcomes, outputs and distributional effects and how they affect

the sustainability of the NHIS. The elements in the policy triangle –content, context, actors and processes were found to be relevant and useful in the analysis of the formulation processes and content (design) of the NHIS including accreditation, the role of actors in particular health care providers- their motivation, capacity, performance and attitudes can influence the sustainability of the scheme and therefore has to be managed well. The study has further looked at the role of actors (health care providers) in the sustainability of the health insurance scheme as a major health policy which is relevant in the on- going review of the National Health Insurance Scheme.

Study limitations

As with any qualitative data, the views described and discussed in this study reflect those of the health care providers who participated in the interviews. The in-depth interviews were designed to capture the views and experiences of health care providers working in the health facilities providing health services in the Cape Coast Metropolis. As with in-depth interviews, the findings do not necessarily represent the views and experiences of health care providers in general even in the Metropolis where the field work was conducted. Rather, they provide information on aspects of the views of some health care providers, which when taken together with other studies and data from the institutions, will help build a picture on the views and experiences of health care providers in the country.

Areas for Further Research

Two main angles of sustainability - financial and organizational- emerged from the study. The financial analysts tended to focus on financial sustainability while technical and management personnel were occupied mainly by organizational challenges and sustainability (non- financial) issues such as staff behaviour, staff capacity, claims management and processes, accreditation and quality assurance attitudes and ethical considerations. The apparent differences in perceptions among respondents largely arose to some extent from their professional training, personal values, and attitudes and how the introduction and implementation of the scheme has affected their work.

The respondents were largely health professionals. In doing so the study drew on informants across the health sector (facility type, ownership and professional category).Another picture can be obtained from the views of scheme managers and registered card bearers/clients. This will then complement the views of the providers.

Comparative studies on the views of health care providers, NHIS staff and other stakeholders at the national (macro) regional (mesa) and facility or district (micro) levels would be needed to identify issues of sustainability at these levels. Studies can also focus on implementation across geographical areas e.g. regions and districts for diversity. In addition to the above, studies can explore the relationships among the key stakeholders in the implementation and sustainability of the NHIS i.e. health care providers, scheme managers and clients to examine the broader perspective of sustainability of the NHIS.

Finally, in 2012 the NHIA started to pilot the capitation payment policy in the Ashanti Region as an alternative provider method. The capitation policy, which is one of the policy responses to the challenges in implementation of the fee-for service and the Diagnostic Related Groups (DRGs), has implications for service delivery and provider reimbursement. It is necessary to explore the effect of the capitation policy on the sustainability of the scheme.

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APPENDICES

APPENDIX A: BACKGROUND CHARACTERISTICS OF RESPONDENTS

A1. Background Information

- Profession (e.g. Medical Officer, Nursing officer etc
- Grade.....
- Position:
- Age at last birthday : ☐ ☐
- Experience/Number of years served:(No. of years) ☐ ☐
- Gender :Male/Female ☐ ☐
- Are you Licensed/Registered? A) Yes B) No
- Year of Registration/Licensure./Graduation (...../...../.....)
- Highest Education (Please indicate).....

A2.Type of Facility/Location

- Regional Hospital ☐
- Specialized Hospital ☐
- Hospital ☐
- Health Centre ☐
- Clinic ☐
- Maternity Home ☐
- Pharmacy Shop ☐
- Diagnostic/Laboratory Centre ☐
- Chemical Shop ☐
- CHPS Compound ☐

A3. Accreditation Status

- Is the facility accredited? A) Yes [ ] B) No [ ]
- If yes, when was it accredited? DD [ ][ ] MM [ ][ ] YY [ ][ ][ ][ ]

A4. Ownership/Management

- Public ☐
- Private ☐
- Mission ☐
- Quasi-Government ☐
- NGO ☐
- Other (Please Specify) ☐

APPENDIX B

IN-DEPTH INTERVIEW GUIDE

A STUDY ON THE SUSTAINABILITY OF THE NATIONAL HEALTH INSURANCE SCHEME: THE VIEWS OF HEALTH PROVIDERS IN THE CAPE COAST METROPOLIS

As you are aware the National Health Insurance Scheme has been adopted as a national policy in the country I would like to discuss with you a few issues about the scheme.

