UNIVERSITY OF CAPE COAST

CLIENTS' PERCEPTION ON NATIONAL HEALTH INSURANCE SCHEME IN JOMORO DISTRICT

AWIAH RAYMOND

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BY

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DECLARATION

Candidate's Declaration

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

Candidate's Signature: ..... Date: .....

Name: Awiah Raymond

Supervisor's Declaration

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

Supervisor's Signature: ..... Date: .....

Name: Dr. James Atta Peprah

ABSTRACT

The National Health Insurance Scheme was introduced in 2003 with the passing of the National Health Insurance Act, Act 650, with the objective of improving healthcare delivery services to all residents in Ghana, especially the poor and the vulnerable in society upon realising the problem that the 'cash and carry' was posing in healthcare delivery. The study therefore examined how clients perceived the services of national health insurance scheme, the basic healthcare services received from healthcare providers by clients and staff relationship with clients in the Jomoro District. Data was collected from 150 clients of the District scheme through questionnaire administration, interviews and observations. The data were analysed using descriptive statistics and SPSS software package.

The study revealed that NHIS is working to improve the health status of Ghanaians, by reducing financial barrier and promoting access to basic healthcare. Clients were satisfied with the premium fees and staff behaviour. However, there were long waiting times for registration, renewal of memberships and the issuance of NHIS membership cards. There is lack of knowledge on NHIS benefits package; and non availability of drugs at health facilities due to delay in reimbursement of claims. The study recommends for an urgent need for NHIA to streamline the reimbursement procedure to curb the delay in claims payment, spearhead the biometric registration programme, a periodical review of the benefit package and drugs list; and intensive education on the minimum benefit package by the district scheme.

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DEDICATION

This study is dedicated to my dear daughters: Mame Benie Awiah, Vivian Awiah Benie and Diane Tobony Kone. It is also dedicated to my parents Mr. Kwasi Nweah Awiah and Madam Adonle Benie.

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CHAPTER ONE

INTRODUCTION

Background of the study

Health care financing continues to stir debates around the world. Many low and middle income countries keep on exploring different ways of financing their health system. This is due the fact that these middle and low income countries' health systems are chronologically underfunded (James, Hanson, McPake, Balabanova, Gwatklin & Hopwood, 2006). User fees were initially introduced at the point of service delivery in some of these countries to generate revenue for the running of their health care systems. The introduction of the user fees led to improvements in the quality of health care services. However, vast evidence suggest that user fees constitutes a strong barrier to the utilisation of health care services, as well as preventing adherence to long term treatment among the poor and vulnerable groups in particular (Palmer, Mueller, Gilson, Mills & Haines, 2004). These problems led to yet another debate to look for other alternatives of health care financing.

Prepayment and risk pooling through social health insurance and taxation are found to provide protection against some of the undesirable effects of the user fees. In low-income countries, Social Health Insurance (SHI) is increasingly recognised as a promising tool for the financing of equitable health care. Social Health Insurance is seen as helping to pool health risk, prevents health related impoverishment, improvement in efficiency and quality of health care services and helps mobilises revenue for providers (Carrin, 2002). By pooling risks and

resources, social health insurance promises to ensure better access and provide risk protection to poor households against the cost of illness (Ekman 2004; Carrin & Waelkens, 2005). Although, the alternatives such as cost-recovery strategies have been criticised on equity grounds of affecting access to health care, the social health insurance scheme has been challenged in terms of cost containment and ensuring universal coverage. Due to this, few social health insurance schemes are operating on large scale in developing countries (Dalinjong & Laar, 2012).

Ghana is among the few African countries that had successfully implemented health insurance scheme on large scale. Health care financing in Ghana has had a chequered history. During the post-independence era, the government introduced some policies; prominent among them were the free medical care and free education. These were possible due to the small population size (about 8 million) at the time and a flourishing economy (Assensoh & Wahab, 2008). With time, due to economic difficult, funding for the health sector reduced resulting in the deterioration of health facilities and services which continued through the 1970s (MOH, 2004; Blanchet, Fink & Osei-Akoto, 2012).

In the early 1980s, the Provisional National Defence Council (PNDC) government, in line with austere International Monetary Fund (IMF) aid-related conditionality, including the removal of government subsidies, introduced partial payment of user fees at government health facilities. Later on, the introduction of a policy of full cost recovery known as 'Cash and Carry' with limited exemption for the aged and children under five years, restricted access to health care and worsened the plight of health care seekers. Patients were made to pay for the full

cost of medication and care. The argument for the user fees was to generate revenue and discourage the frivolous use of health care services. The consequences were serious as health care became unaffordable for many. The 'Cash and Carry System' resulted in increased in self medication, reduction in hospital attendance, delayed in seeking medical care and very high incidence of avoidable deaths (MOH, 2004; NHIA, 2011; Dalinjong & Laar, 2012).

In early 1990s, Ghana began to seek other ways of financing health care, including Non-Governmental Organisation (NGO)-initiated Community-Based Health Insurance Schemes (CBHIS). The CBHIS were targeted to specific areas, had limited benefit package and failed to addressed key social insurance issues. Also, CBHIS were international donor funded at the time and were not supported by general government revenue to allow them cater for the poor. Most importantly, with the CBHIS covering only 1% of the population, the 'cash and carry' remained the predominant means of paying for health care (Atim, Grey, Apoya, Anie & Aikins, 2001; Blanchet, Fink & Osei-Akoto, 2012; Blanchet & Acheampong, 2013).

Pursuant to finding a lasting solution to health care financing in Ghana, the government in 2003 initiated a National Health Insurance Scheme (NHIS) as a humane approached to financing health care. The National Health Insurance Scheme was established by the National Health Insurance Act 2003, (Act 650) to provide financial access to quality basic health care for residents in Ghana. The Government initiated this policy in line with the Ghana Poverty Reduction

Strategy (GPRS) to deliver equally accessible, affordable, and good quality health care to all Ghanaians, especially the poor and most vulnerable in the society.

The NHIS had initial policy objective that, within the next five years after its establishment, every Ghanaian should belong to a health insurance scheme that will cover him or her against the need to pay out of pocket at the point of service use, in order to obtain access to a defined package of acceptable quality health service. Achieving a universal health financial protection in a low income country like Ghana is laudable idea but technically difficult and challenging. Currently, Rwanda and Ghana are among the few Africa countries in the Sub Sahara Africa that have taken insurance to great lengths in term of scope and coverage. Whilst Rwanda has achieved 91% from 7% in 2003, the National Health Insurance Scheme in Ghana has reached coverage of about 89% (21,392,402 people) since its inception in 2003. Meanwhile the total active membership of the scheme at the national level was 8,227,823 representing 33% of the country's population as at 2011 (NHIA, 2011).

The NHIS Act 650 and Legislative Instrument (L.I.) 1809 required each Metropolitan, Municipal and District Assembly to establish its own mutual health insurance scheme to cater for the financial needs of its residents. Based on the above, the Jomoro District Health Insurance Scheme was established. The district scheme became operational in October 2004. Jomoro district has a population of 150,107 (GSS, 2010), out of which 55,329 people are active members of the scheme representing 36.86% of the district population as at September, 2013.

Feedback from clients with respect to NHIS services is minimal and insufficiently reflected in the current operations of the scheme. Placing the client in a central position of the scheme is vital. This implies that NHIA should attempt to understand clients' perception and practices of health care in the context of the community in which they live.

Statement of the problem

The National Health Insurance Scheme has come a milestone in its implementation. It has engendered improvement in health seeking behaviour of many people, as they now seek medical attention early. There has been an increase in membership and utilisation of health care services. Mass registration exercises are conducted across the country to further expand the coverage for the poor and vulnerable. The free maternal care programme under the NHIS continues to offer free medical care to pregnant women and drives to reduce maternal mortality under Millennium Development Goal Five (MDG 5). The NHIS in Ghana has also become the hub for knowledge and experience sharing, hosting an increasing number of delegates from United Nations, South Africa, Congo, Sierra Leone, Zambia, Cameroon and recently Nigeria (NHIA, 2013).

Despite such strides, emerging evidence reveals a variety of implementation problems such as perceived poor quality of care rendered by service providers and clients making co-payments to some health facilities due to untimely reimbursement of claims by NHIA. There are also high registration related complaints such as delay in NHIS card production and distribution, long

waiting times for insured clients and high enrolment dropout rates (NHIA, 2010).These are indication that NHIS is falling short of its equity and universal coverage goals. Also much has not been done to research into how the clients feel or perceive the NHIS policy now particularly in Jomoro District.

Against this background, that this study is being carried to assess the clients perceptions in relation to health care providers (quality of care, service delivery adequacy, and staff attitudes) and health insurance scheme (premium payment, membership and ID card management, renewal of cards and general benefits the scheme offers).

Objectives of the Study

The general objective of the study is to explore how clients perceive the National Health Insurance Scheme in the Jomoro District.

The specific objectives are to:

i. Examine the services of the scheme in terms of premium paid by clients, registration and renewal processes, minimum benefit package, and how clients perceive those services.
ii. Assess clients views on basic health care services received from the various health care providers in the district in terms of quality of the care, service delivery adequacy, staff attitudes and convenience to access to the health facilities.
iii. Ascertain NHIS staff relationship with clients in the district and convenience of clients' access to scheme office.

Research Questions

The study is guided by the following research questions:

i. How do clients perceive the services of the National Health Insurance Scheme in the district?

ii. How do clients perceive the health care services provided by health care facilities in the district?

iii. To what extent has NHIS achieved its equity goal by improving the health status of clients?

Significance of the Study

The evaluation and improvement of the quality of service provided by NHIS, is very vital in the scheme's operations. Client's perception is a significant indicator of the quality of services the scheme renders. Perception survey is a source of feedback from clients about health care services and as such, informs decision and stimulates proposal to restructure service delivery which can be used to evaluate the effect of any change of policy.

The results of the study will add to the existing body of knowledge, affirm the theories on health delivery and implementation of insurance schemes. It will also give an understanding of how the scheme is perceived currently in the district, suggest ways of improving it services if there be any deficiencies and assist National Health Insurance Authority in designing appropriate policies, strategies and programmes to rebuilt or/and maintain the public confident in the scheme.

Delimitation of the Study

The study focused on services rendered by the NHIS in Jomoro District and covers the registration and renewal processes, premium payment, identification cards management and the benefit package. It was also focused on the services received by clients from the various health facilities. The category of people the study covered were the insured clients of the district scheme.

Organisation of the study

The study is organised into five chapters. Chapter one provides the background of the study and therefore gives the general overview of the health insurance implementation in Ghana. The rest of chapter one describes the statement of the problem, objective of the study, research questions, significance of the study and scope of the study. Chapter Two focus on review of literature on health insurance scheme within the international perspective and national health insurance scheme in Ghana. Chapter Three gives an in-depth depiction of the methodology employed in this study. This includes the research design, the study population, sample size and sample technique, research instrument and data collection technique. Chapter Four analyse, presents and discuss the empirical results from the research findings. Chapter Five presents the summary of major findings of the study, conclusions, recommendations and suggestion for further study.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter surveys the literature on health insurance implementation within the international perspective and assesses the implementation ability of health insurance scheme in Ghana. The chapter looked at health care financing, overview of national health insurance scheme, its origin and benefits. There is a review of literature on health insurance in Germany, Thailand and Rwanda, and the Ghanaian system. The chapter also discussed health care financing in Ghana, historical context of health insurance in Ghana, health insurance legislation, principles underlying the design of national health insurance in Ghana, types of health insurance schemes in Ghana, funding of the NHIS, provider payment mechanism under NHIS, minimum benefit package, health status of Ghanaian and the new Health Insurance Act. It also outlined some perceptions and underlying challenges of the scheme.

Health care financing

Health care financing comes with some concerns. The first aspect has to do with the special nature of medical care as consumer goods. Health care, whether in preventive or curative form is widely regarded as a 'merit good'- a commodity that ought to be available for use by everyone irrespective of the ability to pay. The second dimension of the financing arises due to social externalities in the consumption of health care, that is, social effects of health care

such as public prevention from infectious diseases due to health maintenance activities of the individual (Mwabu,1997).

Sustaining a health care system is built on reliable access to human, capital and consumable resources. Securing these inputs require financial resources to pay for investment in building and equipment, to compensate health service staff and to pay for drugs and other consumables. The process of generating revenue and pooling funds raise an important issue for policy makers and planners to design a system of funding that meet the specific objectives. Most countries, including developed countries feel constant pressure because health care expenditure is increasing and resources are scarce. Policy makers therefore have an option of containing cost, increasing funding for health care services or both (Mossialos, Figueras, Kutzin & Dixon, 2002).

There are four alternative funding methods of financing health care. They are:

- the tradition direct payment by users to the health care providers,
- payment by the government to health providers on behalf of the users,
- payment made by a compulsory social insurance set up by the government, and
- a private health insurance where a small minority of people in some countries take insurance which pays for them when they need health care services.

Proponents of user charges claim such charges reduce overall demand for services and raise revenue to expand health service provision. In most Africa countries, donations, grants from Non-Governmental Organisations (NGOs) and donor assistance from international agencies account for a significant funding of health care expenditure.

In 1978, at the Alma Ata Conference, the entire world recognised the promotion and protection of health as a very vital to human welfare and sustained socio-economic development. It was however noted that effective access to health care could be practically impossible without a well-functioning financing system that determines people ability to use health services at the time they need them.

In recognition of this global threat to human health, members of the World Health Organisation (WHO) pledged their commitment to develop their health financing system in order to make it financially accessible to their citizenry so as to reduce the hardship caused by upfront payment for health care services. In 2000, WHO recommended that, a pre-payment scheme was the ultimate way for poor people to get access to health services. It argued that these schemes were the best tool to fight poverty and at the same time to bridge the inequality gaps in health care delivery to the poor and the vulnerable. Thus, health financing has become a vital element in the quest to secure social protection in health for populations (Andoh-Adjei, 2013).

Overview of National Health Insurance System

Health insurance is insurance against the risk of incurring medical expenses among individuals. By estimating the overall risk of health care and health system expenses among a targeted group, an insurer can develop a routine finance structure, such as a monthly premium or payroll tax, to ensure that money is available to pay for the health care benefits specified in the insurance agreement. National Health Insurance (NHI) sometimes called the Statutory Health Insurance (SHI) is health insurance that insures a national population for the cost of health care and usually instituted as a health care reform program. It is enforced by law. It may be administered by the public sector, private sector or a combination of both.

Funding mechanisms vary with the particular type of program and country. National or statutory health insurance does not always equate to government run or government financed health care, but is usually established by national legislation.

Origin of National Health Insurance

Germany has the world's oldest national health insurance. In the 1880's through Chancellor Otto van Bismarck, old age pension, accidents insurance, medical care and unemployment insurance that formed the basis of the modern European Welfare state were introduced. These programs won the German industry because, their goal was to win the support of the working classes for the Empire and reduce the outflow of immigration to America, where wages were

higher but social welfare did not exist (Hennock, 2007). Chancellor Otto van Bismarck's social legislation led to the introduction of the Health Insurance Bill of 1883, Accident Insurance Bill of 1884, and the Old Age and Disability Bill of 1889. As a mandatory health insurance, this bill originally applied only to low-income workers and certain government employees in Germany (phontuis.com).

In the United States, health insurance originated as accident insurance in the 19th century by Benjamin Franklin. The Franklin Health Assurance Company of Massachusetts offered insurance against injuries arising from railroad and steamboat accidents. In 1929, the first modern group health insurance plan was formed in Dallas, Texas by a group of teachers. The teachers contracted Baylor Hospital for rooms, boards and medical services in exchange for a monthly fee. Several large life insurance companies entered the health insurance field in the 1930's and 1940's as the popularity of health insurance increased.

Most other countries' national health insurance system were implemented in the period following the Second World War as a process of deliberate health care reform, intended to make health care affordable to all in the spirit of Article 25 of the Universal Declaration of Human Right of 1948 by nations which had adopted the declaration as signatories.

Health Insurance in Germany

Germany has the oldest European's universal health care system, with origin dating back to Otto van Bismarck's social legislation, which included the health insurance bill of 1883, accident insurance bill of 1884 and old age and

disability bill of 1889. The state-mandated health insurance in Germany begun in 1884, and initially covered low-income workers in factories, mines, banks, dockyards, railroads, and certain government workers. The blanket coverage was extended over increasing portion of the workforce in 1885 and1892, with family members of workers included after 1892. In 1911, workers of the agriculture and forestry occupation were added and by 1928, practically every trade, occupation and craft in Germany was enveloped in the health system. Since 2009 it is compulsory to anyone living in Germany to have a health insurance scheme (phontuis.com).

Currently, 85 percent of German's population are covered by a basic health insurance plan provided by the statute, which provide a standard level of coverage. The statutory health insurance is funded by combination of employee contributions, employer contributions and government subsidies. The government partially reimburses the costs for low-wage workers, whose premiums are capped at a predetermined value. Higher wage workers pay a premium based on their salary. Reimbursement to providers is on fee for services basis; however the amount to be reimbursed for each service is determined retrospectively to ensure that spending targets are not exceeded. Co-payments were introduced in the 1980s in an attempt to prevent over utilisation of health care services and control of cost.

Despite attempts to contain costs, overall health care expenditures rose to 10.7% of GDP in 2005, comparable to other Western European Nations, but substantially less than that spent in the U.S. (nearly 16% of GDP), (Borger, Smith & Truffer, 2006).

Germany has two main types of health insurance system - the law enforced health insurance or public health insurance and private health insurance. About 87.5 percent of people with health insurance are members of the public system while 12.5 percent are coverage by private insurance. Under the statutory health insurance, all insured persons have fundamentally the same entitlement of health care benefits. The scope of benefits is regulated in German Social Law-Social Insurance Bill Five (Sozialgesetzbuch V - SGB V). Under SGB V, benefits have to be adequate, appropriate and economic and shall not overshoot what is necessary for the insured person. Considering this background, additional benefits can only be given based on special regulations based on formal law.

Health Insurance Scheme in Thailand

The development of health insurance in Thailand started in 1975 with the establishment of the Medical Welfare Schemes for the poor and the vulnerable population. In 1980, a Civil Servant Medical Benefit Scheme (CSMBS) was introduced for government employees, retirees and dependants (spouses and up to 3 children under 18 years of age). The CSMBS was managed by the Ministry of Finance and tax funded with fee-for-service provider reimbursement model. In 1983, a Voluntary Health Card Scheme (VHCS) was introduced to further expand coverage to the poor (Agyepong, 2013).

In 1990, the Social Security Scheme (SSS) was introduced as a classical Social Health Insurance Scheme for the private formal sector employees. This Social Health Insurance Scheme was Ministry of Labour managed and payroll tax

funded with an inclusive capitation contract model for provider payment. Though these multiple schemes increased insurance coverage in Thailand, they could not provide universal coverage, and by year 2000, thirty percent (30%) of the Thai population remained without any type of insurance coverage.

With a great deal of popular support, the Thai government passed the National Health Security Act in 2002. The Act established a Universal Coverage Scheme (UCS), which has since become one of the most important social tools for health systems reform in Thailand. The UCS was introduced under a popular slogan of the '30 Baht scheme'. The 'thirty Thai Baht' is approximately one US dollar. Under that scheme, subscribers did not pay any premium or registration fee. All they had to do was to go to a health clinic in their district of residence, and present an evidence of their Thai membership such as the national identification cards to get an insurance card issued.

Any time they needed to use health services, they present the insurance card at the clinic serving their district, paid an initial 30 Baht and then all treatment for that illness was free regardless of the cost of the service. Since October 2001, the UCS or '30 Baht Scheme' has combined the previous Medical Welfare Scheme and the Voluntary Health Card Scheme to further expand coverage to an additional 18 million people (Joanne, 2012).

The benefits package is a comprehensive health care package that ranges from health prevention, primary health care, and hospitalisation due to traffic accidents, renal replacement therapy and access to ART treatment for HIV (Bangkok, 2013). The scheme is financed solely from general tax revenue. Public

hospitals are the main providers, covering more than 95 percent of the insured. About 60 private hospitals joined the system and registered around four percent of the beneficiaries. The Baht 30 co-payment was abolished by the government in November 2006, and the system is now totally free of charge.

Currently, Thailand is the only lower middle income country that has virtually achieved universal health insurance coverage covering 99 percent of the population. Achieving a coverage rate of 99 percent is more than a just meeting a national objective; it represents a source of inspiration to other low and middle income countries such as Ghana. The universal coverage scheme in Thailand has contributed significantly to reducing instances of catastrophic health care expenditure, especially in impoverished areas in the country which is not the case of health insurance in Ghana. Based on the recent evaluation of the ten years of the scheme in Thailand, the number of impoverished households dropped from 3.4 percent to 0.8 percent between 2006 and 2009, thus contributing to poverty reduction, building greater financial stability to vulnerable household and improving long-term livelihood security (Bangkok, 2013). The scheme has improved life of household of Thai citizen with their life expectancy at birth now at 74.1years, maternal mortality rate at 48 per 100,000 live births and under five mortality rates at 6.5 per 1,000 live births (Gruber, Hendren & Townsend, 2012; Agyepong, 2013).

The general perception of Thailand's UCS is that there is clear indication of success in the implementation of the scheme. The UCS, has led to significant increase in government health spending and a marked decline in out of pocket

expenditure on health and, more importantly, the rich-poor gap in out of pocket payment has been eliminated. Moreover, the UCS has improved equity of health service utilisation and prevented medical impoverishment (Joanne, 2012).