MODULE A: DESIGN AND FORMULATION PROCESSES OF NHIS:

- Were you involved in the formulation of the scheme?

(If yes in what capacity were you involved? Please describe in detail how you were involved?

- How will you describe your involvement? (Probe for level of involvement in the formulation of the scheme)What was your level of involvement?
- If yes, in what way. Probe
- Have you been involved in any other policy formulation? Did the experience in the previous policy formulation differ/was similar to that of the NHIS? How would you compare? On what basis did they differ/were similar?
- Do you have any suggestions on the process which was adopted for the formulation of the policy?
- Did that inform your involvement in the NHIS?
- If you were not involved in the formulation process why you were not involved? Probe for reasons.
- Describe how your involvement or non- involvement and / or health

care providers in general in the formulation process has or can affect the sustainability of the NHIS?

- What do you think should be the process for any future policy formulation on health which should be adopted and why that process? Is your view informed by your involvement/non-involvement in the NHIS policy formulation process? Probe for reasons.

MODULE B: Accreditation Process

As you know, accreditation is a major process in the implementation of the National Health Insurance Scheme: It is a requirement for participating in the scheme. In this section I want to discuss the accreditation process in the National Health Insurance Scheme with you I believe your facility is accredited? If accredited;

- Can you briefly describe the process?
- What was your understanding of accreditation?
- What was your involvement in the process? What do you think about the process?
- What were your expectations of the accreditation? (Probe for expectations and whether they were met or not .If met in what way? If not, why were they not met?)
- How would you describe the accreditation process? (Probe for views).
- What did you learn from the process? Probe for major lessons learnt.
- Do you think these have been useful for the implementation of the scheme?

- Do you think it is necessary? If yes, why are they necessary? (Probe to obtain reasons for its necessity or otherwise)
- Please give me any suggestions to improve the accreditation process or anything you would like to see changed or added? Probe for aspects and reasons for suggesting them)
- If not involved, why were you not involved?
- If never involved in the process what is your knowledge about the accreditation process? What is your understanding of the process?
- Do you think it is necessary to accredit institutions? (Probe for views)
- Now to the critical question- How does accreditation affect the sustainability of the NHIS? Probe for views).

If not accredited

- What have you heard about the accreditation process?
- Do you think it is necessary? Why so? Probe for views.
- What will it take for your institution to get accredited?(Probe for process)

MODULE C: Motivations, Regulatory and Ethical practices

Let's now discuss some important but sensitive topics: incentives, regulatory and ethical practices. Health service provision is associated with motivation, regulation and ethical standards. This is to assure quality of service, promote public safety and ethical behaviour.

- What do you think about incentives, regulation and ethical behaviours in the service on the sustainability of the scheme? Probe separately for each of them.
- Can you mention some of the incentives in the service? Do you

consider them to be enough to promote the sustainability of the scheme? Probe

- Specifically what are your views on the existing provider payment methods?
- What are your views on incentives in relation to the sustainability of the scheme? Probe for reasons
- Give me any suggestions you have on how to improve on the incentives.
- Let's us discuss regulatory mechanisms and ethical mechanisms which of them you are familiar with? What are your views on them? (Probe for aspects that affect sustainability. Make sure they are mentioned. Do you think they are sufficient in promoting ethical behaviour? Probe
- Have you ever been confronted with any ethical issues with regard to the scheme? What were they? How did you deal with the issue? What do you consider the implications of your experience on the sustainability of the scheme? Probe

MODULE D: Benefit Package and Exclusions

As you are aware there is a benefit package and a number of excluded conditions under the scheme.

- What are your views on the benefit package? (Probe to make sure the person understand the packages. If not mentioned ask about them.
- What are your views on the specific disease conditions excluded under the scheme?