Health Insurance Scheme in Rwanda

Rwanda upon gaining independence in 1962 from Belgium, inherited a free of charge health care policy which revealed later to be unrealistic, ineffective and unattainable. It was therefore abandoned. Apart from insurance for occupational disease and injuries for the formal sector employees, the abandonment of the system created a vacuum, leaving the entire population exposed to diverse risks, related to health without an insurance coverage. The vacuum was partially covered only with the creation of mandatory health insurance for public servants and military personnel (Kayonga, 2007).

The Rwandan vision for health care for all was supported by the Bamako initiative of 1988, which was adopted by many sub -Sahara nations and aimed to revitalised health care strategy and strengthen equity in access to health care via decentralisation to the local level. The genocide of 1994 destroyed the strides made by the government in achieving the health care vision. Rwanda was left a hollow government infrastructural, and society plagued by ill health and disease. With the advent of peace, the government began working to restructure health care into increase utilisation rates and improved overall health with free health care for all. The system of free health care for all again was under resource, which

again affected availability and quality of care, leading to the government introduction of user fees in 1994 to supplement meagre health care budgets.

A survey in 2001 by Rwanda MOH found that, utilisation of primary health care declined and health outcome deteriorated, with HIV/AIDS and other infectious disease burden on the rise due to high user fees for primary, secondary and tertiary level care. To increase the utilisation and improve health outcome, the Ministry of Health initiated a pilot community based insurance known in Rwanda as *mutuelles de santé or* simply *mutuelles*. The mutuelles are state-community based health insurance organisations that offer voluntarily, non-profit health insurance for the rural and the informal sector of the economy, which include the majority of the poor in Rwanda.

Rwanda health insurance policy is guided by the principle of equity, risk sharing and solidarity which means the cost of illness for the sick are shared by the healthy and the cost of illness for the poor are also shared by the wealthy Rwandans; the principle of ownership, empowerment and participation which is, the government partners the grassroots institutions, communities based and Non-Government Organisations; principle of universality and quality that is each person benefit from health services of high quality regardless of his or her socio professional activities, social status and level of contributions (MOH, Rwanda, 2010).

According to MOH, approximately, 50 percent of the mutuelle funding is comprised of annual membership premium. Households pay annual premium of 1000 Rwandan francs equivalent to two US dollars per person. The remaining

funding is obtained from charitable organisations, NGOs, development partners and the government of Rwanda. Beneficiaries of Rwandan CBHI are entitled to all preventive and curative services provided by the health centre which form the minimum benefit package, all curative care provided by district hospital as supplementary package and curative services provided by national referral hospital also as supplementary package. Fee-for-service is the payment mechanism adopted in reimbursement of claims submitted by health care providers. At the end of 2009, the health insurance policy in Rwanda has achieved coverage of 92 percent from 7 percent in 2003 (MOH, Rwanda, 2010).

One critical success factor of Rwanda health insurance scheme is the strong community orientation or involvement in the programme. There is a general perception that the health status of the people of Rwanda has improved due to implementation of the mutuelles. The less than five mortality rates have declined from 152 to 132 per 1000 in 2010. The life expectancy has improved from 47 year to 52 years according to the ministry of health. Some major challenges the scheme faces are; although the CBHI scheme provides a comprehensive benefit package, the availability and completeness of products to communities and services for treatment at a partner health centres need to be improved. Co-payments at the district and referral hospital seem to remain a burden for the people (MOH, Rwanda, 2010).

Health Care Financing in Ghana

The issue of health care financing in Ghana has travelled a long winding road from colonial times through the First Republic under Osagyefo Dr. Kwame Nkrumah through the "Cash and Carry" era under the Provisional National Defence Council (PNDC) and the National Democratic Congress (NDC) governments both under former President Jerry John Rawlings to the present health insurance regime of health care financing promulgated under the New Patriotic Party (NPP) under former President John Agyekum Kufour, and still seeking refinement under the NDC government to meet the aspirations of Ghanaians (NHIA, 2011).

Under the First Republic, from 1950s to up to 1966, healthcare financing was virtually free as was education and other social services. Financing of health in public sector was, therefore, entirely through tax revenue. The sustainability of this form of financing became questionable as the economy began to show signs of decline and there were competing demands on the same source.

The economic stagnation in 1972, led to the introduction of very low out-of-pocket fees at point of service use in the public health sectors to discourage frivolous use of health care services. The decline in Ghana's economy led to a widespread shortage of essential medicines, supplies and equipment, and poor quality health care in the health sector. In 1983, the PNDC government adopted a traditional IMF and World Bank Economic Recovery Programme (ERP). Under ERP, the government was tasked to remove subsidies on goods and services. In 1985, the public sector user fees for health care services were raised significantly

as part of the structural adjustment policies and became known as the 'cash and carry'. The aim of the 1985 user fees was to recover at least 15 percent of recurrent expenditure for quality improvements. The financial aims were achieved, shortage of essential medicines and some supplies improved, however, these achievement were accompanied by inequalities in financial access to basic health care and essential services. The cash and carry system of health care financing survived until 2004 when the present health insurance system came into being (MOH, 2004; NHIA, 2011).

Historical Context of Health Insurance in Ghana

The first Community Health Insurance (CHI) scheme in Ghana was the Nkoranza Health Insurance Scheme which was started by Saint Theresa's Catholic Mission Hospital in 1992. It proved popular and endured the test of time. By the end of 2004 the Nkoranza scheme had enrolled nearly 30 percent of the district population (Atim & Sock, 2000). In the 1990, a unit was created in the Ministry of Health (MOH) to establish a national health insurance scheme as an alternative to cash and carry system. The unit focused its effort and resources on consultancies and feasibility studies for a pilot Social Health Insurance (SHI) scheme for the formal sector and organised groups such as cocoa farmers in the Eastern Region.

By 1999, the proposed SHI pilot had died a stillbirth without ensuring anybody. No public acknowledgement or explanation was given for the demise, however, it appeared to be partly related to lack of leadership, consensus and

direction in the MOH as to the way forward, as well as failure to sufficiently appreciate the difficulties of implementing centralised social health insurance in low-income developing country. Following the demise of the Eastern Region pilot, the Social Security and National Insurance Trust (SSNIT) started planning for another centralised health insurance scheme to be run by a company called the Ghana Healthcare Company (GHC). Like the Eastern Region pilot, it never took off despite some public expenditure on personnel, feasibility and software (Atim, Grey, Apoya, Anie & Aikins, 2001).

In 1993, UNICEF funded exploratory research on the feasibility of district-wide Community-Based Health Insurance Scheme (CBHIS) for the non-formal sector in Damgbe West, a purely rural district with subsistence economy and wide spread poverty (Arhin, 1995). The study showed enthusiasm among the community members for the concept of CBHIS. A pilot CBHIS was planned in the same district with MOH finance for scheme design and implementation, and European United (EU) finance for monitoring and evaluation (Agyepong, 2006).

Several other CHI schemes, popularly called Mutual Health Organisations (MHO) also sprung up in Ghana in the same year-2000. Many were sponsored by faith-based organisations. Development partners that played major role in their support were Danish International Development Assistance (DANIDA) and Partnership for Health Reforms plus (PHR-plus) - an organisation funded by the United States Agency for International Development (USAID). These two organisations also jointly supported the development of training manual for administrators and governing bodies of MHO (Atim & Sock, 2000). Many of the

MHOs were in the Brong Ahafo and Eastern Regions. As at 2003, the CBHIS and MHO had covered only one percent of the country's population, leaving many uncovered against high health care costs (Sulzach, Garshong & Owusu-Banahene, 2005).

National Health Insurance in Ghana

The National Health Insurance Scheme was introduced in 2003, by the National Health Insurance Act, 2003, Act 650 with the view to improving health care access to Ghanaians, especially the poor and the vulnerable. The then system of out-of-pocket payment for health care at the point of service delivery popularly known as 'Cash and Carry' was posing a financial barrier to health care access. The 'cash and carry' system makes it obligatory for patients to pay money immediately before or after treatments. The 'cash and carry' was not within the means of most Ghanaians, and as such many were not utilising health care services. This resulted to treatment with orthodox medicines or self-medication, late attendance to clinics and hospitals and avoidable deaths among Ghanaians.

The New Patriotic Party, under former President John Agyekum Kufour took a decision in establishing a national health insurance scheme in 2003 to replace the cash and carry system as a way of ensuring equitable and universal health care for all residents of Ghana irrespective of their socio-economic background. The national health insurance scheme then became fully operational in all the districts in Ghana in the year 2005 (MOH, 2004; NHIA, 2011).

Health Insurance Legislation

Adequately enforced legislation is regarded as a fundamental prerequisite for the delivery and improving health care services. Since 2003, there has been a landmark strategy developed in line with health insurance in Ghana. The two pieces of legislation that are the legal framework necessary to facilitate the establishment of the National Health Insurance Law in Ghana are the National Health Insurance Act, 2003, Act 650, and the National Health Insurance Regulations, 2004, Legislative Instrument (L.I.) 1809. The NHI Act, 2003, Act 650 has been amended by new NHI Act 2012, Act 852.

The Act establish a National Health Insurance Authority (NHIA) to implement a National Health Insurance Scheme (NHIS), establish a National Health Insurance Fund (NHIF) to pay for the cost of healthcare services to members of the scheme, establish a private health insurance schemes, and to provide for related matters. The revised law also streamlines the operations of the scheme and provides a unified NHIS with district offices instead of fragmented NHIS, (Republic of Ghana, 2012).

Principles underlying the Design of National Health Insurance in Ghana

The health insurance has been designed with the aim to offer healthcare access to the poor and the vulnerable in society. Thus the design took into account the following principles:

Equity

This implies that everybody has access to the minimum benefit package irrespective of ones' socio-economic background. This means that everybody should have the opportunity to join a health insurance scheme, thus health insurance should be at the door steps of every resident in Ghana. Also health insurance should be available all the time so that subscribers are not denied access to health care when they needed it.

Cross-subsidisation

the design of the scheme should be such that contribution in the informal sector is based on the ability to pay. In this case the rich will pay more while the poor pay less. Also, it ensures that all persons contribute and not only who have high risk of falling ill joined the scheme.

Quality of care

The main tenet of quality care is value for money. When clients perceived health services used as value for money their propensity to utilise health care increases. Perceived quality of care is also linked to health care access as poor quality of care is a barrier to access (MOH, 2004).

Solidarity

This is a desire virtue in social health insurance. The purpose of health insurance in Ghana is to remove financial barrier to health care access which ultimately will impact on health status of the population. It is important to note that our individual health status is interlinked especially when dealing with communicable diseases which are the main causes of morbidity in this country.

To be free of such disease one has to help his or her neighbour who happens to have been afflicted with a communicable disease in order to get rid of these diseases in most cases. The vulnerable groups are the poor, children and the elderly. These groups need the support of the rest of the population in terms of health care access.

Efficiency

This is vital in collection of contributions and administration of claims. There are two issues relating to efficiency. The collection of contributions is vital for building a sustainable fund for the social type of health insurance in the country. Another issue is about how fast the system would reimburse service providers since they depend very much on internally generated funding to complement government regular budgets.

Sustainability

This is essentially about how well the schemes are managed, especially in the area of risk management and fraud control.

Partnership

With the government is key to the sustainability of the scheme based on the fact that as a pro-poor scheme, government will be required to provide central fund to bridge the gap that may result from the expected contribution level and the actual contribution as well as payment of contribution on behalf of the poor, children under 18 years, pregnant women and the aged (MOH, 2004).

Types of Health Insurance Schemes in Ghana

The Act establishes three main categories of health insurance in Ghana. They are the nation-wide health insurance scheme known as the National Health Insurance Scheme, private commercial health insurance scheme and the private mutual health insurance scheme. Aside the nation-wide health insurance scheme, the remaining two schemes shall be registered under the Companies Act 1963, Act 179 as either a company limited by guarantee or liability as the case may be. There is no restriction on the number and type of scheme that one can join, however Act 852 mandates all residents of Ghana to belong to the National Health Insurance Scheme.

Funding of the NHIS

Health insurance as a funding mechanism replaces out of pocket payment at point of health service use. General tax revenue continues to be used for funding of health services as in the past through 2.5% levy on selected goods and services. The 2.5% tax on goods and services known as the National Health Insurance Levy (NHIL), is by far the largest source, comprising about 70 percent of the total revenue to the National Health Insurance Fund (NHIF). Workers who are in the formal sector and contribute to the Social Security and National Insurance Trust (SSNIT) contribute 2.5% of their monthly contributions to SSNIT into the NHIF. The social security contributions into the NHIF also accounts for about 23 percent (NHIA, 2011).

Like all insurance schemes, different types of premiums are available under the country's NHIS for the non-formal sector. Ghanaian contributors are grouped according to their levels of income. Based on the group a Ghanaian contributor may fall in, there is specific premium that ought to be paid. This was done since the socio-economic condition of contributors is not the same and the contributions was to be affordable for all to ensure that nobody is forced to remain in cash and carry system. People in the non-formal sector thus pay between Seven Ghana Cedis Twenty Pesewas (GHC 7.20) and Forty Two Ghana Cedis (GHC 42.00) as premium per the Act 650. However, pregnant women, core poor, indigents, persons above 70 years of age and children under 18 are exempted from paying any premium into the fund (MOH, 2004).

The premium from the non-formal sector accounts for about five percent of the funding. Another source of funding to the NHIS is funds from donors, investment returns, and government allocation which accounts for two percent of the total funding.

Provider Payment Mechanism under NHIS in Ghana

A fee-for-service type of provider payment mechanism was used for paying health care providers initially. Under the fee-for-service, providers are paid according to the number of services provided. For example consultations, consumables, laboratory test, drugs and number of hospital days. But this was replaced with the Ghana Diagnostic Related Groupings (GDRGs) in April; 2008.The reason for the replacement was that the fee for each service was found

to be low and hence unattractive, especially for the private providers to participate. Providers are encouraged to participate in the NHIS, in order to reduce congestions and delays for clients when seeking health services. With the fee- for- service, providers were also required to submit detailed information on all services and charges for claims submissions. This involves a lot of paperwork which providers were not happy with. Hence the GDRGs were introduced to help remedy some of these issues (Akuamoah, 2012; NHIA, 2012; NHIA, 2013).

Currently, the NHIA has experimented capitation as another payment mechanism in the Ashanti Region of Ghana, to test its feasibility for nationwide roll-out, along-side the G-DRGs. Capitation is a payment mechanism, where a pre-determined fixed rate is paid to providers to provide a defined set of services for each individual enrolled with the provider for a fixed period of time.

Minimum Benefit Package

The government came out with a minimum benefit package of diseases which the scheme was to cover for residents in Ghana. This package covered about ninety five percent (95%) of diseases in Ghana. The package covered outpatient services such as consultations, diagnostic testing and surgical operations like hernia repairs, incisions and drainage, inpatients services, including special care, surgeries, hospital accommodations (general wards); oral health services; all maternity care services, including caesarean deliveries; eye care services, including eye lid surgery, and finally all medicines on the NHIA Medicines List. The NHIA package excludes some cancer treatments (other than

breast and cervical cancer), organ transplantation, and dialysis for chronic renal failure, cosmetic surgery, assisted reproduction and HIV antiretroviral drugs (MOH, 2004; NHIA, 2011).

The Benefit of Health Insurance Scheme

If one registers under any of the schemes, the fellow will be given a card after waiting for at least three months. The card can be used to seek treatment in any accredited health facility in the country without paying any money, unless one ask for an extra services which are outside the minimum benefit package. The medical bills are then sent to the scheme office which then pays the money to the health facility after vetting the claims (medical bills). The NHIS cards can also be used to buy prescribed drugs free of charge at NHIS accredited pharmacies or chemical stores that will latter contact the scheme for reimbursement.

Health Status of Ghanaians

According to a report released by United Nations Population Fund in June 2011, the health status of Ghanaians is improving with the implementation of the NHIS policy and also an attempt by government in achieving the Millennium Development Goal 4 – Reducing child mortality and Goal 5- improving maternal health. In 2010, the maternal mortality rate per 100,000 births in Ghana was 350. This is compared with 409.0 in 2008. The infant mortality rate, per 1,000 births is 72. The lifetime risk of death for pregnant women is 1 in 66. Life expectancy of Ghanaians in general is 64 years (UNDP, 2011).

In spite of the improvement, the health status of many Ghanaians is still poor as compared with industrialised countries, and other middle income countries such as Thailand which has a population of about 69.5 million but has managed to achieved universal health insurance coverage and has an average life expectancy of 74.1 years and infant mortality rate of 11 per 1,000 births as at 2010. Also there is high prevalence of preventable infections and parasitic diseases and poor nutritional standard. The inequality of health status between urban and rural areas and the different regions of the country which existed decades ago is still prevalent today.

The New Legal Regime - NHIS Act 2012, Act 852

The review of the legal framework is to deal with structural challenges in the NHIS. The new governance framework for the administration of the scheme is now NHIS Act 2012, Act 852 instead of the previous NHIS Act 2003, Act 650. Under the new law, the 147 District Mutual Health Insurance Schemes (DMHIS) have become consolidated, and are now unified NHIS. The consolidation rectifies the situation where the schemes operated as 147 autonomous entities limited by guarantee with their own individual Boards and the inherent administrative and other difficulties that entailed, such as the lack of accountability.

Some provisions under the new NHIS Act are:

- A mandatory NHIS
- A unified NHIS with District Offices instead of the fragmented NHIS
- Premium exemptions for people with Mental Disorders

- Expenditure cap of 10 percent on non-core NHIS activities
- Relevant family planning package
- Ambiguity between the roles of the Board and Management refined

Perceptions of NHIS

The main mandate of the NHIS programme was to remove the financial barrier that residents in Ghana face in accessing health care. Thus the scheme seeks to grant residents in Ghana financial access to health care, therefore under no circumstances should financial constraints be a barrier to health care access.

Since the inception of the NHIS, many studies have been carried out on the willingness and acceptability of the NHIS, the determinant of enrolment into the NHIS, perception and experience of providers and clients on NHIS among others. In a study into household perceptions and their implications for enrolment in the national health insurance scheme, Jehu-Appiah, Aryeetey, Agyepong, Spaan & Baltussen (2011) found an increased in health service utilisation and improvement in health of Ghanaian. However, the premium paid had been a barrier to most people in enrolling and renewing their membership with the scheme. Clients over waiting to get registered, delays associated with NHIS cards production and distribution were also identified under the study as preventing people to accessible health care.

Again, medicines on NHIA's medicine list are being sold to members, whilst some providers deliberately prescribe outside the medicine list to cause NHIS cards bearers to still buy these medicines even though alternatives are on

the medicine list that should have been given them free of charge. Similar findings were reported by Dalinjong & Laar (2012) in a study on perceptions and experiences of health care providers and clients in two districts in Ghana, where delayed in reimbursement of claims has caused some providers to prescribed drugs to clients to buy and even turned away clients from facilities. Again, a study by MyCare on engaging clients in monitoring health care and health insurance at Fatima Clinic in the Jomoro district revealed that, although NHIS is delivering on what is promised, the instances of non-availability of drugs at the health facilities was on the high side. All these issues create the impression that the NHIS has not created the financial access to health care as it was supposed to do, thus create a great challenge to management of the scheme and other authorities to address.

The NHIS Act 2013, states that the NHIA may 'ensure that health care services rendered to beneficiaries of the schemes by accredited healthcare providers are of good quality'. Quality is however a multi-dimensional phenomenon. Satisfaction is a judgment that a product or service feature, or the product or service itself provided or is providing a pleasurable level of consumption related fulfilment. Satisfaction to quality of healthcare is consumers' view of services received and the result of the treatment (Oliver, 1997). The quality of care that patient received does not depend only on clinical services provided by physicians but on all services provided by auxiliary workers as well. There is an indication that clients do what is termed as 'doctor shopping or provider shopping', whereby clients hop from one health care provider to another with the same illness.

The incident of clients visiting multiple providers shows that they are less satisfied with quality of care expected from these providers. This study, however, sought to specifically examine the perception of clients on the national health insurance scheme in Jomoro district of western region of Ghana.

Conclusion

Establishing a social health insurance system takes time. Countries like Germany have taken a century to reach a universal coverage through this route. The National Health Insurance Scheme of Ghana which was established just a decade ago is underscoring its social protection credentials. It has been credited with improvements in the health care seeking behaviour of many people who now tend to seek medical attention earlier than before. The scheme currently caters for about nine million active subscribers. In the relatively short period of its implementation, the NHIS has gained international recognition.

In spite of the above, it is important that the scheme is monitored and the challenges and negative perceptions facing it is openly debated and addressed. The challenges of perceived poor quality of services rendered by both the health care providers and district schemes, financial sustainability of the scheme and the like cannot be undermined in achieving the equity and the universal coverage goals. Satisfaction surveys or clients' perceptions are main source of feedback from clients about health care services and as such they inform decision and stimulate proposal to restructure service delivery and can be used to evaluate the effect of policy change such as the National Health Insurance Scheme.

CHAPTER THREE

METHODOLOGY

Introduction

The chapter discusses the research methodology that was employed in the study. It described the study areas, the research design, the study population, sample and sampling techniques used in the data collection, data collection procedure, type and source, how data are analysed and presented, and ethical consideration of the study.

Study Area

The study focused on NHIS in Jomoro district in the South Western part of Western Region of Ghana. The district is located between latitude 04^{o}55N and longitude 02^{o}15-024W and is bounded to the West by La Cote d' Ivoire, Ellembele District on the East, Wassa Amenfi and Aowin Suaman Districts in the North, and the Gulf of Guinea to the South. The district capital is Half Assini. Jomoro district covers an area of an about 1,344 sq. km. with coastal vegetation being cashew, mangrove swamp. The climate condition is classified as equatorial with mean annual temperature, air pressure, humidity fluctuating throughout the year. Two main rainy seasons are experience within the year- from April to July and September to November while December to March being the dry season. Most of the citizens are farmers and fishermen.