- In your opinion do you think the benefit package has effect on the sustainability of the scheme? Probe
- Do you think the benefit package should be reviewed? Why should it be reviewed? In what direction? Please indicate the form in which the review should take.

MODULE E: Implementation of the scheme

The policy has been in operation for over five years now. Let us now discuss the implementation of the scheme.

- What have been the major stakeholders in the implementation process?
- What have been their roles and why do you say so?
- Can you describe the process of implementation of the policy?
- What do you think about the process? Probe for issues in any specific area of the implementation?
- In general what do you think have been some of the positive aspects of the Scheme? Probe for as many as possible? What about the negative aspects of the scheme? Probe for as many as possible
- Do you think the policy has achieved its intended objectives? If no why not?
- If yes in what way? Probe for explanation
- Can you give me suggestion(s) on how to improve implementation?

MODULE F: Challenges and Constraints facing the Scheme

Though it appears the challenges and constraints facing the scheme are obvious, for emphasis and in order of relative importance, in your opinion

- What are the main challenges facing the scheme?

- Why do you say so?
- How should the challenges you have identified be addressed?

MODULE G: The One- time Premium Payment Policy.

Now let us discuss another sensitive issue with regard to the Scheme: the plan to introduce the one- time premium payment by the present government What is your understanding of the one- time premium payment in relation to the NHIS?

- What are your views on the introduction of the one- time premium payment as proposed by the government? Probe for feasibility and implementation
- In your view what are some of the implications for sustainability of the NHIS?
- Why do you say so?
- Any suggestions on the one-time premium payment policy?

MODULE H: Sustainability of the NHIS

Let's us now discuss issues of sustainability.

- Please share your understanding of sustainability of the scheme with me
- In your view what factors can affect the sustainability of the Scheme?
- Can you describe in detail how each can affect the sustainability of the scheme?
- Do you think the scheme as being implemented in your facility can be sustained?

- Probe for reasons as to why the scheme can be sustained or not
- What do think should be done to sustain the scheme ?(Probe)
- What should be the role of the following in sustaining the scheme:
    - As a health professional
    - As Hospital Manager/Administrator/Accountant/
    - The Ghana Health Service
    - The Ministry of Health
    - As Scheme Manager
    - The National Health Insurance Authority
    - Government
    - Registered clients

Summary

The interview has been on the sustainability of the National Health Insurance Scheme. Before we end are there any other issues that you would like to add to the discussion?

Thank you.

APPENDIX C

CONSENT FORM FOR RESPONDENTS

A study on the sustainability of the national health insurance scheme: the views of health providers in the Cape Coast Metropolis Consent to participate in an interview

I have been asked to participate in in-depth interview on the sustainability of the National Health Insurance Scheme. I have read (or the foregoing information has been read to me) and

I have had the opportunity to ask questions which have been explained to my satisfaction. I consent voluntarily to participate in the interview. I also understand that I have the right to withdraw from the discussion at any moment without any obligation.

Name of Interviewee:

Date:

Signature:

APPENDIX D

LETTER OF INTRODUCTION

UNIVERSITY OF CAPE COAST
FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF POPULATION AND HEALTH

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UNIVERSITY POST OFFICE
CAPE COAST, GHANA

Our Ref: DPH/G.3/15

9th August, 2011

Your Ref:

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

LETTER OF INTRODUCTION

The bearer of this letter **Nana Kwame Owusu-Boampong** is a PhD student of the Department of Population and Health, Faculty of Social Sciences, University of Cape Coast. His research topic is "**Sustainability of the National Health Insurance Policy in Ghana: The Views of Health Service Providers in the Cape Coast Metropolis**"

He is supposed to conduct in-depth interviews for his PhD thesis. We should be very grateful if you would give him your maximum cooperation in this matter

Thank you for your cooperation in this matter.

Yours faithfully,

Dr. Akwasi Kumi-Kyereme
Head