According to the Ghana Statistical Service (2010), the district has a population of 150,107 and an annual growth rate of 2.5 percent. The district has

about 60 communities. The communities in the district are grouped into six zones. They are Newtown zone, Half Assini zone, Tikobo 1 zone, Beyin zone, Elubo zone and Samenye zone. The scheme operates in all the communities and has a total active membership of 55,239 representing 36.86% of the district population as at September, 2013.

Research Design

Research design is the overall plan for collecting data in order to answer the research questions and also the specific data analyses techniques and method that the researcher used. It denotes all the stages and the processes involved in reaching the respondent (Twumasi, 2005).

The method used for this study was the descriptive survey. The descriptive strategy is used to obtain a snapshot or a description of a specific group of individuals and thus described individual variables as they existed naturally. The descriptive research strategy was considered the most appropriate design for conducting the study, since it is one that answers questions concerning the current state of the individual variables for a specific group of individuals. The descriptive survey enabled the researcher to gain some insight into the data collected from the sample of the population on the perception of clients on the NHIS in Jomoro District.

Study Population

Population refers to the complete set of individual (subjects), objects or event having a common observable characteristic in which the researcher is interested. It involves all members of a defined category of elements that are of interest to the researcher. The study was conducted in the Jomoro District, and therefore, the members of the district scheme constitute the sampling universe for the study. The sample population for the study was made up of the 55,329 membership of the scheme. The sampled groups were used by responding to items of the instrument of the study.

Sample and Sampling Procedure

The researcher used both probability and non-probability sampling for the study. The probability sampling involved some form of random selection in choosing the communities from the zones or strata and the respondents from the communities. Thus every member of the population had an equal chance of being selected to be part of the sample of the study. The sample size for the study was made up of 25 clients from each of the six stratum/zones in the Jomoro District adding up to 150 respondents.

Stratified and simple random sampling techniques were also used for the study. The stratified sampling technique was used to group the communities into six strata or zones in line of their proximity. Each stratum or zone consisted of 10 communities. The stratified technique gave opportunity to every community in

the district to be under a stratum or zone leading to the possibility of its members being selected for the study. The communities in each stratum are listed below:

Stratum 1: Newtown, Efasu, Mangyea, Mpeasem, Boakwaw, Jaway, Jaway Wharf, Enzemetianu, Anlomatuope and Metika.

Stratum 2: Half Assini, Ekpu, Atwebanso, Edobo, Ahobre 1, Ahobre 2, Egbazo, Takinta, Aduasuazo and Old Kabenlasuazo.

Stratum 3: Tikobo 1, Ellenda, Nuba, Allowulley, Bonyere, Ezinlibo, Nawule, Ndumsuazo, bonyere Junction and New Kabenalsuazo.

Stratum 4: Beyin, Ekebaku, Old Nzulezo, Ngelekazo, Kengen, Elloyin, Twenen, Agyeza, Allengezule and Ehoaka.

Stratum 5: Samenye, Bawia, Mpim, Tikobo 2, Nvellenu, Ebonla, Azuleti, Mpataba, Nzulezo and Tweakor.

Stratum 6: Elubo, Cocotown, Anwiafutu, Kwabre, Ankasa, Amokwaw, Sowodadzem, Ghana Nugua, Dogye and Fawoman.

The simple random sampling technique also was used to draw five communities from the ten communities under each stratum. In choosing the five communities from the stratum, all the 10 communities were numbered from 01 to 10. The numbers were then written on pieces of papers, folded and put into container. An assistant was blindfolded and asked to pick the folded papers one after the other till five papers were picked. The communities that corresponded with the picked folded paper were chosen as sample community. The respondents were then drawn from the target communities. The target communities in each of the stratum are also as follows:

Stratum 1: Newtown, Efasu, Jaway Wharf and Metika;

Stratum 2: Half Assini, Edobo, Ahobre 2, Egbazo, and Takinta.

Stratum 3: Tikobo 1, Bonyere, Ezinlibo, Nawule and Nuba.

Stratum 4: Beyin, Elloyin, Twenen, Agyeza and Ehoaka.

Stratum 5: Samenye, Mpim, Tikobo 2, Azuleti and Mpataba.

Stratum 6: Elubo, Cocotown, Kwabre, Ankasa and Sowodadzem.

Table1: Questionnaire Distribution and Collection

Zones	Questionnaire Issued	Questionnaire Retrieved	% Retrieved
Stratum 1	25	25	16.67
Stratum 2	25	25	16.67
Stratum 3	25	25	16.67
Stratum 4	25	25	16.67
Stratum 5	25	25	16.67
Stratum 6	25	25	16.67
Total	150	150	100

Source: Fieldwork, 2013

The convenience non-probability sampling technique was used to draw 25 clients from each of the six targeted strata This gave a total sample size of 150 respondents. This technique was considered appropriate because the respondents were chosen in the target communities based on their availability and willingness to respond to the questionnaires. The researcher in order to avoid the data being flawed, ensured all participants that responded to the questionnaires were really registered members of the scheme. The respondents were chosen during a visitation to the target communities. There was a brief introduction by the researcher and the purpose of the study, the client after accepting the proposal to

be interviewed, was then asked to respond to the questionnaires. The process was followed till the five respondents needed in a target community were obtained.

Data Collection Instrument

Data collection instruments according to Agyei and Boadu (2007) are the tools used to record data or information that will be guided by a particular method. In other to obtain the relevant information for the study, a set of questionnaire was used as the instrument for the study. The questionnaires were made up of open and closed–ended questions. The questionnaires were self-administered, however due to the low literacy rate in the Jomoro District most clients were assisted in responding to the questionnaires.

In order to supervise and control the questionnaire among the illiterate clients, the researcher used personal interview with the questionnaires to elicit response from the clients. The respondents were made to express their views on the open-ended questions in the questionnaire so as to make the data more valid and reliable. Also, in order to make sure that some of the responses made by the respondents during the interview with regard to the services and relationship that exist between district scheme staff, health care provider and clients were true, direct observation was undertaken at the health insurance office and some of the health facilities where the clients visit for medical attention.

Data Collection Procedure

Due to the scattered nature of the communities in the various stratum and the desire of the researcher to cover as many clients as possible to make the data more reliable, two people were employed to assist in the data collection process. Prior to the administration of the questionnaire, the data collection assistants were given some training to ensure standardisation of procedure. They were also taken through the questionnaire and steps involved in conducting the survey. A total of 25 clients were selected from six stratum out of the five communities in each stratum. As a result, 150 clients were selected from 30 communities in the district.

A period of two months was used to collect the data. This was from December, 2013 to January, 2014. There was personal interaction with the clients. The personal interaction resulted in a high answering rate. The survey was carried using structured questionnaire. Data was gathered on age, gender, occupation, education, insurance membership status and perception on the insurance policy. For this study, the clients are the insured member who have registered and have paid full premium, irrespective of whether they are awaiting or holding NHIS cards. The clients also covers those who have registered but have not paid any premium and those whose cards have expired and are yet renew their membership with the scheme. The responses were recorded and analysed.

Data Analyses and Presentation

Data analysis according to Twumasi (2005) is a critical examination of material in order to understand its parts and relationship and to discover trends. It

means the separation of the research data into its constituent parts. Data collected were analysed using version 16 of Statistical Package for Social Science (SPSS). The Questionnaires were examined to find out whether all the questions have been answered properly. Descriptive statistics was used to organise and summarised the entire set of scores or data into tables, frequencies and percentages. The quantitative aspect of the data was presented in the form of tables for further interpretations and analyses using the percentages. The qualitative aspect was also analysed in the form of text for easy description and interpretation. Therefore, both quantitative and qualitative methods were employed to interpret the data collected.

Ethical Consideration

Permission for the research was obtained and all participants were given informed written consent to be interviewed or surveyed. Confidentiality of data was ensured by avoiding respondents to use their names in answering the questionnaires.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

The study sought to examine the perception of clients on the national health insurance scheme in Jomoro district. A total of 150 respondents were interviewed for the study. Tables and percentages are provided to illustrate and support the findings. The chapter has been organised to reflect the data gathered at the time of the study through interviews with questionnaires and observations.

Characteristics of Respondents

It was deemed necessary to consider the background information about the respondents in the study because such information would help in determining the extent to which the data provided could be relied upon. The background information consists of gender of respondents, ages, marital status, education background, occupation, religion and household statuses of respondents.

Table 2: Sex and Age

		Age				
		< 20	21-45	46-69	70+	Total
Sex	Male	0	35			
	24	6	65			
	Female	4	44	33	4	85
Total		4	79	57	10	150

Source: Fieldwork, 2013

From Table 2, out of the 150 respondents, 65 were males representing 43 percent of the respondents and 85 were females also representing 67 percent of the respondents. These show there are more female clients than male clients in the study area. Also among the respondents, 79 representing 52.7 percent were between the ages of 21 years and 45 years, 57 respondents representing 38 percent were also between the ages of 46 and 69 years. Persons of 70 years and above among the respondents were 10 representing 6.67 percent. Again there are 77 female respondents between the ages of 21 and 69 years more than male respondents in the said age groups.

Table 3: Sex and Marital status

		Marital Status		
		Single	Married	Total
Sex	Male	24	41	65
	Female	31	54	85
Total		55	95	150

Source: Survey Data-2013/2014

Findings from Table 3 indicates, out of the 150 respondents, 95 representing 63.3 percent were married. Among the marital status, 54 of the respondents were female and 41 are males. The results also depict that 24 of the respondents were male while 31 were female who were single. From the findings, more respondents on the scheme were married 95 against 55 who were not married.

Further analysis of the results indicates that the average occupation of the respondents are fishing and farming since they represent 48.7 percent of the total respondents. This may mean that the incomes of the clients in the study area are on seasonal basis which in one way or the other may affect the registration and renewal of their NHIS memberships.

Table 4: Sex and Educational Background

		Educational Background				
		None	Primary	Secondary	Tertiary	Total
Sex	Male	21	18	16	10	65
	Female	39	18	22	6	85
Total		60	36	38	16	150

Source: Fieldwork, 2013

On educational background, 60 respondents representing 40 percent of total respondents had no formal education, which may have effect on how they perceive or view things in general with respect to the scheme, as compared to the 90 of the respondents, representing 60 percent who have passed through some form of formal education. An analysis of the sex and educational backgrounds showed that more female respondents do not have formal education than male respondents as shown in Table 4.

Table 5: Sex and Household Head

		Household Head		
		Yes	No	Total
Sex	Male	61	4	65
	Female	35	50	85
Total		96	54	150

Source: Survey Data-2013/2014

Again, 96 respondents representing 64 percent are heads of the various households. Almost all the male respondents in the study group head the various household. Among the female respondents, 35 of them are also the head of the various households. This in other words may mean majority of the clients in the study are having responsibilities and other commitment such as caring for a number of dependants and relatives. This may again affects clients' financial commitment to the scheme in terms of renewal of membership.

Table 6: Respondents' responses on variable with 'Yes' and 'No' questions

Variables	Resp	Freq	Percent
Satisfaction to time spent for registration	No	79	53.7
	Yes	71	47.3
	Total	150	100
Satisfaction with duration for card issuance	No	132	88
	Yes	18	12
	Total	150	100
Problem encountered during registration	No	144	96
	Yes	6	4
	Total	150	100

Table 6: Continued	No	44	29.3
Annual renewal of membership			
	Yes	106	70.7
	Total	150	100
Satisfaction with time spent for renewal	No	59	39.3
	Yes	91	60.7
	Total	150	100
Problems encountered with renewal of cards	No	112	74.7
	Yes	38	25.3
	Total	150	100
Easy access to scheme office	No	105	74.7
	Yes	45	25.3
	Total	150	100
Satisfaction with NHIS benefit package	No	119	79.3
	Yes	31	20.7
	Total	150	100
Easy access to health facility	No	27	18
	Yes	123	82
	Total	150	100
Diagnosis and examination of NHIS holders	No	14	9.3
	Yes	136	90.7
	Total	150	100
Provision of drugs after diagnosis	No	81	44
	Yes	69	56
	Total	150	100
Co-payments/purchase of drugs outside facility	No	52	54
	Yes	98	65
	Total	150	100
Treatment of illness on NHIS benefit package	No	50	33.3
	Yes	100	66.7
	Total	150	100
Discrimination of NHIS against cash & carry	No	101	67.3
	Yes	49	32.7
	Total	150	100

Table 6: Continued

NHIS helps in improving health status	No	0	0
	Yes	150	100
	Total	150	100
NHIS reducing financial barrier to health care	No	0	0
	Yes	150	100
	Total	150	100
NHIS providing equal access to basic healthcare	No	0	0
	Yes	150	100
	Total	150	100
Recommendation of NHIS to uninsured	No	0	0
	Yes	150	100
	Total	150	100

Source: Fieldwork, 2013

Clients' accessibility to the scheme office has been captured in Table 6. While 30% of the respondents said they can easily access the scheme office, the remaining 70% said the scheme office is far from their community. High transportation cost to the scheme office was cited by the clients as reason why the scheme was not easily accessible. A further investigation to respondents who said the office was not accessible shows that most of such clients often rely on the services of the agents for the renewal of their cards because it cost them much to travel to the scheme office. A client during the interview said it costs her twenty Ghana cedis (GHC 20.00) on transportation alone to reach the scheme office to renew a card which only costs her twelve Ghana cedis (GHC12.00). Others also said the inaccessibility of the office was one main cause for the delayed in renewing their membership card unless they are sick.

Easy access to health facility by clients

As captured in Table 6, all clients have an access to a health facility. The district has 21 accredited facilities which provide services to patients (JMHIS, 2013). Community-based Health Primary Services (CHPS) and clinic have been cited at all vantage points in the district for easy accessibility to the public. The study revealed that, most clients attend Half Assini government hospital since it is the biggest health facility that serves the district and have most diseases on NHIS benefit package treated than the other health facilities in the district.

Coverage of NHIS

The study in quest to discover from clients if all sicknesses on NHIS benefit package are treated for free, revealed that, majority of clients themselves are not fully aware of the type of disease the scheme covers as has been indicated earlier. Clients go the clinic with a particular type of sickness and once they are treated that ends it. Some clients responded that, since they are not aware, they rely on what the nurse in charge or the Doctor tells them. Few clients who said they are aware of the minimum benefit package indicated that, they are not satisfied with it, because the package excludes some diseases which normally affect the poor.

Again, as captured in Table 6, 98 (65%) were made to pay for some health care services and drugs which in their view were supposed to be treated or supplied free of charge. A client said she was aware that fibroid surgery and deliveries are catered for under NHIS, but she was made to pay a certain amount

of money before the fibroid surgery was done. A pregnant woman also testified that she has been paying for scan and other laboratory services anytime she visited the hospital although she was aware those services are covered by the scheme. The incidents of co-payment were not reported to the scheme office for redress, because clients have fear of being victimised by nurses.

Discrimination against NHIS holders and Cash and Carry Patients

As shown in Table 6, about 67% of the respondents said they were not discriminated in favour of cash and carry patients when they visited a health facility. Some respondents said, although they kept long at the health facility before receiving treatments that did not mean they are being discriminated against. Others said they are aware of the documentations that go into the NHIS cards processing. The remaining 32% of the respondents answered that NHIS cards holders are being discriminated in favour of the cash and carry patients.

Some testified that they have been at clinic where nurses attended to cash and carry patients than the NHIS card holders. The clients cited a reason that those cash and carry patients made upfront cash payment therefore favoured the health facilities since the health insurance claims took a longer time to be reimbursed.

Table 7: Duration of membership

Duration	Frequencies	Percentage (%)
Since inception	48	32.0
5 to 8 years	73	48.7
2 to 4 years	29	19.3
Total	150	100

Source: Fieldwork, 2014

The study aimed at determining the number of years respondents have been members of the scheme and their understanding with the NHIS policy. As shown in Table 7, 121 (80.7%) have been with the scheme for more than four years and 29 representing 19.3% have been members of the scheme for at least four years.

Table 8: Clients' understanding of NHIS policy

Understanding of NHIS	Frequencies	Percentage (%)
Prepayments towards free health care	122	81.3
Government giving free health care	28	18.7
Total	150	100

Source: Fieldwork, 2014

. This shows respondents have got some form of understanding and experiences with the scheme which will contribute to the richness of the study. More so, almost all the clients had enough understanding about the NHIS irrespective of their educational background. Most clients viewed the NHIS as prepayment made towards free health care delivery at hospitals and clinics. A few

of the respondents however viewed the NHIS as government giving free health care delivery to the citizen as presented in Table 8.

Table 9: Premium fee paid for registration and renewal of cards

Amount	Frequency	Percentage (%)
Free	20	13.3
GHC 7.20 to GHC 10.00	129	86.0
GHC 12.00 to GHC 15.	1	0.7
GHC 18.00 to GHC 36.0	-	-
GHC 42.00 and above	-	-
Total	150	100

Source: Fieldwork, 2014

The study sought to determine the amount of premium and registration fees paid for registration and renewal of cards by respondents and whether they are satisfied with the said amount. From Table 9, 129 (86 %) pay between 7.20 cedis and 10.00 cedis as premium fee for both new registration and renewal of the ID cards. The remaining 13 percent of the respondents pay no premium for the services. A further revelation on why such respondents do not pay any premium for registration or renewal of their cards, revealed that majority of them are pregnant women who enjoyed the government policy on free maternal health care delivery and persons who are very poor in society and are 70 years and above.

Table 10: Perception on premium fee paid

Perception	Freq	Per (%)
Very high	-	-
High	8	5.3
Affordable	142	94.7
Total	150	100

Source: Fieldwork, 2014

Furthermore, 142 (94.7) concluded that the premium fee charged by the scheme was affordable (Table 10). A respondent said, “Paying 10.00 Ghana cedis for a year’s medical care is nothing because that amount of money cannot even provide a day’s meal for a household’’. Only eight respondents viewed the premium fees as high. This is in contrast to the findings of Jehu-Appiah, Aryeetey, Agyepong, Spaan & Baltussen (2011), that high premium was preventing clients to renewed their membership with schemes.

Table 11: Duration for Registration and Renewals of cards

Duration	Frequencies	Percentage (%)
Instantly/ less than 10 minutes	5	3.3
10 to 20 minutes	24	16.0
25 to 30 minutes	79	52.7
More than 30 minutes	42	28.0
Total	150	100

Source: Fieldwork, 2014

Duration for Registration, Renewals and Issuance of cards

The rationale behind that question was to determine the average time clients spent at the scheme office for such exercises and their satisfaction level. From Table 11, there is indication that about 79 (52.7%) spent between 25 and 30 minutes at the scheme office for both the registrations and renewals of their expired NHIS ID cards. Twenty eight respondents (42%) spent over 30 minutes at the scheme office for the same exercise. Less than five percent spent few minutes to go through either the registration or renewal of their expired cards.

As shown in Table 6, 71 representing 47.3 percent of the respondents said YES to their satisfaction with time spent at the scheme office for registration. Over 52 percent are not satisfied with time spent on such exercise at the scheme office. This implies that clients spent too much time at the scheme office to go through registration and renewal exercises.

Table 12: Waiting Period for NHIS ID Issuance

Waiting Period	Frequencies	Percentage (%)
Instantly	11	7.3
1 to 2 months	20	13.3
3 to 4 months	98	65.3
After 4 months	21	14.0
Total	150	100

Source: Fieldwork, 2014

From Table 12, 119 (79.3%) said it took clients three to four months and even more than four months to get their NHIS cards issued to them after

registration. While 13.3 percent of the respondents said the ID cards were issued between 1 and 2 months, 7.3 percent of the respondents said the NHIS ID cards were issued to them immediately after their registration. A further interaction with the respondents who said cards were issued to them instantly showed that those cards were temporary cards for only the pregnant women which were to be used for only a specific period of time, precisely three months. These categories of clients do not serve any waiting period because of the policy of free maternal care initiated by the government to curb maternal and infant mortality rate. Respondents who had their NHIS ID cards issued to them within a period of one to two months were also those clients who registered during a special mass registrations and promotional exercises organised by NHIA which then reduced the waiting period.

Again, from Table 6, 132 (88%) responded NO to whether they are satisfied with the waiting period before the NHIS ID cards are issued to them. Some respondents went further to plead for temporary cards to be issued to them while waiting for the NHIS cards. This backed the study conducted by Jehu-Appiah, Aryeetey, Agyepong, Spaan and Baltussen (2011) that clients are over waiting for their NHIS cards. From an indication, it is clear that NHIA has identified the continual delayed of issuance of ID cards to clients on time and had recently piloted in Accra a biometric registration for issuance of instant NHIS ID cards to subscribers to curtail the long time lapse between registration and issuance of the cards, while waiting to be rolled out in all district offices (Daily Graphic, 2013).

Table 13: Period Clients Renew their Membership

Duration	Frequencies	Percentages (%)
Within one month after expiration	21	14
2 to 3 months after card expiration	46	30.3
6 months after card expiration	43	28.3
Will not renew until I fall sick	40	26.3
Total	150	100

Source: Fieldwork, 2014

On yearly renewal of cards, about 70.7 percent of the respondents said they do yearly renewal of their membership as shown in Table 6. A further study showed that although majority of clients renewed their membership yearly, 30.3 percent of the respondents wait for two to three months before renewing their cards after its expiration dates, 28.3 percent renewed their membership six months after cards expiration date. About 26.3 percent of the respondents do not renew their NHIS membership until they fall sick as indicated in Table 13.

An observation to this showed that most clients visit health facilities for health care before realising that their NHIS cards have expired and then rushed to the scheme office for the renewal of such cards. Clients whose cards have expired for more than a year and above were allowed to observe additional three months as waiting period before their cards are finally renewed. This was done to curb a situation where only sick people get enrolled into the insurance policy. Clients therefore have to pay for their own medical bill within such periods which they are waiting to get their cards renewed.

Knowledge of diseases / Minimum Benefit Package

When clients were asked about their knowledge on the minimum benefit package or diseases the scheme covers, 128 (85%) answered NO to having any adequate knowledge. Some explained that they have not been educated on such package. Others narrated that they are aware of few diseases like malaria, ante natal and post natal attendance, dysentery, cough, minor accidents and some laboratory investigations. Again, 119 (79.3%) said they are not satisfied of the diseases the NHIS covers and suggested the NHIS should cover all diseases.

Table 14: Attitude and Behaviour of Scheme Staff

Attitude	Frequencies	Percentage (%)
Excellent	5	3.3
Very good	52	34.7
Good	86	57.3
Bad	7	4.7
Total	150	100

Source: Fieldwork, 2014

As shown in Table 14, about 95.3 percent of the respondents are satisfied with the attitude and behaviour of staff at the district scheme office. Only 4.7 percent of the respondents rated the attitude as bad.

Problems encountered during registration and renewal of cards

When clients were asked whether they encountered some problems or difficulties in the course of registration, almost all respondents said they did not

encounter any problem, however they re-echoed the initial waiting period before issuance of the ID cards as worrying, they have to battle with payment of medical bills anytime they have to visit a health facility. On renewals, 38 respondents representing 25.3 percent had problems during the renewal of their membership. The NHIA software application was cited as causing them much delay at the office due to its frequent downtime. Again, it is important to note that almost all clients contacted want NHIA to improve its services and ensure that NHIS cards are either issued instantly or the waiting periods reduced.

Table 15: Health facilities' staff attitude and behaviour

Attitude	Frequencies	Percentage (%)
Excellent	5	3.3
Very good	22	14.7
Good	98	65.3
Bad	25	16.7
Total	150	100

Source: Fieldwork, 2014

The study discovered that, more than half of the clients interviewed viewed the nurses and health staff attitudes as satisfactory. This is shown in Table 15, in which 5 (3.3%) responded that the behaviour were excellent, 22 (14.7%) and 98 (65.3%) responded that the attitudes and behaviour of staff were very good and good respectively. About 16.7 percent of the respondents saw the behaviour as bad. The credibility of the health system in relation to quality of care factor is a decisive factor in the way people perceive health insurance. Negative nurses'

attitude and interpersonal relationship have been a longstanding concern in public health facilities in Ghana. This has been more pronounced with increased in utilisation since the establishment of the NHIS. The negative nurses' attitudes and interpersonal relationship however had not been the situation in this study.

Diagnosis and examination of NHIS holders

The study sought to discover whether providers do good physical examination of clients before administering drugs to them. According to the study, 123 (90.7%) responded they were well examined before the administration of drugs. A client said: "I was allowed to go through the laboratory test three conservative times at Half Assini Hospital before the Doctor could finally prescribe drugs for me". However, only 14% of respondents said they were not well diagnosed. "The nurse in charge after listening to my complaints just gave me drugs without examining me further'', a respondent said.

Further to whether Nurses or Doctors provided all drug a clients needed after any diagnosis, 69 respondents representing 46% answered in the affirmative. The remaining 54 percent said not all the drugs were provided to them. They again said they were made to buy some of the drugs from the hospital itself and others from a chemical shop. An inquiry to why they were made to buy such drugs, majority of them said the facility told them such drugs are not covered under NHIS. Other reasons that were cited are; 'the NHIS owed the health facilities a lot and that the facility has no money to get drugs from medical stores; medical store has not been supplying them drug so they have to buy from a

different source which cost higher than what NHIS pays''. A respondent said he was made to buy a paracetamol syrup for his child at the clinic with a reason that the one for NHIS patient had just got finished. This confirms the study of Dalinjong & Laar (2012) where the delayed in reimbursement of claims caused some providers to prescribed drugs to clients to buy and even turned away clients from facilities. These derail the objectives for establishing the NHIS policy.

According to a report by the Deputy Director of Corporate Affairs at the NHIA, the delay to reimbursement to providers was due to providers themselves submitting their claims late and also delayed by the finance ministry to release funds for the claims payment, (Daily Graphic, 2013). "The delays, aside stifling and choking the health institutions, made it difficult for them to serve the many rural communities which required services'', Most Rev. Joseph Afrifa-Agyekum a Bishop of Catholic Diocese of Koforidua said, (Daily Graphic, 2013).

Table 16: Quality of services received by NHIS cards holders

Respondent	Frequencies	Percentage (%)
Excellent	0	0
Very good	15	10
Good	102	68
Bad	33	22
Total	150	100

Source: Fieldwork, 2014

From Table 16,102 (68%) rated the quality of services received at the various facilities as good, 10% rated the services as very good and 22% rated the

quality of service as bad. None of the respondents rated the service quality of the providers as excellent. This however calls for much concern for all stakeholders since the policy replaced the then cash and carry regime to fully satisfy the health needs of all Ghanaians.

NHIS improving health status

The study sought to discover from clients whether their health status have improved with the introduction of the NHIS. All respondents answered in the affirmative, that their health statuses have really improved. A respondent said, "The introduction of the health insurance has reduced disease burdens by making more people conscious of their health related problems". A 100% response means in spite of the challenges pertaining to the implementation and operation of the health insurance policy in Ghana; it is contributing to the well-being of most of the citizens and need to be pursued.

Again, one of the policy objectives for the introduction of the NHIS was to eliminate the financial barrier to basic health care access, particularly the poor and the vulnerable in the society. From Table 6, all the respondents again said the policy has been able to reduced financial barrier to basic health care access. In 2013 alone, the government released an amount of two million, two hundred and twenty five thousand, one hundred and twenty two Ghana cedis, twenty two pesewa-(GHC 2,225,122.22) to the Jomoro district scheme office alone for payment to service providers who rendered services to insured clients (JMHIS,

2013). This implies that the policy objective is gradually being achieved as the government has been devoting much resource into the schemes operations.

Another principle that underlined the design of the NHIS is the principle of equity, which ensures that every registered member had access to the minimum benefit package irrespective of one's socio-economic background. When clients was asked about the ability of NHIS to provide equal access to health care, again, almost all the respondents answered in the affirmative.

Comparison of Cash and Carry regime to NHIS policy

The cash and carry system- a system that makes it obligatory for everyone to pay money immediately before and/or after treatment was not within the means of most Ghanaians and that led to the introduction of the health insurance policy. The study discovered that, clients still preferred the NHIS policy than the cash and carry in spite of some challenges and frustrations they have been going through both at the scheme and the health facilities levels. Some female respondents even praised the free maternal policy which was introduced under the NHIS in the year 2007 and said; the policy has improved maternal deliveries and reduced child mortality. A respondent said, "The cash and carry increased the death rate while the NHIS has reduced the death rate''.

Recommendation and promotion of NHIS

All respondent answered YES, they will promote or recommend to a friend and relative about the NHIS. Some respondents have even gone to the extent of paying the registration and renewal fees for relatives and friends. The

study revealed that most clients have been accompanying uninsured friends and relatives to the office and the registration centres to ensure that their relatives and friends register with scheme, with a reason that they wanted to avoid situations where they will have to contribute to the medical bills of their uninsured relatives when they incidentally fall sick.

Summary

The chapter was organised to reflect the data gathered at the time of the study through questionnaires administration. Critical analysis and discussion of the data collected were made to ascertain the findings of the study. Some of the views of the respondents were organised under variables that have bearing on the research question. Tables showing frequencies and percentages were provided to illustrate and support the finding where applicable. The opinions expressed by the respondents on the study clearly revealed that clients have both positive and negative perception on the NHIS that needs attention of all stakeholders.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMEDATIONS

Introduction

This chapter presents a brief summary of the research problem, objectives, methodology and the major findings of the study. It provides conclusion drawn from the study, recommendations for improving on NHIS operations as well as suggested areas for further study. The main objective of the study is to explore the perception of clients on NHIS in Jomoro district.

Summary

The study took a look at the perception on the national health insurance scheme with a focus on clients in the Jomoro district. The method used for the study was descriptive survey using questionnaire made up of close and open ended questions. The questionnaires were designed by the researcher with the assistance of the supervisor in collecting the data from clients. The researcher used both probability and non-probability sampling procedure for the study. The questionnaires were pre-tested to evaluate the validity of the instruments used for the main research.

The study revealed both positive and negative perception about the national health insurance scheme in the district. After a critical analysis of the responses the following are the findings:

Firstly, on the positive perceptions, the study showed that NHIS is working to improve the health status of Ghanaians, reducing financial burden and promoting access to basic health care. Majority of clients were satisfied with the premium fees paid for the registration and renewal of cards. The findings also indicated that the relationship between the scheme staff and the clients was good. The inseparability characteristics in health care delivery, presents it as more of a handicap than other services because the patients literary place themselves in the hands of the sellers (nurses). The attitude of nurses and health facility staff is therefore a catalyst to quality health care delivery. The study showed that health facilities staffs' attitude to the clients was satisfactory.

There is an easy accessibility of health care by clients as the district has one district hospital, six health centres and 14 Community-based Health Primary Services (CHPS) which have been spread across the district for easy access by the public. The study also showed that all clients see the NHIS policy as much better than the cash and carry system, and are eager to promote the policy to others.

Secondly, on the negative perceptions or findings, the study identified the following: Clients long waiting times both at the point of registration, renewal of membership and the awaiting period for issuance of membership cards after registration are of great concern. The study also showed that, although clients renew their membership annually, majority renewed after the cards have expired for more than six months and more particularly when they have fallen sick. There has been a consistent drop-out in the rate of renewal of cards in the Jomoro district. The accessibility to the scheme office adds extra cost to clients'

expenditure on the registration and renewal of their membership cards through high transportation fares.

The issue of clients' knowledge on NHIS minimum benefit package is not very encouraging. Clients have not had enough knowledge about the diseases the scheme covers; this compel clients to make extra payments at the health facilities for services which should have been covered under the NHIS. There is also a finding that, the frequent delay of reimbursement of claims submitted by service providers to NHIA affects the provision of drugs and delivery of health services to clients, and this might be one of the underlying reasons for which service providers extort monies from the clients. Thus, the removal of financial barrier to health care still remains a challenge as co-payments are still practiced at some health facilities.

Conclusions

For any state policy to work as expected, it needs all stakeholders to be committed and dedicated towards the goals and objectives of such policy. The national health insurance scheme is one of the numerous state policies that every Ghanaian has embraced and would like to see to be successful because of its nature and coverage. It is also seen as one of the best social services ever provided by the state. Today, every Ghanaian talks about NHIS, its policy's goals and objectives, and whether such goals and objectives are being achieved or dwindling.

The study was set to explore clients' perception on the national health insurance scheme. This was achieved by assessing the views of clients in the Jomoro district. Although, the NHIS was seen by all participants in the study to be beneficial, helped improved the health status of Ghanaians and even seen to be much better than the former cash and carry system, there are other negative perceptions that need to be addressed. The long waiting times for registration, renewal and particularly issuance of NHIS cards need to be addressed. Also lack of accessibility to scheme office, inadequate knowledge and unsatisfied NHIS minimum benefit package and non-availability of drugs at most health facilities need much attention.

Another great challenge was the delayed in reimbursement of claims, which has caused clients to make co-payments for health services, and purchased drugs outside the health facilities. The under mentioned recommendations, according to the researcher, are the modest way forward to curb the negatives perceptions, rebuilt clients' confidence and sustain the policy in other to achieve the ultimate goal of removing financial barrier to basic health care among Ghanaians.

Recommendations

The national health insurance scheme was put in place by the government to address the problems associated with the cash and carry regime, and thus provide equal health care access to residents in Ghana particularly the poor and the vulnerable, by eliminating all financial barriers in basic health care delivery.

The main objective of the study is to explore the perception of clients on the NHIS in Jomoro district. After a thorough study into the views of clients, the researcher deems it appropriate to give recommendations for improvement in the NHIS implementation and operations. The recommendations are however based on the findings the study revealed and are as follows:

- The immediate policy required would be on the issue of the delay in reimbursement of claims by the NHIA. There is an urgent need for the government and NHIA in particular to streamline the reimbursement procedure to curb the situation where service providers turn away and or make clients to make payments for service which in normal circumstances would have been covered by NHIA had it not been the late reimbursement. An adequate and prompt reimbursement of claims is vital for the sustainability of the scheme, avoiding co-payments, and more importantly achieving the universal coverage goals under the NHIS. This is not saying that claims should not be duly vetted to avoid the overbilling and other claims fraud. The electronic-payment of claims (E-claims) which is being engineered by the NHIA must be pursued vigorously to cover all service providers to ease such delays associated with payments of claims.
- Another issue that needed urgent attention is the long waiting period for the registration and issuance of NHIS cards. The printing of the NHIS cards should be decentralised to the district scheme level or a quick implementation of the biometric membership registration system to ensure

the instant issuance of NHIS membership ID cards as publicised, since the long waiting period is causing a great deal of frustration and discomfort for almost all clients.

- The minimum benefit package which is purported to cover about 95% of diseases in Ghana needs much publicity and education among clients. The district office should make sure clients have adequate knowledge about the type of diseases the policy covers to put them on their toes to avoid situation where monies are extorted from them. During the period of registration and issuance of the NHIS membership ID cards, leaflets that contains the benefits package should be given to the clients who can read whilst those who cannot read are well educated on the package. Again, intermittent community visitations should be carried out to educate the folks about the benefit package and any other related issues.
- Furthermore, NHIA should periodically assess and reviewed the benefit package in accordance with section 30 subsection 3 of the NHIS Act, 2013, Act 852. Since some ailments do not have their drugs covered under NHIS, all drugs covered by the scheme must be made readily available in all the accredited health care facilities for effective treatments. Drugs list also should be reviewed periodically and adequately by NHIA to include drugs which are essential for health care delivery to avoid the situation where clients have to pay for uncovered drugs.
- Clients spent so much on transportation to get to the scheme office. The district scheme should decentralise its operations by providing sub offices

at various zones to enable clients have immediate access to some of the services such as the registrations, collections and renewals of NHIS cards. The scheme should also collaborate with other agencies such as the District Assembly, Ghana Health Service and the National Commission for Civic Education (NCCE) to educate clients on the need to renew ID cards immediately its expires than clients waiting to fall sick before rushing to schemes offices for renewal.

- The attitude of nurses and health facility staff is a catalyst to quality health care delivery, and the relationship an organisation creates with customers determines the goodwill of the company and the quality of its services. Although most clients perceived the services received at the health facilities as good in the district, more need to be done to improve the quality of those services and the attitude of health facilities staff. Health facility staff and nurses should be monitored to ensure they continue to behave positively towards the patients and render excellent services to build confidence of the public in the health insurance policy. It is recommended that the health professional and other paramedical staff should be periodically orientated about their code of conduct and other regulatory by the Ghana Health Service to always keep them on their toes in performing their professions so as to maintain the standard set in the district.
- The affordability of the NHIS must not be comprised. Although the premium paid in the Jomoro district is seen as affordable, not all

Ghanaians are able to afford the premium payment, it would be appropriate if NHIA widens its sources of revenue generation and investments; and the government too devotes a portion of its annual budgets to finance the national health insurance scheme, so as to make NHIS more financially sound to achieve the universal financial access to the basic health care goal. This would ensure the continual improvement of the health status of Ghanaians and therefore a nation of healthy citizens.

Limitations and Suggestions for Further Studies

This research and its findings on clients' perception on national health insurance scheme are limited in scope, and therefore are confined to clients in Jomoro District. Health care providers and NHIS management's views were not sought on those perceived views of the clients. The generalisation of the study on the perception of clients on NHIS in Jomoro District can therefore be concluded. However, the results and conclusion as well as the generalisation may not be wholly applicable in the national context because only one district out of the 147 district schemes implementing the policy was used for the study. There is a need for further study to cover a lot more districts and other stakeholders for the generalisation on the national context to be more valid. This work can therefore be considered as stepping stone for further research investigations.

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APPENDIX

QUESTIONAIRE FOR CLIENTS

UNIVERSITY OF CAPE COAST

SCHOOL OF BUSINESS

DEPARTMENT OF ACCOUNTING AND FINANCE

Dear Sir/Madam,

I am a student of the above mentioned university, conducting a study on the perception of clients on the NHIS in the district. I would like to seek assistance in acquiring information, which is of relevant to this study. I will therefore appreciate it if you could assist by responding to the following questionnaire. Information provided will be treated with much confidence.

Please tick [√] the appropriate responds where options have been provided, where there is no option, kindly give your view on the question.

Thank you.

SECTION A. Background Information

1. Gender: Male [ ] Female [ ]

2. Age: ……

3. Marital Status: Single [ ] Married [ ]

4. Educational Background:

None [ ] Primary [ ] Secondary [ ] Tertiary [ ]

5. Occupation: Fisherman/Farmer [ ] Government Employee [ ]

Student/Unemployed [ ] Self-employed/Trading [ ]

6. Religion: ……

7. Are you the head of the Household: Yes [ ] No [ ]

SECTION B. Scheme Services

I. Registration

1. How long have you been a member of the National Health Insurance Scheme?

Since inception [ ] 5 – 8yrs [ ] 2 – 4yrs [ ]

2. What is your understanding about the NHIS? ……..

3. How much did you pay as premium for the registration?

Free [ ] GH¢7.20 – GH¢10.00 [ ] GH¢12.00 – GH¢15.00 [ ]

GH¢18.00 – GH¢36.00 [ ] GH¢42.00 and above [ ]

4. How do you view or value the premium fees paid?

Very high [ ] High [ ] Affordable [ ]

5. How long did it take you to get registered? Less than 10mins [ ]

10mins – 20mins [ ] 25mins – 30mins [ ] more than 30mins [ ]

6. Are you satisfied with the time you spent during the registration?

Yes [ ] No [ ]

7. How long did you wait after registration before getting your NHIS card?

Instantly [ ] 1 - 2 months [ ] 3 - 4 months [ ] After 4 months [ ]

8. Are you satisfied with the waiting period before the NHIS cards are issued?

Yes [ ] No [ ]

9. If NO what do you think should be done about the issuance of cards? .....

10. Did you encounter any major problem during the registration? Yes [ ] No [ ]

11. If Yes what was the problem? …….....

II. Renewal

12. Do you renew your NHIS ID card annually? Yes [ ] No [ ]

13. Where do you normally renew your NHIS card? Scheme Office [ ] Agents [ ]

14. When do you normally renew your expired NHIS card? Within 1 month after expiration [ ] 2 - 3 months [ ] After 6 months [ ] The moment I fall sick [ ]

15. How long did you wait to get your expired NHIS card renewed the last time? Instantly [ ] 10 – 20 mins [ ] 25 – 30 mins [ ] more than 30 mins [ ]

16. Are you satisfied with the time you spent to renew your card? Yes [ ] No [ ]

17. Did you encounter any major problem in renewing your card? Yes [ ] No [ ]

18. If Yes what was the problem? ……

19. Is the scheme office far from your community? Yes [ ] NO [ ]

20. How does the accessibility of the scheme office affect your registration/renewal and complaint reporting? ……...

21. Do you know or have an idea about the type of diseases (minimum benefit package) the scheme covers? Yes [ ] No [ ]

22. Are you satisfied with the minimum benefit package or the diseases the scheme covers? Yes [ ] No [ ]

23. What was the staff attitude/behaviour during your visit to the Scheme Office? Excellent [ ] Very good [ ] Good [ ] Bad [ ]

24. What do you suggest should be done to improve the services rendered by the scheme? …….....

SECTION C: Services of Health Facilities

1. Do you have easy access to a health facility whenever you needed health services? Yes [ ] No [ ]

2. Which health facility in the district do you normally attend for treatment?

3. What is the attitude/behaviour of staff/Nurses at the health facility towards NHIS card holders? Excellent [ ] Very good [ ] Good [ ] Bad [ ]

4. Does the Doctor/Nurse in charge make good diagnosis or clinical examination of clients with NHIS cards? Yes [ ] No [ ]

5. Does the Doctor/Nurse in charge provide you with all the drugs you needed after any diagnosis? Yes [ ] No [ ]

6. Have you been told to buy any prescribed drugs from a health facility or any pharmacy shop? Yes [ ] No [ ]

7. What reason was cited for that? ……

8. Do the health facilities treat all illness specified in the NHIS minimum benefit package free of charge? Yes [ ] No [ ]

9. Do the health facilities sometimes discriminate against NHIS card holders and cash and carry patients? Yes [ ] No [ ]

10. If Yes, what could be the reason? …….....

11. How would you rate the quality of service rendered to NHIS card holders by the health facilities? Excellent [ ] Very good [ ] Good [ ] Bad [ ]

SECTION D: General Opinion about NHIS

1. Has NHIS policy helped in improving your health status? Yes [ ] No [ ]

2. Has NHIS policy been able to reduce the financial barrier to health care access particularly to the poor? Yes [ ] No [ ]

3. Has the NHIS policy been able to provide equal access to basic health care?
Yes [ ] No [ ]

4. How do you compare the cash and carry regime to NHIS policy?

5. Will you recommend/promote NHIS to a relative or friend? Yes [ ] No [ ]

6. What other comment about NHIS do you have? .....

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